VIRGINIA IN THE SUPREME COURT OF VIRGINIA

MICHELLE H. MITCHELL,

Appellant,

Case No.:

v.

MARK P. BROOKS,

Appellee.

**BRIEF OF BIRTH RIGHTS BAR ASSOCIATION ET AL.
AS AMICUS CURIAE IN SUPPORT OF APPELLANT
MICHELLE MITCHELL**

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STATEMENT OF INTEREST

Amici curiae ("Amici") are four organizations that advocate for maternity care that respects birthing women's legal and human rights. Amici are interested in this case because Mitchell's experience echoes that of many other women who have related to Amici that violations of the fundamental rights to informed consent and bodily autonomy are systemic and widespread in maternity care; that the violations lead to emotional and physical harms, as well as a loss of trust in the maternity care system; and that most women lack access to any meaningful system of accountability. This case's excluded testimony exposes the faulty medical foundation upon which these violations are built; correcting this error makes redress and accountability possible. This Court's decision will impact maternity care and the treatment of birthing women in the state of Virginia and, due to media attention, throughout the United States. Amici offer the Court a substantive understanding of the frequent absence of informed and free consent in maternity care, a detailed explanation of economic incentives and liability fears that lead doctors to perform too many c-sections, and potential positive systemic change to the medico-legal system of checks and balances.

SUMMARY OF THE ARGUMENT

The right to give or withhold consent to medical treatment is the manifestation in the healthcare setting of the basic human right to physical autonomy and bodily integrity. All competent patients have the right to be recognized as the authority in decisions about their care. Healthcare providers have a corresponding legal and ethical duty to inform, advise, and support patients in decisions about their care.

This right is in urgent need of legal reinforcement in American maternity care. Women giving birth in the United States must navigate a system with a 32% Cesarean section rate, wide variability in provider practices, and recommendations for care that are not always based in clinical reasoning or evidence-based practices, but often motivated by economic incentives and fear of litigation. In the face of these dysfunctions, the right to refuse surgery is vital.

Like most patients, pregnant women typically acquiesce to their providers' clinical recommendations; the right of consent and refusal is tested only when patients disagree with those recommendations. Surprisingly, many women are unsure of their right to refuse care during pregnancy and childbirth. Sometimes when they try to exercise this right,

those they hired to provide care proceed as if the right is suspended during labor and birth. Women may sign a “consent” form in such circumstances, but without the right to refuse care or revoke that consent, their power to consent is meaningless.

Consumer advocacy organizations have emerged in response to widespread reports of disrespect and abuse in maternity care, including battery and other violations of informed consent. When these women seek a legal declaration that their treatment was unacceptable, they are often told that they “have no damages” and reminded that their babies are healthy. A vicious cycle ensues: because no one expects women’s rights to be legally enforced, they become in fact unenforceable. What is most extraordinary about Mitchell is not that she was bullied, threatened, and operated on against her will, but that she – unlike so many other women – has been able to bring her story to Court.

The significance of this case and its consequence for Mitchell are best explained through the case’s placement into the larger context of current maternity care practices. In this brief, Amici include quotes from the personal narratives of women who have experienced similar violations of

consent while giving birth, and who call on the Court to affirm women's right to authority over their body during the vulnerable process of childbirth.[1] The Amici ask the court to find that the Circuit Court abused its discretion by refusing to allow Mitchell's doula to testify to her personal observations of Mitchell's cervical dilation. As long as the experts complicit in this system are unchallenged by direct, contradictory testimony, these violations will continue to occur.

ARGUMENT

Introduction

This case is about Mitchell's right to freely give or withhold true and informed consent to medical intervention. Patients have the right to be informed about the purpose of a proposed treatment, its risks and benefits, and the risks and benefits of alternatives, including the risks and benefits of declining care; to receive recommendations; and to be supported in decisions about care, including the decision to decline recommended

[1] *Women should not be subject to being treated as if their voices don't matter. – A. M. (TX) I am not a mannequin, dummy, or teaching instrument. I am a patient too. – Anonymous 1 (TN)* Brief of Human Rights in Childbirth et al. as Amicus Curiae Supporting Plaintiff, Dray v. Staten Island U. Hosp. et al, Supreme Ct. of the State of New York (2014) (No. 500510/14) hereinafter, Brief Supporting Dray.

treatment.[2] "[A]n individual's physical, emotional, and psychological integrity should be respected and upheld. This principle recognizes the human capacity to self-govern and choose a course of action from among different alternative options."[3] Additionally, consent must not be simple agreement to a suggested course, but "free" consent, which is "incompatible with being coerced or unwillingly pressured by forces beyond oneself."[4] This doctrine, grounded in both common and constitutional law, is recognized not only by courts in this country[5] including the United States Supreme Court,[6] but also around the world.[7]

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[2] American Medical Association, *Informed Consent* (Mar. 7, 2005), http://www.leg.state.nv.us/Session/77th2013/Exhibits/Senate/HHS/SHHS1054M.pdf.

[3] American Medical Association, *Opinion 10.02 – Patient Responsibilities* (June 2001), http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1002.page.

[4] American College of Obstetricians and Gynecologists, Opinion 439 – Informed consent (August 2009), http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Ethics/co439.pdf?dmc=1&ts=20140426T0406259778.

[5] *See Cruzan v. Dir., Mo. Dep't. of Health*, 497 U.S. 261, 271 (1990) (noting that "most courts have based a right to refuse treatment either solely on the common law right to informed consent or on both the common law right and a constitutional privacy right.").

[6] *See, e.g.*, *id.* at 278 (competent person has a constitutionally-protected liberty interest in refusing unwanted medical treatment).

[7] *See, e.g.*, *Konovalova v. Russia*, no. 37873/04, at 5-8 (Eur. Ct. H.R. 2014) (holding that under the Right to Privacy, women can refuse the

Amici, as organizations that advocate for the rights of women in pregnancy and childbirth, urge this Court to recognize that the right to free consent is not diminished during pregnancy, nor does the law tolerate violations of that right. This brief explains that the lack of legal redress for such violations is associated with economic and liability factors that allow forced interventions to continue. It also examines the mechanisms by which such violations occur in maternity care and the harms that result. It is the hope of Amici that this brief will encourage judicial action to correct misunderstandings about the rights of pregnant women and thus incentivize maternity care providers to respect those rights.

I. Economic and Liability Factors Are Proven to Incentivize Obstetricians to Impose Interventions Without Medical Necessity.

Obstetric providers recommend intervention on the basis of numerous non-clinical factors, including financial incentives and intervention rates therefore vary widely by provider. When patients' clinical needs are not driving providers' recommendations, patients need a clear

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presence of medical students when they give birth) (noting the importance of the right of refusal in international authority, including The Convention for the Protection of Human Rights and Dignity of the Human Being, The Committee on the Elimination of Discrimination Against Women, and A Declaration on the Promotion of Patients' Rights in Europe).

legal right to refuse, which can be assured only if courts impose meaningful damage awards for violations of informed consent and refusal.

A. In a Maternity Care System with a C-Section Pandemic and Proven Economic Incentives at Play, the Right to Refuse Treatment has Never Been More Critical. An Enforceable Legal Right to Refuse Interventions is a Birthing Woman's Only Shield Against Dysfunctions in Maternity Care.

It is widely acknowledged that provider behavior is affected by economic incentives, including perception of liability risk, which can lead to good or bad practices and outcomes.[8] The public relies on courts to make rules that deter harm and incentivize the careful assessment of risks and benefits in decision-making. Courts must attune themselves to the economic factors and liability incentive effects of cases before them that are relevant to obstetric practice.

Empirical studies show – and doctors confess – that hospitals perform c-sections for non-medical reasons including financial gain, time convenience, and perceptions of liability pressure.[9] The fact that doctors

[8] *See, e.g.*, Richard A. Posner, *Economic Analysis of Law* 157-214 (7th Ed., 2007); Louis Kaplow & Steven Shavell, *Economic Analysis of Law*, Handbook of Public Economics, Vol. 3 (Alan J. Auerbach & Martin Feldstein, eds., 2002).

[9] *See, e.g.*, Emmett B. Keeler & Mollyann Brodie, *Economic Incentives in the Choice between Vaginal Delivery and Cesarean Section*, 71 The

perform unnecessary surgery for financial gain or time convenience does not prove their collective or individual moral turpitude, only their very human response to economic incentives and systemic constraints.

When a provider decides whether to recommend an intervention for a given patient, financial considerations and time-convenience factors likely operate on a subconscious level. While higher costs and longer inpatient stays for surgical deliveries benefit hospitals more directly than individual doctors, these institutional economic forces can translate into imperatives that constrain doctors from providing individualized care, or into a medico-

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Milbank Quarterly 365 (1993) (finding that pregnant women with private, fee-for-service insurance have higher C-section rates than those who are covered by staff-model HMOs, uninsured, or publicly insured); Jonathan Gruber & Maria Owings, *Physician Financial Incentives and Cesarean Section Delivery*, 27 RAND J. Econ. 99 (1996) (analyzing the correlation between a fall in fertility over the 1970-1982 period and the rise of cesarean delivery as an offset to lost profit); H. Shelton Brown, 3rd, *Physician Demand for Leisure: Implications for Cesarean Section Rates*, 15 J. Health Econ. 233 (Apr. 1996); Joanne Spetz et. al, *Physician incentives and the timing of cesarean sections: evidence from California*, 39 Med. Care 535 (June 2001); David Dranove & Yasutora Watanabe, *Influence and Deterrence: How Obstetricians Respond to Litigation against Themselves and their Colleagues*, 12 Am. L. & Econ. Rev. 69 (2010) [hereinafter Dranove] (finding a short-lived increase in cesareans following the initiation of a lawsuit against obstetrician or colleagues); Lisa Dubay et al., *The impact of malpractice fears on cesarean section rates*, 18 J. Health Econ. 491 (Aug. 1999) [hereinafter Dubay] (finding that physicians practice defensive medicine in obstetrics, resulting in increased cesarean sections).

cultural argument that “this is the way we do it around here.” On a macro level, these forces play out in significantly higher c-section rates in for-profit medical settings around the world.[10]

Within individual doctor-patient encounters, the proven role of non-clinical factors in recommendations for surgery is ethically problematic, as is the lack of transparency about these factors in discussions with patients. While economic pressures and incentives faced by physicians may drive

[10] *See, e.g.*, Nathanael Johnson, *For Profit Hospitals Performing More C-Sections*, California Watch (Sept. 11, 2010), http://californiawatch.org/health-and-welfare/profit-hospitals-performing-more-c-sections-4069 (“women are at least 17 percent more likely to have a cesarean section at a for-profit hospital than at one that operates as a non-profit”); Elias Mossialos et al., *An Investigation of Cesarean Sections in Three Greek Hospitals: The Impact of Financial Incentives and Convenience*, 15 Eur. J. Pub. Health 288 (2005) (“[P]hysicians are motivated to perform CS for financial and convenience incentives.”); Hannah G. Dahlen et al., *Rates of obstetric intervention and associated perinatal mortality and morbidity among low-risk women giving birth in private and public hospitals in NSW (2000–2008): a linked data population-based cohort study*, 4 BMJ Open e004551 (2014); Piya Hanvoravongchai et al., *Implications of Private Practice in Public Hospitals on the Cesarean Section Rate in Thailand*, 4 Hum. Res. Health Dev. J. (Jan.-Apr., 200-), *available at* http://www.who.int/hrh/en/HRDJ_4_1_02.pdf (concluding that care in a private hospital includes higher rates of intervention, higher rates of neonatal morbidity and no evidence of reduction in perinatal mortality); Kristine Hopkins et al., *The impact of payment source and hospital type on rising cesarean section rates in Brazil, 1998 to 2008*, 41 Birth 169 (June 2014) (noting that publicly funded births in public and/or private hospitals reported lower c-section rates than privately financed deliveries in public or private hospitals).

them to recommend surgery that patients do not need, doctor and patient alike must understand unequivocally that the patient can decline.

Doctors' recommendations for intervention, including c-section, are colored also by their own perspective and values. Studies show that obstetricians choose cesarean deliveries for themselves in higher numbers than the general population,[11] and are more likely to undervalue physiological birth while considering cesarean delivery a good solution to "perceived labor and birth problems."[12] If providers believe that cesarean delivery is a good choice and vaginal birth is undesirable, they may pressure patients that refusal of surgery is an unnecessary choice.[13]

The many factors that influence each obstetric provider's decision-making process are reflected in the significant variability of protocols and intervention rates across states, hospitals, and individual doctors, with c-

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[11] *See* Raghad Al-Mufti et al., *Obstetricians' personal choice and mode of delivery*, 347 Lancet 544 (Feb. 24, 1996).
[12] Michael C. Klein et al., *Attitudes of the new generation of Canadian obstetricians: how do they differ from their predecessors?*, 38 Birth 129-39 (June 2011).
[13] *" The OB stated that she didn't have all day to wait for the baby to move down and I was taking up an OR with my twin birth. She also stated I could've saved myself the trouble and had a C-section. She proceeded to use the vacuum, without consent, causing tearing in my vaginal wall." – M. A. (TX)* Brief Supporting Dray.

section rates ranging from 7.1–69.9% across U.S. hospitals.[14] These variations are not supported by differences in maternal diagnoses or pregnancy complexity of individual patients.[15] From the consumer perspective, this means that a pregnant woman might visit five different doctors or hospitals and receive five different recommendations for induction, cesarean, or episiotomy.

Maternity care's variability of practice, and the ubiquitous overuse of interventions that profit the provider at the patient's expense, might reasonably lead an informed consumer to exercise her right to informed consent and refusal as she navigates the health care system. Women need to know that they have a legal right to be supported as the authority in the decisions about their care. All participants bring a constellation of issues, values, and experiences into the decisions of childbirth, but informed consent and refusal means that the birthing woman, like all patients, has

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[14] Katy B. Kozhimannil et al., *Cesarean Delivery Rates Vary Tenfold Among US Hospitals: Reducing Variation May Address Quality and Cost Issues*, 32 Health Aff. 527 (Mar. 2013).

[15] Katy B. Kozhimannil et al., *Maternal Clinical Diagnoses and Hospital Variation in the Risk of Cesarean Delivery: Analysis of a National US Hospital Discharge Database*, PLOS Medicine (Oct. 21, 2014), http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001745.

the right to weigh all the factors at stake and make the final call.

B. Provider Perception of Liability Risk Currently Reflects Perverse Incentives. Courts Must Find Liability for Forced Interventions in Order for Providers to See The Violation of Informed Consent and Refusal as a Liability Risk.

Obstetric providers experience liability risk as a heavy pressure in their practice.[16] The testimony in the Mitchell case makes clear that the doctor perceived himself to face a significant professional or economic risk if he did not perform surgery on Ms. Mitchell, even over her non-consent. Whatever liability analysis directed Ms. Mitchell's care seemed to assume that the doctor's risk assessment trumped the patient's, and that a competent woman's explicit non-consent could be overridden.

Doctors commonly report a strong perception that liability mandates the overuse of interventions in maternity care, citing these liability concerns as a significant driver of the rising c-section rate.[17] A series of studies show that the role of liability pressure is in reality far more modest: doctors are not necessarily rationally responsive to litigation, nor do c-section rates fall

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[16] *See, e.g.*, Carol Sakala et al., Maternity Care and Liability: Least Promising Policy Strategies for Improvement, 23 Women's Health Issues e15 (Jan. 2013).

[17] *See, e.g.*, Dubay, *supra* note 9.

with tort reform.[18] Nevertheless, since doctors report a strong *belief* in liability pressure, their perceptions about liability risk shape discourse about problems and solutions in maternity care.[19]

If liability is even just one factor in obstetric decision-making, it should incentivize careful provision of the health care support each woman needs as she is giving birth and encourage doctors to utilize interventions at the precise moment when a careful provider would recognize that they are needed. It should also call on doctors to remember their fundamental medico-legal relationship and obligation to the patients they are serving: the duty of informed consent and refusal.

Liability incentives in obstetrics currently do not incentivize good care. For this reason, judicial action is urgently needed. Reports on the role of liability pressure in obstetrics rest on an assumption that providers can protect themselves from liability risk if they impose interventions, including

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[18] Janet Currie & W. Bentley MacLeod, *First Do No Harm? Tort Reforms and Birth Outcomes*, 123 Q. J. Econ. 795 (2008); *see also* Dranove, *supra* note 42.

[19] Jeffrey Klagholz & Albert L. Strunk, *Overview of the 2009 ACOG Survey on Professional Liability*, 16 ACOG Clin. Rev. 13 (2009); Richard Hyer, *ACOG 2009: Liability Fears May be Linked to Rise in Cesarean Rates*, Medscape Medical News (May 20, 2009), http://www.medscape.com/viewarticle/702712.

cesarean surgery.[20] A liability rule that inclined doctors toward cesarean delivery might make sense if cesarean surgery carried no risks or costs, and vaginal birth were risky and dangerous, but that is not what the evidence shows. When cesarean surgery is medically needed, it can save lives, but it also carries a long list of risks and costs, including a significantly elevated risk of maternal death.[21] Courts must recognize that women are giving birth in environments where doctors claim that "liability" compels them to push for a surgical birth that happens to profit and convenience the hospital, but imposes risks on mother[22] and baby,[23] up to and including the risk of death. Obstetric providers perceive a "liability" mandate that urges

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[20] *See, e.g.*, Sakala, *Least Promising*, *supra* note 16, at e15.

[21] Catherine Deneux-Tharaux et al., *Postpartum maternal mortality and cesarean delivery*, 108 Obstetrics & Gynecology 541 (2006).

[22] *See* Henci Goer, *Do cesareans cause endometriosis? Why case studies and case series are canaries in the mine*. Sci. & Sensibility (May 11, 2009), http://www.scienceandsensibility.org/?p=147; Anne K. Daltveit et al., *Cesarean delivery and subsequent pregnancies*, 111 Obstetrics & Gynecology 1327 (2008).

[23] *See* James M. Alexander et al., *Fetal injury associated with cesarean delivery,* 108 Obstetrics & Gynecology 885 (2006); Anne K. Hansen et al., *Risk of respiratory morbidity in term infants delivered by elective caesarean section: Cohort study*, 336 Brit. Med. J. 85 (2008); March of Dimes, *Analysis shows possible link between rise in c-sections and increase in late preterm birth* (Dec. 16, 2008), http://208.74.202.108/24497_25161.asp.; Astrid Sevelsted et al., *Cesarean Section and Chronic Immune Disorders*, Pediatrics (2015).

intervention and ignores informed consent and refusal, while failing to incentivize judicious decision-making or health care that optimizes maternal and infant health. In this way, profit accrues to the provider while the interventions' costs and risks are passed to mother and baby.

Ms. Mitchell testified at trial that her doctor did not inform her about any of the risks that cesarean surgery imposed on her, her baby, or her future pregnancies. Instead, he said if she didn't submit to surgery, *he* faced a "risk" of a lawsuit or of losing his license. Only legal clarity that birthing women retain a right to give or withhold a consent to treatment can relieve maternity care providers of the fear that they will be held responsible for their patients' informed, non-coerced healthcare decisions.

If it were clear to everybody in the room that the birthing woman has the right to be supported and respected in all decisions about her care, there could be a significant reduction in intervention rates as well as disrespect and abuse, and an improvement of maternal health.

As Justice Cardozo affirmed in *Schloendorff*, liability in damages is the mechanism through which the human right to autonomy in health care

decision-making becomes a legally enforceable right.[24] We call on the Court to protect that right in a maternity care system in which it is in critical need of reinforcement.

II. Legal Recognition That The Right to Consent Applies In Maternity Care Would Have Widespread Positive Effects.

In law and bioethics, an individual's right to bodily integrity and self-determination is absolute, even when the death of another is at stake.[25] As the *McFall v. Shimp* court explained, in a case where one cousin sued another for potentially life-saving bone marrow, to require someone to submit to intrusion would "impose a rule which would know no limits."

The court refused to order forcible extraction of the potentially life-saving bone marrow, and it warned of the "revulsion to the judicial mind" that such a forced procedure would cause, stating that it would "raise the spectre of the swastika and the Inquisition, reminiscent of the horrors this portends."[26]

Regrettably, the prospect of forced treatment, and its individual and societal repercussions, has failed to constrain the behavior of some

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[24] 105 N.E. at 93.
[25] *See, e g. McFall v. Shimp*, 10 Pa. D. & C. 3d 90 (Allegheny County Ct. 1978).
[26] *Id.* at 92.

hospitals and providers. Accounts suggest that some obstetric providers believe they may ignore or override a woman's explicit non-consent.[27] Judicial action in this case would educate providers that informed consent and refusal rights apply with equal force throughout a woman's life, including during labor and delivery.

The World Health Organization, the International Federation of Gynecology and Obstetrics, and the International Confederation of Midwives have recently identified coercive and unconsented medical procedures in childbirth, like those illustrated in this brief and in Ms. Mitchell's case, as breaches of women's fundamental human rights.[28] Consumer advocacy organizations, like Amici, have formed in response to such violations–violations that are not uncommon in this country. For example, a 2013 survey reported that 25% of women who had experienced

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[27] I hope change is made in how doctors treat women during childbirth. It is an absolute disgrace what is happening now. – M. H. (IL) Brief Supporting Dray.

[28] World Health Org., *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*, 1 (2014) [hereinafter *WHO Prevention*], http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf?ua=1&ua=1. and FIGO Guidelines for Mother-Friendly Birthing Facilities (2015) http://whiteribbonalliance.org/wp-content/uploads/2015/03/MBFBF-guidelines.pdf

an induction of labor or a cesarean section felt pressured to accept those interventions.[29] A 2014 study found that women who perceived pressure to have a cesarean were more than five times more likely to have one, more than six times more likely to have one with no medical basis, and nearly seven times more likely to have an unplanned cesarean.[30] Moreover, 59% of women who received episiotomies did not give consent at all.[31] Finally, 20-38% of women reported that the provider made the "final decision" about whether they would receive a planned cesarean surgery.[32]

These numbers can be fully understood only by listening to the women they represent. Their words convey how the birth of a child can be experienced as assault. Women ask advocacy organizations if they have a legal right to refuse labor induction and surgery. An abstract right is a weak shield if maternity care providers do not believe that respecting patient

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[29] Eugene R. Declercq, et al., *Listening to Mothers III: Report of the Third National U.S. Survey of Women's Childbearing Experiences*, Childbirth Connection, 35 (May 2013) [hereinafter LtM III], http://transform.childbirthconnection.org/wp-content/uploads/2013/06/LTM-III_Pregnancy-and-Birth.pdf.
[30] Judy Jou et al., *Patient-Perceived Pressure from Clinicians for Labor Induction and Cesarean Delivery: A Population-Based Survey of U.S. Women*, Health Serv. Res. (Sept. 2014).
[31] *LtM III*, *supra* note 10, at 36.
[32] *Id.* at 38.

autonomy is required as part of the care they provide.

A. Clarification that the Right to Informed Consent and Refusal is Applicable During Maternity Care Would be Instructive.

Ms. Mitchell's case, and the many stories received from U.S. women by Amici, suggests that some maternity care providers and patients are unclear about whether pregnant women retain the right to consent to medical treatment. Women who attempt to exercise their right to informed consent in childbirth are too often told that they are "not allowed" to make decisions about their care due to hospital policy or "doctor's orders." When the standards of institutionalized maternity care leave no room for the legal right of a patient to decline interventions, the judiciary must declare that hospital policies do not trump the fundamental right to informed consent and refusal, even with signed formal "consent" documents.

B. Any Effort to Reduce the Rate of Surgical Births in This Country Must Ensure that Birthing Women Have a Right to Say "No" to Surgery.

Although the national c-section rate has risen from 4.5% in 1965 to 32.8% in 2012,[33] this increase has not improved outcomes.[34] To the

[33] Joyce A. Martin et al., *Births: Final Data for 2012*, Table 21, Nat'l Vital Stat. Rep., Centers for Disease Control and Prevention (Dec. 30, 2013), http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_09.pdf - table21.

contrary, the United States is one of only eight nations with a rising maternal mortality rate.[35] The CDC has urged that the C-section rate be reduced, and has concluded that variations in rates of non-medically indicated cesarean surgery demonstrate that there is no systematic pattern of decision-making about its use.[36] In other words, the variability of the c-section rate between states and providers appears to be random.[37] This apparent randomness reveals that providers' personal preference rather than science lies behind the decision to perform a surgical birth: "[m]any authors have shown that physician factors, rather than patient characteristics or obstetric diagnoses are the major driver for the difference

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[34] The Joint Commission, *Specifications Manual for Joint Commission National Quality Measures (v2013A1), Perinatal Care/Cesarean Section*, (2013) [hereinafter Joint Commission], https://manual.jointcommission.org/releases/TJC2013A/MIF0167.html.
[35] Anna Almendrala, *The U.S. Is The Only Developed Nation With A Rising Maternal Mortality Rate*, The Huffington Post (May 19, 2014, 8:12 AM), http://www.huffingtonpost.com/2014/05/19/us-maternal-mortality-rate_n_5340648.html.
[36] Wanda D. Barfield, *CDC Expert Commentary, Reducing the C-section Rate* (Aug. 25, 2014), http://www.medscape.com/viewarticle/830154.
[37] *See* Steven L. Clark et al., *Variation in the Rates of Operative Delivery in the United States*, 196 Am. J. Obstetrics & Gynecolology 526e1 (2007) (noting the variations within geographical locations of c-section rates were random and attributable to lack of standardized decision-making and appropriate tools for making these decisions at patient's bedside).

in [c-section] rates within a hospital."[38]

The widespread violation of the patient's right to refuse interventions, in a maternity care system with a massive overutilization of expensive interventions and some of the worst perinatal and maternal outcomes in the developed world, is nothing short of alarming. No one should face being taken captive by the medical system or operated on without consent. We do not allow such infringements on men, non-pregnant women, parents, or the dead–even the procurement of life-saving organs requires proxy consent. It cannot follow then, that society imposes a special duty on pregnant women to relinquish their civil rights to bodily autonomy whenever a physician demands. The American College of Obstetricians and Gynecologists agrees that "[p]regnant women's autonomous decisions should be respected. … judicial authority should not be used to implement treatment regimens aimed at protecting the fetus, for such actions violate the pregnant woman's autonomy.[39]

The prospect of such bullying and coercion in maternity care being

[38] Joint Commission, *supra* note 34.
[39] American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 321: Maternal Decision Making, Ethics, and the Law* (2005).

permitted to continue with impunity–as a finding of no liability in the Mitchell case would essentially validate–should alarm us all, whether pregnant or not. These violations call into question whether courts will adhere to the basic American legal principle of physical autonomy and enforce that principle with a finding of liability and damages. The core principle behind the fundamental duty of care that runs from doctor to patient is "that every human being of adult years and sound mind shall have the right to determine what shall be done with his own body."[40] Every human being. Including pregnant women.

III. Most Women who Experience Unconsented Maternity Care Cannot Access Accountability or Redress for Their Harms.

Mitchell's case describes events similar to many other instances of unconsented interventions in maternity care. What is unusual here is not that a pregnant woman was operated on against her explicit non-consent, but that the case has come before a court. Few of the women who relate instances of forced interventions to Amici have been able to obtain redress or accountability for their harms, a fact that plays into the perverse liability incentives discussed in Section I, above. Access to justice is further curbed

[40] *Schloendorff v. Soc'y of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.).

for many would-be litigants through additional barriers, whether from family, friends, doctors, or lawyers.

A. Access to the Civil Justice System is Inadequate for Women Harmed in Childbirth.

While access to the civil justice system is far from secure for the general population, women who have suffered violations of informed consent and refusal during childbirth are particularly challenged, all the more so if they are economically or racially disadvantaged. Studies show that the instances of medical negligence vastly outnumber claims that are brought, much less any successful awards: "...just about 2% of the overall population that experiences negligent injury appears to make a claim, about half of those receive any compensation for damages, and most of the payouts appear to go to legal expenses rather than plaintiffs."[41] Patients are generally not being compensated for their injuries, with victims of abusive treatment in childbirth facing more hurdles than most.

[41] Carol Sakala et al., *Maternity Care and Liability: Pressing Problems, Substantive Solutions*, Childbirth Connection, 6 (January 2013), http://transform.childbirthconnection.org/wp-content/uploads/2013/02/Maternity-Care-and-Liability.pdf.

B. The Medical Malpractice System Discourages Claims for Violations of Rights in Childbirth.

Restrictions on access are further hampered by findings in medical malpractice cases that downgrade maternal injury, the consequent anticipated and real limitations on potential damages, as well as the impact of statutes of limitation on these cases.

Courts tend to privilege claims for damages to fetuses or babies over those of mothers, for "[I]n the few cases where birthing women have prevailed in maternal harms cases, it is generally through a fetal injury derivative."[42] A mother who seeks representation for her own physical injury will have difficulty finding counsel, whereas those who address fetal harm abound. The lasting damage many women incur from forced treatment is emotional trauma,[43] but tort remedies for infliction of emotional

[42] Jamie R. Abrams, *Distorted and Diminished Tort Claims for Women*, 34 Cardozo L. Rev. 1955, 1980 (2012-13).

[43] A 2009 study identified between 1.7%-9% of the postpartum mothers studied as meeting clinical criteria for Post Traumatic Stress Disorder. Cheryl Tatano Beck et al., *Posttraumatic Stress Disorder in New Mothers: Results from a Two-Stage U.S. National Survey*, 38 Birth: Issues in Perinatal Care 216, 217 (2011).

distress are still evolving.[44]

Like many patients who have suffered injuries, most women who have been coerced or harmed in childbirth look to litigation only as a last resort. They turn first to discussions with their providers, then to formal complaints, and finally, in desperation, to litigation in order to uncover the facts of their experience and to make sure that what happened to them does not happen to others.[45]

One Florida mother took her concerns all the way from the Labor and Delivery nurses up to her state's hospital regulatory agency. [46] A New York woman was forcibly twisted from her position on her hands and knees onto her back for no medical reason, just as her baby's head was emerging. She pursued accountability directly with her providers, but her treatment was

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[44] Daniel Givelber, *The Right to Minimum Social Decency and the Limits of Evenhandedness: Intentional Infliction of Emotional Distress by Outrageous Conduct*, 82 Colum. L. Rev. 42, 44-60 (1982).

[45] Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. Health & Life Sci. L. 125, 133 (2009).

[46] *…[I] was belittled, laughed at, ignored and told I had "issues" by L&D nurses, the hospitals' risk manager, the hospitals' CEO, and AHCA"–V. M. (FL),* Brief Supporting Dray.

condoned as hospital policy.[47]

Medical treatment without consent is widely recognized as assault and/or battery. One would expect the fundamental autonomy rule expressed in *Schloendorff* to have the plaintiffs' bar leaping to represent victims of unconsented obstetrical surgeries.[48] Indeed, Virginia courts have affirmed that an operation with a signed consent form but "contrary to…will" is battery."[49] Few attorneys are willing to bring cases for these violations, reflecting a cultural assumption that injury during childbirth is inevitable, and that a mother should be grateful to have a healthy baby.[50] [51]

Both medical and legal actors maintain a curious reluctance to acknowledge that unwanted cesarean surgery, even when perfectly and

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[47] *However, they firmly stated that all women deliver on their backs in that hospital, and if a woman is not on her back when the doctor wants her to be, she will be forcibly moved into that position. They said they were sorry there had not been time for the doctor to explain that this was the way their hospital worked. They promised to implement new training to help nurses be more gentle when they forced women on to their backs.–J. R. (NY),* Brief Supporting Dray.

[48] 105 N.E. at 93.

[49] *Pugsley v. Privette,* 263 S.E.2d 69, 75 (1980).

[50] *See, e.g.*, Cheryl Beck, *Birth trauma: in the eye of the beholder*, 53 Nursing Res. 28-35 (2004).

[51] *[H]e ultimately told me I got my healthy baby and that we were all ok, and that was what I needed to focus on. Everyone told me that.–M.H. (IL),* Brief Supporting Dray.

expertly performed, constitutes an injury. If no meaningful "damage" is perceived, juries will not be instructed with formula to translate significant harms to bodily integrity into dollar values, beyond the professional and facility fees for the surgery itself. While these costs are significant for many families, they are insufficient to cover the costs expended by an attorney to win a compensatory award, let alone the real value of the wrongdoing. Attorneys cannot be expected to mount cases without both clear precedent and the prospect of adequate reimbursement.

In the end, attorneys play the same role of assuming dysfunction from the tort system as physicians do from perverse malpractice liability incentives.[52] In addition, most attorneys share physicians' cultural misbelief that doctor knows best, so patients should defer to medical expertise. The result is that women whose legal rights have been violated are told everywhere they turn that what happened to them was actually acceptable. Their rights are meaningless, because nobody expects them to be legally enforced.

V. Women Need Legal Assurance of Their Decision-Making Authority Over Their Babies Throughout the Birth Process, in Order for Their Fundamental Right to Informed Consent and

[52] See Section I, supra.

Refusal to have any Meaning.

A. Violations of Informed Consent and Refusal in Maternity Care are Committed Through an Assertion of Maternal-Fetal Conflict.

Despite the many factors that drive providers' recommendations for cesareans,[53] only one tends to be discussed with patients: clinical need, expressed in terms of risk. Doctors usually fail to disclose to patients when "liability pressure" is causing them to recommend surgery. Instead, they warn the patient that her baby might be at risk of injury or death–a truism, as risk exists throughout the birth process, no matter how a baby is delivered. People give birth in hospitals for the express purpose of minimizing the risks of childbirth, so when their doctor suggests that their baby is in danger, they are likely to do whatever their doctor says is necessary to save the baby. Even so, it is important to recognize that the mere signing of a document is not consent, especially if the patient has been threatened and has not been given complete information.[54]

Some women, like Mitchell, disagree with their attending doctor's

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[53] *See* section I, *supra*.

[54] American College of Obstetricians and Gynecologists, Opinion 439 – Informed consent (August 2009), http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Ethics/co439.pdf?dmc=1&ts=20140426T0406259778.

assertion that the circumstances mandate intervention, and decline treatment. The disagreement can therefore turn on a discussion of risk to the baby. Without legal clarity that birthing women retain a right of informed consent and refusal, some providers assert the authority to make the decision on behalf of women's unborn babies. When women are pressured, bullied, and forced into submitting to unconsented care in childbirth, it happens in the name of their babies' safety, with the ostensible maternal threat extending beyond birth. This exchange from Mitchell's testimony at trial is significant:

> *Q. What did you think what would happen if you didn't sign that form?*
> *A. I was afraid that my son would be taken from me.* [55]

Unfortunately, the use of that particular threat is a theme in the coercion of laboring women. [56]

1. No Law has Nullified the Right to Informed Consent and Refusal for Birthing Women by Conferring on Doctors the Right to Make Decisions for Babies *in utero*, or the Right to Perform Surgery on Women Against Their Will in the Name of Their Babies.

Under the U.S. legal system, individuals bear no legal obligations to

[55] Trial Tr., vol. 1, 85.

[56] *When I asked why I needed a c-section, they started to threaten me. The nurse said in a very strict tone that I needed to cooperate, otherwise I could have my baby taken away. She pointed out that I was a young mother.–S.I. (AZ)*, Brief Supporting Dray.

save others or to allow use of their own bodies to do so. While it is sometimes suggested that parents' special duties to their children override this tenet, the law does not in fact impose such obligations. No court has compelled a father to submit to an operation to remove a kidney–a body part that he could survive without–to save a child dying from renal failure. If parents are not held to a heightened obligation to undergo surgery to save their ailing children, why must a pregnant woman submit to any bodily intrusion that a physician deems necessary? Indeed, the U.S. Court of Appeals for the District of Columbia has explicitly opposed this stance in *In re A.C.*, stating, "Surely, however, a fetus cannot have rights in this respect superior to those of a person who has already been born."[57]

In explicitly finding that a forced cesarean section violated A.C.'s rights, the court pondered aloud the "practical consequences" of court orders that force care or permit physicians and courts to unilaterally override informed refusals.

> *…Enforcement could be accomplished only through physical force or its equivalent…Such actions would surely give one pause in a civilized society, especially when A.C. had done no wrong.*[58]

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[57] 573 A.2d 1235, 1244 (D.C. 1990).

[58] *In re A.C..* Supra note 54, at n8.

As unthinkable as such a scene was to the *A.C.* Court, Mitchell and the women who shared narratives for this brief have in fact experienced such scenes. If obstetric providers are in the practice of imposing care in the belief that they possess legal authority over their patients' babies *in utero*, courts must declare that no legal basis supports that belief.

2. Women Need Legal Protection Against the Contention that Declining Obstetric Intervention Puts Them into Conflict with Their Babies and Nullifies Their Right to Informed Consent and Refusal in Maternity Care.

The assertion of maternal-fetal conflict in cases of forced care rests upon the assumption that a woman is aligned with her baby's needs only so long as she complies with her provider's recommendations. Should she exercise informed consent by declining or questioning a recommendation, she is said to fall into conflict with her baby to the point that she loses the basic parental authority to make healthcare decisions for a child she has not even given birth to yet.

The assumption that a medical provider is more invested in the outcome of a birth and the well-being of the baby than is the baby's own mother would be disrespectful toward any woman who has for nine months devoted her body to her baby. In an obstetric system with perverse

economic incentives and a 32% c-section rate, this assumption is both preposterous and dangerous. Yet it emerges every time the right to informed consent and refusal in childbirth is debated with the question, "What if a woman puts her baby at risk?" No decisions in childbirth are risk free; bad outcomes sometimes occur whether or not the doctor's advice is followed. The information provided in the informed consent process can be manipulated and presented in a way that is coercive and misleading to the patient. When the choice for surgery carries a risk of maternal death, only the woman should have the authority to decide whether to take on that risk.

If they are listened to, birthing women reveal that in their exercise of informed consent and refusal, they are trying to make good decisions for themselves *and* their babies, and should be supported in that process. The person giving birth is the person best positioned to weigh her needs and options in combination with the needs of the child *in utero*, in whom she is investing her womb and her labor. Mitchell was not listened to on this issue; rather, her testimony on this topic was blocked on the grounds that her baby was not the plaintiff.[59]

[59] Trial Tr., vol. 1, 100.

Women want to trust providers' assertions that babies are in danger and intervention is warranted. In the current maternity care climate, however, where blind trust is not always merited, some consumers will decline unnecessary interventions that carry risks and can cause harm. When doctors are recommending surgery to a third of their patients or more, with the assertion that vaginal births carry "risk" to the baby, some women may decline surgery that was actually essential in their individual cases, and bad outcomes may result. The solution to this scenario is not to force surgery on all women, but for the medical community to focus on rebuilding patient trust in its recommendations.

The enforcement of meaningful informed consent and refusal in maternity care would verify to providers and women alike that the woman, and nobody else, holds the final authority to make the decisions for herself and the baby she carries. The resulting reorientation of responsibility and support would promote the respectful exchange of medical information and opinions to best equip women to make the complex personal decisions that arise throughout pregnancy and childbirth.

CONCLUSION

"Q. How did you feel while you were laying on that operating table while Dr. Brooks was preparing to cut you open?
A. I was very frightened. I felt powerless, defeated, hopeless.
Q. How did you feel with regard to your body and the power you had over your body?
A. I felt like I was completely defeated, that I had no rights over my own body and my child.
Q. How did you feel about what rights you had to make decision for your child?
A. I felt like I had been stripped of all of my rights."[60]

Pregnant American women are currently giving birth in the world's most expensive maternity care system, with some of the world's worst outcome rates. Medical interventions that were developed to save lives are used to actively manage healthy births, at great cost to consumers and insurers. Direct accounts indicate that the use of interventions has been institutionalized to the point that hospital staff impose them as "policy." These reports suggest a need for legal clarification that hospital policies do not trump human rights. Pregnancy and childbirth are challenging enough without having disrespect, abuse, and trauma meted out by the health care professionals hired to support women. When institutional mandates and economic incentives drive providers to impose surgeries that patients do not need, every patient must be legally armed with the right to say "No."

[60] Trial Tr., vol. 1, 88.

That shield against dysfunctional or abusive care is the right to informed consent and refusal.

Mitchell courageously sought out a lawyer in order to obtain a legal declaration that her providers violated their fundamental duty of care toward her by performing surgery on her without her consent. She was lucky to find one able to raise this issue before the Court. Behind her stands a long line of women who were subjected to surgery against their consent. Although none of them reached a courtroom, they share Mitchell's desire to see that what happened to them does not happen to other women. The best hope for achieving that goal is for courts like this one to unequivocally assert patients' legal right to informed consent and refusal, and its undiminished validity during pregnancy and childbirth.

RULE 5:17 CERTIFICATE

The Amici certify as follows:

1. Seven copies of this Motion for Leave to File a Brief as Amici Curiae have been hand-filed with the Clerk of this Court today.

2. The Appellant is Michelle Mitchell. She is represented by James J. O'Keeffe, IV (VSB# 48620)

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4. A copy of this Motion for Leave to File a Brief as Amici Curiae has been mailed this day to opposing counsel.

5. The Amici wish to state orally and in person the reasons why this Motion for Leave to File a Brief as Amici Curiae should be granted.

Dated this 29th day of February, 2016.