The Case for Affirmative Consent in Childbirth

Alexa Richardson[†]

ABSTRACT

Recent decades have brought a major shift in legal and cultural understandings of sexual consent. The #MeToo movement spurred a national conversation about what constitutes consent in sex, and the legal standard of affirmative consent, where "yes means yes" and anything but means "no," has been adopted by states across the country. But in childbirth, the old ways prevail. Violations of bodily integrity during the birthing process, referred to as "birth rape" and "obstetric violence" by survivors and advocates, occur with alarming frequency. Birthing people, familiar with new norms of sexual consent, are emerging shocked and traumatized from the birthing room. Forced medical procedures, physical restraint, threats and manipulation, and emotional abuse are routinely enacted by providers. And the law does not protect against these acts—rather, courts and regulators have largely sanctioned and enforced providers' violence upon pregnant people.

This Article argues that a legislated, "yes-means-yes," affirmative consent standard is needed in the birthing room to correct the dominant culture of non-consent and create legal protections for when consent is violated. Obstetric violence is analogous to sexual violence. It unfolds within gendered power relationships, is similarly harmful, and faces parallel obstacles to legal redress. Legislated affirmative consent in childbirth has the potential to shift the power relationship between providers and birthing people, clarify communication, and reduce the incidence of unwanted procedures. It would rectify deep inconsistencies in the legal treatment of pregnant people and bring the law in line with prevailing standards of medical ethics. As in sex, the effectiveness of

DOI: https://doi.org/10.15779/Z388C9R50Z

†. Harvard Law School, J.D., 2021; Certified Professional Midwife (CPM). For helpful suggestions and feedback, I am grateful to Glenn Cohen, Carmel Shachar, Rina Spence, Jamie Abrams, Elizabeth Kukura, Michaeljit Sandhu, Alicia Puglionesi, Phebe Hong, Beatrice Brown, Daniel Aaron, Adriana Krasniansky, Sarah Fadil-Alawi, Madeleine DeMeules, Nicole Conrad, Maddy Pilgrim, and Matthew Weaver. I received helpful feedback and comments from participants at the Birth Rights Bar Association conference. I am also grateful to the Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School for making this research possible. And enormous thanks to all the amazing editors at the *Berkeley Journal of Gender, Law & Justice*. All errors are my own.

affirmative consent in birth would be limited by the extent to which providers can coerce birthing people into saying "yes." Even so, affirmative consent in childbirth would significantly shift the legal endowment in favor of birthing people, ensuring them greater control over what the birthing process is now and can be in the future.

ABSTRACT 1
INTRODUCTION 2
I. THE EPIDEMIC OF OBSTETRIC VIOLENCE AND MISTREATMENT 7
A. Defining Obstetric Violence and Mistreatment 7
B. Quantifying Obstetric Violence and Mistreatment 15
C. Current Legal Options to Address Obstetric Violence Are Inadequate 16
1. Tort Law 17
2. Licensing and Regulatory Bodies 20
3. Legislation 21
II. THE PROPOSAL: A LEGISLATED AFFIRMATIVE CONSENT STANDARD 22
A. Affirmative Consent Versus Informed Consent 24
1. Ethical Standards 25
2. Common Law Informed Consent 28
3. Constitutional Law 30
4. Consent in Action 32
B. Addressing the "Exceptional Circumstances" Argument 35
III. AFFIRMATIVE CONSENT IN CHILDBIRTH: THE RATIONALE 37
A. A Heightened Standard for Consent Is Warranted 37
B. The Science Underlying Most Obstetric Recommendations in Birth Is Weak 39
C. Obstetric Violence Is Analogous to Sexual Violence 41
D. The Physician Does Not Represent the Fetal Interest 45
E. Affirmative Consent Can Reduce Physician Liability 48
IV. CRITIQUES AND LIMITATIONS OF AFFIRMATIVE CONSENT IN CHILDBIRTH 49
A. Patients Want Doctors to Decide for Them 49
B. Practicability 50
C. Providers Can Coerce People into Affirmatively Consenting 52
D. Pregnant People Could Be Held Liable for Their Choices 53
CONCLUSION 54

INTRODUCTION

Recent campaigns like Exposing the Silence[1] have chronicled an outpouring

1. *Exposing the Silence Project*, FACEBOOK, https://www.facebook.com/exposingthesilenceproject/ [https://perma.cc/KLT2-3T3Q] ("[A] photography project to expose the silence of women who have experienced birth trauma from

of harrowing birth stories, riddled with abuse and violations of consent. In one typical account, a participant named Chastity, who described her first birth as "more traumatizing than [her] sexually abusive childhood,"[2] explains:

> I had a room full of student doctors, an OB I never met come in and forcibly give me extremely painful cervical exams while I screamed for them to stop and tried to get away. They had a nurse come and hold me down. There was at least 10 students practicing on me. I was a teen mom and my partner hadn't gotten off work yet so I was all alone.[3]

Another participant named Abriana recounts:

> As I was pushing, I got on my side and it was then that I started to feel pain much different from labor pains. I asked, "What is going on?" The nurse replied, "I am doing a perineal rub." I immediately said, "Please stop doing that. You are hurting me." The nurse argued, "It will help you" and didn't move. I asked her again to please stop. I then yelled, while pushing, "Get your hands out of me!" The nurse continued.[4]

In the context of sex, recent decades have brought a major shift in legal and cultural understandings of consent. A new requirement, the affirmative consent standard, where "yes means yes" and anything but means "no," has been adopted in fifteen states.[5] More recently, the #MeToo movement has spurred a national conversation about what constitutes sexual consent and led to a slew of new state-level affirmative consent legislation.[6] But in childbirth, the old ways prevail. Violations of bodily integrity during the birth process, referred to as "birth rape"

---

obstetric violence."). *See also The Obstetric Violence Map*, BIRTH MONOPOLY, https://birthmonopoly.com/obstetric-violence/ [https://perma.cc/58WM-GEJ5] (mapping obstetric violence stories from around the world); *Improving Birth*, FACEBOOK, https://www.facebook.com/pg/ImprovingBirth/photos/?tab=album&album_id=705655609507930 [https://perma.cc/W6DW-47GQ]. The #BreakingtheSilence campaign by Improving Birth collected over 150 stories of obstetric violence and mistreatment on Facebook. *Id.*

2. *Exposing the Silence Project*, FACEBOOK (June 30, 2019), https://www.facebook.com/exposingthesilenceproject/posts/1718540705111906 [https://perma.cc/UTJ7-5U2X] (detailing a traumatizing birthing experience).
3. *Id.*
4. *Exposing the Silence Project*, FACEBOOK (Apr. 26, 2015), https://www.facebook.com/exposingthesilenceproject/photos/a.1385806121718701/1380708832228430/?type=3&theater [https://perma.cc/UTJ7-5U2X] (detailing a traumatic birthing experience).
5. *See* Deborah Tuerkheimer, *Affirmative Consent*, 13 OHIO ST. J. CRIM. L. 441, 442 (2016). Affirmative consent has also been adopted by an estimated 1400 institutions of higher education. *Id.* at 442.
6. *See* Rebecca Beitsch, *#MeToo Movement Has Lawmakers Talking About Consent*, PEW TRUSTS: STATELINE (Jan. 23, 2018), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/01/23/metoo-movement-has-lawmakers-talking-about-consent [https://perma.cc/BS38-Q8SS] (documenting the sharp increase in legislation to define consent for sexual assault affirmatively, extend statutes of limitation for bringing a claim, and allocate rights to survivors).

and "obstetric violence" by survivors and advocates, occur with alarming frequency.[7] Birthing people,[8] familiar with new norms of sexual consent, are emerging shocked and traumatized from the birthing room.[9] Forced medical procedures, physical restraint, threats and manipulation, and emotional abuse are routinely enacted by providers.[10] And the law does not protect against these acts—rather, courts and regulators have largely sanctioned and enforced providers' violence upon pregnant people.[11]

In response, movements against obstetric violence have sprung up both nationally and across the globe. In 2015, the World Health Organization (WHO) issued a statement recognizing that studies on women's experiences in childbirth increasingly "paint[ed] a disturbing picture."[12] The statement called for research,

---

7. *See* Maria T. R. Borges, *A Violent Birth: Reframing Coerced Procedures during Childbirth as Obstetric Violence*, 67 DUKE L.J. 827, 827, 838 (2018) [hereinafter Borges]; Sara Cohen Shabot, *Making Loud Bodies ''Feminine'': A Feminist Phenomenological Analysis of Obstetric Violence*, 39 HUMAN STUD. 231, 233, 237, 238–39 (2016) [hereinafter Cohen Shabot, *Making Loud Bodies "Feminine"*]. *See also infra* notes 293–297 and accompanying text.
8. This article generally uses gender-neutral language that includes gestational fathers and nonbinary pregnant people. Gendered language is used, however, when discussing how gender shapes and frames childbirth systemically. *See, e.g.*, *infra* text accompanying footnotes 32–37. Gendered language is also used when quoting or discussing other scholarship that uses gendered terms and when referencing individual pregnant people who are women. *See, e.g.*, infra notes 68–77. Gestational fathers and nonbinary individuals make up an increasing subset of birthing people. While there is limited data on the rates of transgender gestational fatherhood and nonbinary pregnancies, the out transgender population in the United States has more than doubled in the last ten years to 1.4 million. *See* Andrew M. Flores, Jody L. Herman, Gary J, Gates & Taylor N. T. Brown, *How Many Adults Identify as Transgender in the United States?*, THE WILLIAMS INSTITUTE (June 2016) https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf [https://perma.cc/R5HM-CA7J]. There are a number of active national groups on social media with thousands of trans male members who are either already gestational fathers or hoping to become pregnant soon. *See, e.g.*, Birthing or Breast and Chest-Feeding Trans People and Allies, FACEBOOK, https://www.facebook.com/groups/TransReproductiveSupport/ [https://perma.cc/W9BH-XD6M] (a Facebook group "intended for sharing information and experiences about pregnancy, birth and nursing amongst trans and genderfluid/gender neutral people…"). With larger numbers of transgender individuals between the ages of eighteen and twenty-five than any other category, Flores, et al., *supra*, we can expect numbers of male and nonbinary birthing people to continue to grow significantly in the coming decade.
9. *See* Rachel Reed, Rachael Sharman & Christian Inglis, *Women's Descriptions of Childbirth Trauma Relating to Care Provider Actions and Interactions*, BMC PREGNANCY & CHILDBIRTH, Jan. 2017, at 1, 3, [hereinafter Reed et al.], https://bmcpregnancychildbirth.biomedcentral.com/track/pdf/10.1186/s12884-016-1197-0 [https://perma.cc/Q9CF-8R74] (finding that one third of women reported being traumatized by their births, two-thirds of whom related that trauma to actions by care providers rather than the labor process itself); Antje Horsch & Susan Garthus-Niegel, *Posttraumatic Stress Disorder*, in CHILDBIRTH, VULNERABILITY AND THE LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL, 49, 50 (Camilla Pickles & Jonathan Herring, eds., 2020) [hereinafter Horsch & Garthus-Niegel] (finding that "PTSD following childbirth represents a major public health issue" affecting people after giving birth, as well as their children).
10. Borges, *supra* note 7, at 828.
11. *See infra* Section I.C and Section II.A.iv.
12. WORLD HEALTH ORGANIZATION: THE PREVENTION AND ELIMINATION OF DISRESPECT AND

advocacy, and programming to "eliminate disrespectful and abusive practices" in childbirth and generate new, more respectful approaches.[13] Recently, Puerto Rico, Venezuela, Argentina, Brazil, and some Mexican states have passed obstetric violence laws criminalizing these abuses.[14] In the United States, a "#MeToo movement" against obstetric violence has seen an outcry from parents about the current practices, widespread news coverage,[15] and the formation of activist organizations.[16]

While legal scholars have established that obstetric violence is a problem[17] and identified the lack of existing legal tools to address it,[18] legal strategies to help resolve the issue are only beginning to be seriously explored.[19] Section I.C of this Article reviews the lack of legal remedies currently available for people whose consent is violated during birth. Tort law, the traditional realm of private wrongs

---

ABUSE DURING FACILITY-BASED CHILDBIRTH, WHO/RHR/14.23, at 1 (2015) https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf;jsessionid=FA1C8145B4102C2FC5965F10233BAA93?sequence=1 [https://perma.cc/9ZPF-G2MX].

13. *Id.* at 4, 1–4.
14. Borges, *supra* note 7, at 858; Ley de Acompañamiento durante el Trabajo de Parto, Nacimiento y Post-parto, (P. del S. 414), 2006 P.R. Leyes 414, Ley 156 (Conferencia), http://www.lexjuris.com/lexlex/leyes2006/lexl2006156.htm [https://perma.cc/U43F-4ANB].
15. *VICE* released a recent investigative feature on obstetric violence. *See* Sarah Yahr Tucker, *There Is a Hidden Epidemic of Doctors Abusing Women in Labor, Doulas Say*, VICE, (May 8, 2018, 12:08 PM) [hereinafter Tucker, *Hidden Epidemic*] https://www.vice.com/en_us/article/evqew7/obstetric-violence-doulas-abuse-giving-birth [https://perma.cc/P5J6-M5B4].
16. Improving Birth and Birth Monopoly have been two of the most active advocacy groups, with national protests staged on Labor Day and a full-length documentary on obstetric violence currently in the making. *See* IMPROVING BIRTH, https://improvingbirth.org/ [https://perma.cc/Z8V4-AMHU] and BIRTH MONOPOLY, https://birthmonopoly.com/ [https://perma.cc/6SXJ-YJ7N].
17. *See, e.g.*, Borges, *supra* note 7, at 832; Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 728 (Mar. 2018) [hereinafter Kukura, *Obstetric Violence*]; Elizabeth Kukura, *Birth Conflicts: Leveraging State Power to Coerce Health Care Decision-Making*, 47 U. BALT. L. REV. 247, 294 (2018) [hereinafter Kukura, *Birth Conflicts*].
18. Kukura, *Obstetric Violence, supra* note 17, at 778–95.
19. *See generally* Borges, *supra* note 7, at 860 (noting lack of legal solutions and considering options including a specific, legislatively created tort for obstetric violence and improving options to litigate under existing torts); Elizabeth Kukura, *Obstetric Violence Through a Fiduciary Lens*, in CHILDBIRTH, VULNERABILITY AND THE LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL, 204, 222–23 (Camilla Pickles & Jonathan Herring, eds., 2020) (exploring enforcement of fiduciary duties in the physician-patient relationship as a potential approach to stemming obstetric violence); Karen Brennan, *Reflections on Criminalizing Obstetric Violence: A Feminist Perspective*, *in* CHILDBIRTH, VULNERABILITY AND THE LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL, 226, 232–34 (Camilla Pickles & Jonathan Herring, eds., 2020) (arguing for laws criminalizing some obstetric violence abuses in England and Wales, situating the problem within the movements to criminalize other gender-based offenses previously overlooked or even sanctioned by the law). Professor Jamie Abrams proposes reforming tort law to emphasize methodological standards of care, or "*how* a decision is made, not just the substantive outcomes." Jamie R. Abrams, *The Illusion of Autonomy in Women's Medical Decision-Making*, 42 FL. STATE UN. L. REV. 17, 53–55 (2014) [hereinafter Abrams, *Illusion of Autonomy*] (arguing for tort law standards to require decision-making aids in childbirth that would walk patients and providers through informed consent processes) (emphasis in original).

and medical malpractice, has failed to recognize the kinds of harms caused by obstetric violence.[20] Within tort law, courts have been highly deferential to medical providers, refusing to uphold the doctrine of informed consent by finding that consent was implied even in cases where providers expressly violated birthing people's refusal of treatment.[21] Meanwhile, regulatory bodies have failed to enforce professional standards and issue sanctions against providers that commit obstetric violence.[22] Professional standard-setting alone, the primary mechanism in place to prevent obstetric violence, is insufficient to overcome a persistent culture of violation of consent on the ground.[23] There is a need for new legal solutions to prevent obstetric violence and offer remedies to those who experience it.

This Article argues that a legislated affirmative consent standard is necessary to address the epidemic of lack of consent in childbirth. Like in sexual assault, violations during childbirth center around the issue of consent. Part of solving the problem is establishing what conduct is permissible in relation to clearly defined levels of consent. Currently, the law is ambivalent about what level of consent must be obtained for each procedure in childbirth and whether providers can override patient consent in birth.[24] As a result, providers—and patients—operate on vague and often disparate assumptions about what patients and providers can and cannot do during childbirth.[25] This realm of ambiguity and conflicting beliefs allows for violations of consent to occur more easily.

A defined and enforceable standard of consent, that is protective of patients and recognized by the law, would resolve this dangerous uncertainty and help prevent violations. The proposed consent standard is akin to what is often called the "Antioch" affirmative consent standard.[26] It demands fresh, real-time consent for each new level of activity, or, in the case of childbirth, for each new procedure initiated. Verbal, affirmative consent—saying "yes"— is required, while silence, ambiguity, or saying "no" indicate a lack of consent. If consent is withdrawn at any time, the activity or procedure must stop. Under the proposed standard, a

20. *See infra* Section I.C.i; *see also* Kukura, *Obstetric Violence*, *supra* note 17, at 778–79.
21. *See infra* notes 250–261 and accompanying text.
22. *See infra* Section I.C.ii.
23. *See infra* Section II.A.i.
24. *See infra* Section II.A.iv.
25. In interviews with providers, Professors Jenkinson, Kruske, and Kildea found that while "clinicians espoused respect for women's autonomy," they held a "line in the sand" that they felt could not be crossed. *See* Bec Jenkinson, Sue Kruske & Sue Kildea, *The Experiences of Women, Midwives and Obstetricians when Women Decline Recommended Maternity Care: A Feminist Thematic Analysis*, 52 MIDWIFERY 1, 12 (2017). Clinicians suggested support was available for deviations from recommended care that they "perceived to be 'a little bit different' and 'not really unsafe,'" or for patients to make decisions "'[a]s long as they're not being completely outrageous.'" *Id.* at 13. The "line in the sand" varied amongst clinicians and appeared to shift depending on the person giving birth and their characteristics. *Id.*
26. *See* Wendy Adele Humphrey*, Let's Talk about Sex: Legislating and Educating on the Affirmative Consent Standard*, 50 U.S.F. L. REV. 35, 56 (2016).

violation of consent, including failure to obtain affirmative consent for a procedure, would allow for civil legal action by the patient, with the possibility for criminal sanctions in egregious cases. Legislation requiring affirmative consent in childbirth would necessarily include a provision excluding physician liability where a patient refused recommended care and experienced a poor outcome as a result.

Drawing on existing literature on sexual consent, bioethics, and informed consent, this Article is the first to explore the application of a heightened, legislated, affirmative consent standard to childbirth in order to address obstetric violence.[27] Part I describes the phenomenon of obstetric violence, detailing the kind of harms this proposal seeks to address and the extent of such harms. It also describes the failure of existing legal frameworks to address obstetric violence and the lack of legal remedies available to people who experience it. Part II discusses the existing legal and ethical standards and explores how the affirmative consent proposal itself would interact with or alter these standards. Part III dives more deeply into the rationale for affirmative consent as a legal solution, laying out arguments in favor of its adoption. Part IV addresses critiques of affirmative consent and examines the proposal's potential weaknesses.

Through the foregoing analysis, this Article finds that a legal requirement of affirmative consent in childbirth is a mechanism that would help shift the power relationship between providers and patients, clarify communication, and reduce the incidence of unwanted procedures. In choosing to focus on an affirmative consent standard, this Article seeks not only to identify what the law should protect against, but also probes how law shapes what childbirth could and should look like. To what are we aspiring in birth, and what role does the law play in helping or hindering the realization of that vision? While affirmative consent alone would not fully answer that call, it would significantly shift the legal backdrop to birth and create space for birthing people to have greater control and say over what the birthing process is or can be in the future.

I. THE EPIDEMIC OF OBSTETRIC VIOLENCE AND MISTREATMENT

A. Defining Obstetric Violence and Mistreatment

"Obstetric violence" is a term coined in Latin America that has been adopted

27. Professor Jamie Abrams' proposal that tort law standards evolve to require the use of decision-making aids in childbirth comes the closest to the solutions explored in this Article. *See* Abrams, *Illusion of Autonomy*, *supra* note 19, at 53. Abrams also notes that such a standard would need to "explicitly protect doctors who follow careful methodological decision-making from later litigation." *Id.* at 59. Abrams' proposal and this one have a shared premise: that the solution to obstetric violence lies in legal enforcement of heightened standards for informed consent in childbirth, and in improving the blow-by-blow decision-making in labor. Abrams' solution emphasizes information-giving and the process of decision-making, and uses civil tort remedies as enforcement, while the legislative proposal made here instead centers a clarified standard of consent by importing the rationale and approach used in sexual assault law.

by advocates and scholars in the United States and abroad to capture the phenomenon of abuse, coercion, and mistreatment by providers during birth.[28] Specifically, obstetric violence refers to mistreatment in labor that can range from subtle humiliation and manipulation of consent by providers to unconsented medical procedures and forced surgeries.[29] It can include sexual violation, physical restraint, and other abusive conduct.[30] There is a spectrum of severity of the mistreatment described as obstetric violence, but the incidents are often characterized by violations of consent. This type of mistreatment may be perpetrated by doctors, nurses, or midwives during prenatal care or the birth itself and takes place in the context of a complex power relationship between providers and patients.[31]

The term "obstetric violence" positions these abuses as "part of the broader problem of gender-based violence," implicating issues of power, control, and

28. Borges, *supra* note 7, at 830. Some commentators have urged a shift away from "obstetric violence" and toward obstetric "mistreatment" as a "broader, more inclusive term that better captures the full range of experiences women and healthcare providers have described." *See, e.g.*, Meghan A. Bohren, Joshua P. Vogel, Erin C. Hunter, Olha Lutsiv, Suprita K. Makh, João Paulo Souza, Carolina Aguiar, Fernando Saraiva Coneglian, Alex Luíz Araújo Diniz, Özge Tunçalp, Dena Javadi, Olufemi T. Oladapo, Rajat Khosla, Michelle J. Hindin & A. Metin Gülmezoglu, *The Mistreatment of Women During Childbirth in Health Care Facilities Globally: A Mixed Methods Systematic Review*, PLOS MEDICINE MED., June 2015, at 21 [hereinafter Bohren et al.] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4488322/pdf/pmed.1001847.pdf [https://perma.cc/G5RM-Q44A]; *see also* Jonathan Herring, *Identifying the Wrong in Obstetric Violence: Lessons from Domestic Abuse*, in CHILDBIRTH, VULNERABILITY AND THE LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL, 67, 68–69 (Camilla Pickles & Jonathan Herring, eds., 2020) [hereinafter Herring, *Identifying the Wrong*]. Concern has also been expressed that the term is "stretching violence beyond its natural meaning." *Id.* However, the term has "stuck," *id.*, and advocates urge that "insist[ing]" on describing the conduct as violence is what gives the term "its disruptive and radical edge." Rachelle Chadwick, *Ambiguous Subjects: Obstetric Violence, Assemblage and South African Birth Narratives*, 27 FEMINISM & PSYCH. 489, 492 (2017). Professor Rachelle Chadwick argues that "the term obstetric violence is 'unexpected, jarring and provocative' and is deliberately used by activists as a means of challenging problematic practices that have often been hidden and unacknowledged as forms of violence." *Id.* The violations of consent in childbirth discussed in this article are interchangeably referred to as "obstetric violence," mistreatment, violation, and abuse.

29. *See* Kukura, *Obstetric Violence*, *supra* note 17, at 728.

30. *See id.* Professors Diana Bowser and Kathleen Hill created a seven-part taxonomy of types of obstetric violence, dividing it into physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities. Diana Bowser & Kathleen Hill, *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth*, USAID-TRAction PROJECT, Harvard School of Public Health University Research Co., LLC at 3 (Sept. 20, 2010), https://www.ghdonline.org/uploads/Respectful_Care_at_Birth_9-20-101_Final1.pdf [https://perma.cc/HJD2-ADPT]. A later systemic review of mistreatment during childbirth adopted a slightly different seven-part typology, describing the types of mistreatment evidenced as physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints. *See* Bohren et al., *supra* note 28, at 7.

31. *See id.*

autonomy over women's bodies.[32] As Venezuela's statute prohibiting obstetric violence describes, obstetric violence involves "the appropriation of the body and reproductive processes of women by health personnel."[33] Professor Sara Cohen Shabot describes obstetric violence as "violence directed at women *because* they are women."[34] Underlying acts of obstetric violence is a set of assumptions—that bodily autonomy is eroded by the status of pregnancy; that pregnant women/mothers are a threat to the fetus; that women must sacrifice themselves to their children; and that providers, not pregnant people, are the best decisionmakers about childbirth.[35] The health of pregnant people and the quality of their birthing experiences are positioned as inconsequential, and childbirth as a process in which "all that matters is a healthy baby."[36] This framing allows providers to do whatever is "necessary" to someone's body, a body that becomes simply an impediment to what is most valued by providers: fetal wellbeing. The pregnant individual is stripped of their humanity, constructed as incapable of adult, independent decision-making, and lacking in their own agency.[37] Pregnant bodies are thus understood as existing for the use of others—a collectively owned and governed instrument.

When abuse and coercion take place during childbirth, they often occur at moments of intense vulnerability for pregnant and birthing people, both physically and emotionally.[38] The laboring person may be almost entirely reliant on the provider for information, options, and medical assistance. The incidents generally unfold behind closed doors, with few witnesses. There is typically no viable way for the pregnant person to leave the setting. Patients may have limited mobility by virtue of pregnancy or labor contractions or be fully immobilized by anesthesia,

32. Borges, *supra* note 7, at 830. Though uniquely gendered, it is important to note that obstetric violence can also impact gestational fathers and nonbinary parents, who face related gendered challenges and power dynamics in the birthing process. For more information on the use of gendered and gender-neutral language in this article, see *supra* note 8.
33. Perez D'Gregorio, *Obstetric Violence: A New Legal Term Introduced in Venezuela*, 111 INT'L J. GYNECOLOGY & OBSTETRICS 201, 201–202 (2010).
34. *See* Sara Cohen Shabot, *'Amigas, Sisters: We're Being Gaslighted,' in* CHILDBIRTH, VULNERABILITY AND THE LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL 14, 14 (Camilla Pickles & Jonathan Herring, eds., 2020) [hereinafter Cohen Shabot, *We're Being Gaslighted*] (emphasis in original). Professor Farah Diaz-Tello, acknowledging that obstetric violence sometimes occurs at the hands of providers that are women, pushes back on the notion that this dilutes the gender-based nature of the violence, arguing that obstetric violence is "an act of gender-based violence [] not . . . because the *perpetrator* is a man, but rather because the *victim* is a woman." Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 24 REPRODUCTIVE HEALTH MATTERS 56, 61 (2016) [hereinafter Diaz-Tello] (emphasis in original).
35. *See* Kukura, *Obstetric Violence*, *supra* note 17, at 727.
36. *See Figure 1*, *infra* (explaining behaviors that perpetuate obstetric violence); *see also* Abrams, *Illusion of Autonomy*, *supra* note 19, at 37–40. Professor Jamie Abrams emphasizes that a "shared focus on minimizing all fetal harms" is the dominant approach to childbirth, one that plays out in tort law by "elevat[ing] any fetal risk to an unreasonable risk and reduc[ing] any maternal risk short of death to reasonable," *id.* at 20, 40.
37. *See* Borges, *supra* note 7, at 854.
38. *See* Kukura, *Obstetric Violence*, *supra* note 17, at 727–28.

though still perfectly conscious. From this posture of vulnerability, the birthing person necessarily places substantial trust in their providers. Obstetric violence significantly breaches this trust.[39] In the hospital setting, provider control over the birthing person is girded by an institutional framework that includes other medical professionals, administrative staff, and hospital legal counsel.[40]

Part of the gendered nature of obstetric violence can be tied to the ways in which women's bodies have been constructed within medicine.[41] Frequently construed as mysterious, irrational, and out-of-control, the medical profession has heavily pathologized normal physiological processes of women's bodies.[42] Medicine, historically with men at the helm, has sought to contain, control, and regulate the reproductive bodies of women.[43] Childbirth has been at the forefront of these efforts.[44]

This "reproductive subordination" is exacerbated by racial and economic inequalities.[45] The fetal protection regime, in which pregnant people's bodies are policed by medical staff and legal authorities to protect the fetus from the pregnant person, has targeted low-income women of color.[46] The moral construction of the pregnant mother as a threat to her fetus, used to justify medical and state intervention, has also relied on race- and class-based tropes of these mothers as lazy, promiscuous, and uncaring toward their offspring.[47] In cataloguing forced

39. *See* Herring, *supra* note 28, at 67, 74 (identifying breach of trust as one of the wrongs of obstetric violence).
40. *See* Camilla Pickles & Jonathan Herring, *Introduction,* in CHILDBIRTH, VULNERABILITY AND LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL, *supra* note 9, 3–4.
41. *See* Borges, *supra* note 7, at 855. For more information on the use of gendered and gender-neutral language in this article, *see supra* note 8.
42. *See, e.g.*, Robbie E. Davis-Floyd, *The Technocratic Body: American Childbirth As Cultural Expression*, 38 SOC. SCI. MED. 1125, 1126–27, (1994) (describing how, under the technocratic medical model, male bodies are seen as "properly functioning . . . machine[s]," while "uniquely female biological processes such as menstruation, pregnancy, birth and menopause are seen as inherently subject to malfunction"); Stephanie E. Libbon, *Pathologizing the Female Body: Phallocentrism in Western Science*, 8 J. INT'L WOMEN'S STUD. 79, 88–89 (2007) (describing how medicine in the nineteenth century characterized women as animalistic and how "under the guise of [a cure]," "the unruly woman was now forced [by medical providers] either into compulsory hospitalization, often with accompanying surgical mutilation, or incarceration," *id.* at 89).
43. Professor Cohen Shabot connects the desire to control women's bodies with the violence that occurs in obstetrics, arguing that "[t]he violence performed against the birthing body is not only an expression of the general control and objectification characteristic of medical scenarios but specifically an action against a subversive, rebelling femininity, one that contests alienation, attempting to be one with its body, to feel at home within its embodied existence." Cohen Shabot, *Making Loud Bodies "Feminine*," *supra* note 7, at 243.
44. *See, e.g.*, Davis-Floyd, *supra* note 42, at 1126–28.
45. Abrams, *Illusion of Autonomy*, *supra* note 19, at 32.
46. *See* Michele Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront*, 102 CALIF. L. REV. 781, 784 (2014). *See generally* Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419 (1991) (examining the consequences of prosecuting mothers, particularly poor Black women, who give birth to infants who test positive for drugs).
47. *See* Michele Goodwin & Erwin Chemerinsky, *Pregnancy, Poverty, and the State*, 127 YALE

interventions and arrests of pregnant people from 1973 to 2005, Lynn Paltrow and Jeanne Flavin found that "low-income women and women of color, especially African American women, are overrepresented among those who have been arrested or subjected to equivalent deprivations of liberty."[48] Of those targeted, 71 percent were low-income and 59 percent were women of color.[49] In the ongoing relationship of power and coercion held by providers over patients that enables acts of obstetric violence, race and class aggravate the power imbalances and worsen the lines of reproductive subordination.

The coercive control element of obstetric violence is central to fully capturing the wrong that occurs. Professor Jonathan Herring argues that incidents of obstetric violence, like incidents of domestic abuse, are "best understood not as a one off incident or set of incidents, but rather as an on-going relationship of control."[50] Just as the hallmark of domestic abuse, and the wrong that it involves, has come to be recognized as coercive control over time, Herring argues that this same coercive control pervades the doctor-patient relationship.[51] In this relationship, coercion and violence are used to enforce compliance with the provider's or the institution's wishes.[52] Providers routinely frame birthing options according to what they will "let" or "allow" the laboring patient to do (see Figure 1).

L.J. 1270, 1300 (2018) (reviewing KHIARA M. BRIDGES, THE POVERTY OF PRIVACY RIGHTS (2017)).

48. Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health,* 38 J. HEALTH POL. POL'Y & L. 299, 300–01 (2013) [hereinafter Paltrow & Flavin].
49. *Id.* at 311.
50. *See* Herring, *Identifying the Wrong*, *supra* note 28, at 72.
51. *See id.* at 71–72.
52. *See id.* at 71.

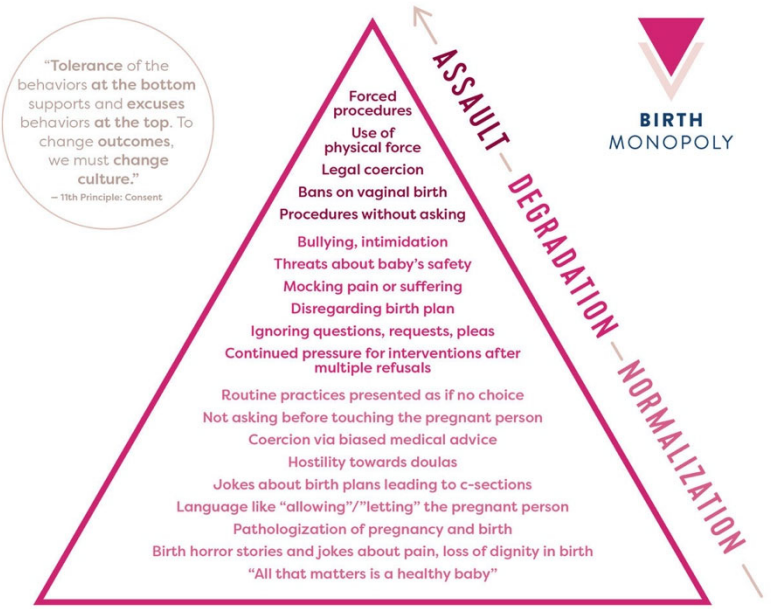

Figure 1 © Copyright BirthMonopoly.com All rights reserved. Obstetric Violence Culture, Birth Monopoly https://birthmonopoly.com/obstetric-violence/ [https://perma.cc/CBN5-M6S4].

Tellingly, many cases of obstetric violence have little to no connection with fetal wellbeing. Rather, the emphasis appears to be on controlling the labor or the woman[53] herself. For example, in *Malatesta v. Brookwood Medical Center*,[54] a hospital had advertised itself as the ideal spot for natural birth, supporting movement during labor, use of birth tubs, and intermittent fetal monitoring.[55] When Caroline Malatesta arrived in labor, she was denied these options, yelled at, forcibly held down on the bed, and had the baby held inside her by a nurse for six minutes of excruciating pain because the doctor had not yet arrived.[56] Malatesta suffered permanent pelvic floor injuries resulting in chronic pain and sexual

53. Here, gendered language is used to emphasize the theme of the gendered nature of coercive control at work in labor. *See also supra* note 8 (describing this article's approach to gendered language around birth).
54. Malatesta v Brookwood Medical Center, No. 01-CV-2014-900939, 2016 WL 4372147, at *1 (Ala. Cir. Ct. Aug. 8, 2016).
55. Beth Greenfield, *Woman Sues Hospital Over Traumatic Birth That 'Turned Our Family Life Upside Down,'* YAHOO! NEWS, Nov. 19, 2015, https://www.yahoo.com/news/woman-sues-hospital-for-traumatic-birth-that-201605478.html [https://perma.cc/MW4Q-USC5] (referring to intermittent fetal monitoring as "wireless monitoring").
56. Tucker, *Hidden Epidemic*, *supra* note 15.

dysfunction, as well as lasting emotional trauma.[57] In an uncomplicated labor like Malatesta's, there is no scientific evidence these actions are in the fetal interest.[58] Instead, such violence appears to revolve around coercive control of the birthing person.[59]

The case of Kimberley Turbin is another example of obstetric violence that cannot be justified by provider concern for fetal interest. Turbin, a rape survivor, asked her providers upon arrival at the hospital to be gentle and ask permission before touching her.[60] During labor, the doctor informed her he was going to cut an episiotomy.[61] She said no. The doctor claimed that if he did not, Turbin would tear and proceeded to cut her perineum twelve times as she protested vocally.[62] The entire episode was captured on video by Turbin's mother.[63] Turbin's labor was progressing normally, and there was no apparent reason why an episiotomy would be necessary.[64] The American College of Obstetricians and Gynecologists (ACOG) recommends against the use of routine episiotomies, as research shows that natural tears are smaller and heal more easily than cuts into the perineum.[65] Turbin sued for assault and battery and ultimately settled out of court.[66]

Coercing patients into compliance with providers' medical recommendations is another common category of obstetric violence. Such coercion can range from bullying and manipulation to court orders or calls to child protective services (or threatening such legal action).[67] For example, in *Goodall v.*

57. *Id*.
58. *Id*
59. *Id*.
60. Rebecca Grant, *"Assault and battery" in the delivery room: The disturbing trend of obstetric violence*, QUARTZ (Jan. 12, 2018), https://qz.com/1177627/assault-and-battery-in-the-delivery-room-the-disturbing-trend-of-obstetric-violence/ [https://perma.cc/ZJD6-V74Z].
61. An episiotomy is a cut into the perineum, which is the tissue between the vagina and anus. Mayo Clinic Staff, *Episiotomy: When It's Needed, When It's Not*, MAYO CLINIC (Aug. 25, 2020), https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/episiotomy/art-20047282 [https://perma.cc/XRG8-JXNW].
62. *Id*.
63. *Id*. The video, now on YouTube along with links about obstetric violence, has received over 900,000 views. Rios jahir, *Birth video epidural and episiotomy*, YouTube, Aug. 27, 2014, https://www.youtube.com/watch?v=lCfXxtoAN-I [https://perma.cc/72K5-8NH8].
64. Grant, *supra* note 60.
65. *Id*.; *see also* Am. Coll. of Obstetricians & Gynecologists, *Practice Bulletin No. 198: Prevention and Management of Obstetric Lacerations*, 132 OBSTETRICS & GYNECOLOGY e87, e97 (Sept. 2018) (providing guidance to practitioners explaining when and how to perform alternate procedures as well as practices for mitigating harm if an episiotomy must be performed).
66. Greenfield, *supra* note 55.
67. Kukura, *Birth Conflicts*, *supra* note 17; *see also* Alexa Richardson, *The Use of Child Protective Services and Court Orders to Enforce Medical Compliance in the Labor and Delivery Room: How Threats of Legal Action Limit Reproductive Choice*, HARV. J.L. & GENDER ONLINE (2019), https://harvardjlg.com/2018/11/the-use-of-child-protective-services-and-court-orders-to-enforce-medical-compliance-in-the-labor-and-delivery-room-how-threats-of-legal-action-limit-reproductive-choice/#_ftn2 [https://perma.cc/69EH-BNL5].

Comprehensive Women's Health Center,[68] a pregnant Florida woman seeking a vaginal birth after three cesarean sections was issued a letter from her providers threatening to report her to child protective services.[69] The letter informed her that the hospital would initiate legal proceedings to compel a cesarean section and explained that if she came to the hospital in labor, a cesarean section would be performed "with or without [her] consent."[70] Goodall sought a restraining order against the hospital, which the court denied.[71]

Similarly, in *Mitchell v. Brooks*,[72] a Virginia hospital informed a woman in active labor that if she did not submit to a cesarean section for "a suspected large baby" the hospital would seek a court order compelling a cesarean section and call child protective services.[73] There was no sign of distress in either the baby or the mother.[74] ACOG guidelines state that a cesarean section is not indicated for large babies unless they are over five thousand grams and that even in such cases, evidence is contradictory and unclear as to the benefits of performing a prophylactic cesarean section.[75] Under threat of court order and losing custody of her child, Mitchell agreed to the cesarean section.[76] The hospital called child protective services on Mitchell anyway, and she was denied her infant after birth.[77] She later sued for battery and lost.[78]

Whether defined broadly to include an ongoing relationship of power and control, or more narrowly to focus on discrete incidents of violation, obstetric violence centers around issues of consent and autonomy of the birthing person.[79] In seeking to eliminate obstetric violence and shift the power relationship, consent and autonomy of decision-making must be central to the solution.

68. Goodall v. Comprehensive Women's Health Ctr., 2014 WL 3587290 (M.D. Fla. Jul. 18, 2014).
69. *Press Release*: *Florida Hospital Says It Will Force Pregnant Woman to Have Cesarean Surgery Federal Court Won't Issue Emergency Order to Prevent Forced Surgery*, NATIONAL ADVOCATES FOR PREGNANT WOMEN (July 25, 2014), http://advocatesforpregnantwomen.org/blog/2014/07/press_release_florida_hospital.php [https://perma.cc/44XL-M8PD].
70. *Id*.
71. *Id*.
72. Mitchell v. Brooks, No. CL13001773-00 (Va. Cir. Ct. filed Aug. 29, 2013).
73. Diaz-Tello, *supra* note 34, at 58–59.
74. Jessica Mason Pieklo, *Coerced C-Sections: The Latest Reach of Fetus-First Laws*, REWIRE NEWS (Nov. 4, 2015, 6:08 PM), https://rewire.news/article/2015/11/04/coerced-c-sections-latest-reach-fetus-first-laws/ [https://perma.cc/X3TQ-5ZV6].
75. Am. Coll. of Obstetricians & Gynecologists, *Practice Bulletin No. 216: Macrosomia*, 35 OBSTETRICS & GYNECOLOGY e18, e26 (2020).
76. Diaz-Tello, *supra* note 34, at 59.
77. *Id.*
78. *Id.*
79. *See* Karen Brennan, *Reflections on Criminalising Obstetric Violence: A Feminist Perspective*, in CHILDBIRTH, VULNERABILITY AND THE LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL, 226, 228–232 (Camilla Pickles & Jonathan Herring eds., 2020) (describing the scope of obstetric violence and the multitude of forms it takes).

B. Quantifying Obstetric Violence and Mistreatment

In 2015, WHO issued a statement "call[ing] for greater action, dialogue, research and advocacy" on provider mistreatment of pregnant people during labor.[80] In that statement, WHO described the mistreatment as an "important public health and human rights issue."[81] While rates of mistreatment in labor have been well-documented internationally,[82] data on the prevalence of obstetric violence in the United States is more limited.

The best available domestic data comes from a recent multi-stakeholder study, convened in response to WHO efforts to track maternal mistreatment, that included more than two thousand participants.[83] The study indicates that 28.1 percent of women birthing in United States hospitals experienced mistreatment by providers during labor; rates were even higher for women of color.[84] The study defined mistreatment as including one or more occurrences of loss of autonomy; being shouted at, scolded, or threatened; or being ignored, refused, or receiving no response to requests for help.[85] Another study found that one-third of birthing people reported being traumatized by their birthing experience.[86] Of those traumatized, two-thirds of participants "described care provider actions and interactions as the traumatic element in their experience," rather than labor itself.[87] Cases of compelled treatment have also been tracked, showing a substantial number of cases where the law intervened to enforce provider demands against patients.[88] More research is needed to adequately quantify the rate and types of mistreatment, but this initial data indicates that mistreatment is alarmingly common.

Another indicator of the prevalence of obstetric violence is the recent growth of national and international advocacy movements. Improving Birth[89] and Birth

80. WORLD HEALTH ORGANIZATION, *supra* note 12.
81. *Id.*
82. *See, e.g.*, Bohren, et al., *supra* note 28, at 6–9; Diana Bowser & Kathleen Hill, *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth*, USAID-TRACTION PROJECT, HARVARD SCHOOL OF PUBLIC HEALTH UNIVERSITY RESEARCH CO., LLC (Sept. 20, 2010), at 6–7 (describing the methodology of reviewing studies from across the globe).
83. Saraswathi Vedam et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, REPRODUCTIVE HEALTH, June 11, 2019, at 1, https://reproductive-health-journal.biomedcentral.com/track/pdf/10.1186/s12978-019-0729-2 [https://perma.cc/8YZR-MSKT].
84. *Id.* The term "women" here is used because the study labeled the participants in that way. For more information on the use of gendered and gender-neutral language in this article, see *supra* note 8.
85. Vedam, *supra* note 83, at 1.
86. Reed et al., *supra* note 9, at 3. This study primarily recruited participants from the United States, Australia, and Europe. 34.2 percent of the study's 943 participants were from the United States. *Id.*
87. *Id.*
88. Paltrow & Flavin, *supra* note 48, at 310. Cases of forced medical treatment are almost certainly undercounted as they rarely make their way into reported opinions or the media. *Id.* at 304.
89. *See* IMPROVING BIRTH, https://improvingbirth.org/ [https://perma.cc/Z8V4-AMHU].

Monopoly[90] are two of the most active US groups resulting from this movement, staging annual national protests on Labor Day, holding "Know Your Rights" trainings for patients and doulas,[91] and offering resources for filing complaints against providers or getting legal support following an incident.[92] A full-length documentary on obstetric violence is in the works, supported by large, successful crowdfunding campaigns.[93] In addition, legal practitioners and scholars have organized around the issue, forming the Birth Rights Bar Association (BRBA). BRBA has designed resources for survivors of obstetric violence, helped respond to incidents, and held annual conferences since 2017.[94] The engagement by large numbers of people in these movements is a signifier of the scope of the problem of obstetric violence and the need for action in this arena.

C. Current Legal Options to Address Obstetric Violence Are Inadequate

The legal system has failed to offer reasonable protection from or remedies for obstetric violence. This Section examines the possible legal recourse available to people after obstetric violence has occurred. In tort law, courts have largely declined to recognize the lasting harm that comes from obstetric mistreatment, particularly when a baby is born healthy.[95] So long as the medical standard of care was followed, mistreatment is rarely recognized as a breach in and of itself. Regulatory bodies, notoriously weak on policing provider behavior, have equally failed to pursue disciplinary proceedings against providers in cases of obstetric violence. Finally, while some countries have instituted statutes banning obstetric violence, legislative remedies are not currently available in the United States.

90. *See* BIRTH MONOPOLY, https://birthmonopoly.com/ [https://perma.cc/S8MT-7JY5].
91. A doula is a trained birthing support person who provides support to a pregnant person throughout the labor process. *See, e.g.*, *What is a Doula?*, DONA INTERNATIONAL, https://www.dona.org/what-is-a-doula/ [https://perma.cc/6GB6-7W3W].
92. Improving Birth offers an "Accountability Toolkit" that assists users in obtaining legal help and filing formal complaints. *See Resources*, IMPROVING BIRTH, https://improvingbirth.org/resources/ [https://perma.cc/DS4X-ACLL].
93. *See* The Birth Monopoly Found., *Documentary: Mother May I?*, KICKSTARTER (July 24, 2018), https://www.kickstarter.com/projects/1455769438/documentary-mother-may-i [https://perma.cc/GHD9-L7RQ]; *Mother May I? The Movie*, The Birth Monopoly Foundation, https://mothermayithemovie.com/ [https://perma.cc/6SXJ-YJ7N].
94. The Birth Rights Bar Association's fourth annual conference to address the issue of obstetric violence took place virtually in April 2021. *See* BIRTH RIGHTS BAR ASSOCIATION, https://birthrightsbar.org/ [https://perma.cc/9MEL-4E9T].
95. Kukura, *Obstetric Violence*, *supra* note 17, at 778.

1. Tort Law

Within tort law, the childbirth event is dominated by claims for harm to the fetus. Such suits are frequent and can bring enormous judgments.[96] In this context, as Professor Jamie Abrams has described, "the fetus has become the *dominant* putative plaintiff in modern obstetric malpractice cases, distorting and diminishing the rights and remedies of birthing women as patients and as plaintiffs."[97] In a culture of childbirth in which medical providers and the law prioritize protecting the fetus, harm to birthing people is considered justified and acceptable.[98] This makes such harm incognizable to courts and many lawyers.[99]

In incidents of obstetric violence, proving an injury that the court will recognize has been a significant barrier for litigants, particularly when the baby is unharmed.[100] While some incidents of obstetric mistreatment can result in physical injury, most do not. Even where physical injuries are present, they can be dismissed as a normal part of the birthing process. Without the presence of a physical injury, battery claims have little value unless punitive damages can be obtained.[101]

Claims for lack of informed consent also require establishing identifiable harm or injury.[102] In a society where highly medicalized births are the norm, demonstrating the harm, for example, of a forced and unnecessary cesarean birth has proven to be difficult.[103] Cesarean section births now make up roughly a third of all deliveries, making them seem "mundane and without significant risk."[104] As Professor Elizabeth Kukura explains, the fact that "episiotomies and cesareans are routinely performed during labor—regardless of medical necessity or support in the scientific literature for their frequent use—precludes courts from understanding them as injuries in situations where they are unconsented or

96. Jamie R. Abrams, *Distorted and Diminished Tort Claims for Women*, 34 CARDOZO L. REV. 1955, 1976 (2013) [hereinafter Abrams, *Distorted and Diminished*] (citing JOHN SEYMOUR, CHILDBIRTH AND THE LAW 348 n.39 (2000)); *see also, e.g.*, Meredith Cohn, *After $229 Million Verdict, Maryland Hospitals Seek New Way to Pay for Injured Babies*, BALTIMORE SUN (Feb. 4, 2020, 4:33 PM), https://www.baltimoresun.com/health/bs-hs-birth-injury-trust-fund-20200204-aqiwynlepve5xe6qmjbc76rmhm-story.html [https://perma.cc/5MY7-F2RN] (documenting a recent $229 million judgment for a case of fetal brain injury during childbirth).
97. Abrams, *Distorted and Diminished*, *supra* note 97, at 1958 (emphasis in original).
98. *Id.*
99. *Id.* at 1960.
100. Kukura, *Obstetric Violence*, *supra* note 17, at 778.
101. *Id*. at 778–781.
102. *Id*. at 789.
103. *See id*. at 789; Abrams, *Illusion of Autonomy*, *supra* note 19, at 21–23.
104. Kukura, *Obstetric Violence*, *supra* note 17, at 789. In *Sceusa v. Mastor*, 525 N.Y.S.2d 101, 103, 121 (N.Y. App. Div. 1988), the court found that "a cesarean section does not constitute a physical injury but is a surgical procedure which is an acceptable method of delivery." In *Miller v. Chalom*, 710 N.Y.S.2d 154, 156 (N.Y. App. Div. 2000), a court declined to find an episiotomy a physical injury, even where "the cut was performed crudely enough to cut off part of the baby's left index finger."

coerced."[105] The normalization of a highly medically interventionist approach to birth and its acceptance by most birthing people has "distort[ed] tort law and undermine[d] patient autonomy" in birth more broadly by making deviation from these norms seem presumptively unreasonable.[106]

"Society's widespread expectation of maternal self-sacrifice" makes it even harder for courts to recognize forced medical treatment as an injury.[107] As Professor Emily Jackson describes, this presumption of maternal self-sacrifice leads to the belief that "there is something worryingly abnormal about a woman who is reluctant to undergo any interventions which a doctor judges necessary."[108] As such, any "harms women experience through medical interventions during labour become completely invisible."[109] The belief that a mother should sacrifice herself completely for her fetus makes juries and judges unsympathetic to plaintiffs claiming to have been harmed in the birthing process.

Another problem in tort cases is proving breach. In the case of medical malpractice, or where provider conduct is being judged, breach is typically defined in relation to how a reasonably prudent provider would behave.[110] In a system where certain types of mistreatment in labor are normalized as part of routine medical care, "coercing a patient to accept treatment out of concern for the fetus 'may be standard operating procedure, or at the very least, sufficiently commonplace that a court could not classify [it] as a violation of the standard of care.'"[111] In addition, finding expert witnesses and proving that such conduct is a breach of care can be challenging. In many cases, providers cite concern for the fetus as a reason for overriding patients' lack of consent or mistreating them, and courts have been sympathetic to this narrative.[112]

In the case of harm to the birthing person, causation is also difficult to establish. Tracing particular injuries after birth to the provider's acts is challenging given that childbirth itself entails some degree of physical harm and recovery.[113] The conflation of harm from birth and from the acts of the provider extends into damages calculations. In such calculations, courts "minimize the damages . . . , finding that some element of [the] post-delivery treatment would have occurred

105. Kukura, *Obstetric Violence*, *supra* note 17, at 789.
106. Abrams, *Illusion of Autonomy*, *supra* note 19, at 17–18, 20–21.
107. Kukura, *Obstetric Violence*, *supra* note 17, at 776.
108. Emily Jackson, *Afterword*, *in* CHILDBIRTH, VULNERABILITY AND THE LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL, 251, 251 (Camilla Pickles & Jonathan Herring, eds., 2020).
109. *Id.*
110. Kukura, *Obstetric Violence*, *supra* note 17, at 783.
111. *Id*. at 779 (citation omitted).
112. Kukura, *supra* note 17, at 787. *See also infra* notes 126–131 and accompanying text (describing a jury that approved a forced cesarean section after only twenty minutes of deliberation after hearing testimony that the doctor felt it was necessary for the health of the fetus).
113. Abrams, *Distorted and Diminished*, *supra* note 96, at 1982.

regardless of the [breach] of the doctor."[114] Where the claim is for a breach of informed consent, to establish causation, plaintiffs must show two things.[115] First, they must prove that they were not given information about the benefits, risks, and alternatives that a reasonable patient would need to make a decision.[116] And second, they must show that they would have declined the care had they been aware of the risks.[117] This requirement often poses an insurmountable bar, particularly in an obstetric culture where most patients do what the doctor says without question.[118]

Finally, tort claims for intentional infliction of emotional distress are notoriously difficult to bring in any realm.[119] High standards for how "outrageous" an act must be, the level of intent necessary, and whether the plaintiff must have been at risk for a physical injury from the conduct make such claims a long shot even in dire cases.[120] In obstetric cases where there is a healthy baby and no physical injury to the birthing person, these claims have been unsuccessful.[121]

The above challenges, as well as a lack of literacy among lawyers about obstetric mistreatment, has made obtaining a lawyer to bring a tort claim a major barrier for plaintiffs.[122] For example, Turbin, the California woman whose doctor cut her perineum twelve times while she repeatedly refused the procedure and who had a video fully documenting the incident, spoke to over eighty lawyers over the course of eighteen months before finding one willing to represent her.[123] Most of the lawyers she spoke to did not see an episiotomy as the patients' choice; it was a decision for the doctor to make.[124] In recognition of this barrier, the BRBA provides a template letter to individuals seeking legal counsel, which helps potential plaintiffs explain their experiences in ways that might translate to lawyers unfamiliar with the issue.[125]

---

114. *Id*.
115. Kukura, *Obstetric Violence*, *supra* note 17, at 784.
116. *Id.*
117. *Id.*
118. Abrams, *Illusion of Autonomy*, *supra* note 19, at 19–20 (noting that while some birthing people may diverge from their providers during childbirth, the "far more common scenario" is that "women and their doctors align in the face of great decision-making complexity and uncertainty").
119. *See* Betsy J. Grey, *The Future of Emotional Harm*, 83 FORDHAM L. REV. 2605, 2607–08 (2015) (describing "[j]udicial skepticism" of emotional harm and the barriers to recovery such claims face).
120. *Id.* at 2610–11; *see* Kukura, *Obstetric Violence*, *supra* note 17, at 785–86.
121. Kukura, *Obstetric Violence*, *supra* note 17, at 785–86.
122. *Id.* at 781–83 (describing lawyers as "gatekeepers to justice" for survivors of obstetric violence); Diaz-Tello, *supra* note 34, at 59–60.
123. Grant, *supra* note 60.
124. *Id.*
125. *Template for Approaching an Attorney for Legal Help for Violations of Your Rights During Birth*, BIRTH RIGHTS BAR ASSOCIATION https://birthrightsbar.org/resources/Documents/Template%20for%20approaching%20an%20attorney%20for%20legal%20help.pdf [https://perma.cc/Y3R5-9GWH].

The outcome in the *Mitchell* case is illustrative of the failure of tort law to redress obstetric violence.[126] Mitchell was coerced into a cesarean section under threats of a court order and loss of parental rights[127] while her provider shouted and swore at her.[128] Still, a jury found in favor of the hospital after deliberating for just twenty minutes.[129] As Professor Farah Diaz-Tello explains, the jury appeared "susceptible to the very biases" that led to Mitchell's mistreatment in the first place, namely "that physicians, instead of pregnant women, are the ones vested with the decision-making authority, thereby justifying threat and coercion."[130] Commenting on the case to the media after the verdict came down, a nurse who had worked for the defendant said that she felt the providers "made the best choice for [Mitchell] and her baby."[131]

The *Malatesta* case, in which a jury awarded Caroline Malatesta $16 million in damages after she experienced physical and verbal abuse in labor,[132] stands out as an exception to the ineffectiveness of tort law for addressing obstetric violence. However, Malatesta's case was unique in that she suffered a permanent pelvic injury that resulted in chronic pain and lack of sexual function and required expensive treatment. Although the jury may have considered her emotional injuries alongside these physical injuries, it is at least possible that without the permanent physical injury she would not have received any compensation at all.[133]

2. Licensing and Regulatory Bodies

Another possible route to accountability for obstetric violence is through licensure boards. However, these entities have been reluctant to respond to complaints of mistreatment or to sanction provider misconduct more broadly. For example, one study on licensing complaints to medical boards for sexual misconduct by providers shows that seventy percent of providers facing such complaints are not disciplined.[134] Another study shows that, of those disciplined, a majority get to keep their medical licenses.[135] With regard to obstetric violence more broadly, advocates from Improving Birth report that licensing boards have

126. *See supra* notes 72–78 and accompanying text.
127. Diaz-Tello, *supra* note 34, at 59.
128. *Id.*
129. *Id.*
130. *Id.*
131. *Id.*
132. *See supra* notes 54–59 and accompanying text.
133. *Cf.* Kukura, *Obstetric Violence*, *supra* note 17, at 785–86.
134. Azza AbuDagga, Sidney M. Wolfe, Michael Carome & Robert E. Oshel, *Cross-Sectional Analysis of the 1039 U.S. Physicians Reported to the National Practitioner Data Bank for Sexual Misconduct, 2003–2013*, PLOS ONE 8–9 (Feb. 3, 2016), https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0147800&type=printable [https://perma.cc/W9WF-NMSZ].
135. *See* Jeff Horwitz & Juliet Linderman, *AP investigation: Doctors keep licenses despite sex abuse*, AP NEWS (Apr. 14, 2018), https://apnews.com/fd90fdeabd1042679513ab0bccdee9ab [https://perma.cc/TS4T-TM94].

been "glacially slow[,] and investigations, if they are conducted, take place behind closed doors."[136] Action by licensing boards requires that providers be willing to police each other's behavior and that states devote resources to properly investigating incidents and complaints.[137] These self-regulatory processes run by providers themselves raise issues about what kinds of provider acts are considered normal within the scope of US obstetric care, where mistreatment is prevalent.

3. Legislation

While the United States has yet to put legislative solutions in place, Venezuela, Argentina, Brazil, and some Mexican states have passed obstetric violence laws prohibiting these abuses.[138] The law in Venezuela, for example, puts obstetric mistreatment in the context of broader gender-based violence, and describes the prohibited conduct as:

> [T]he appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.[139]

Under these laws, most of the conduct may result in civil penalties such as fines and licensing discipline.[140] But some conduct, such as performing a cesarean section without a patient's voluntary consent, is criminalized.[141] These laws have not been universally successful. Many courts have continued to treat obstetric violence like medical malpractice complaints, often siding with providers.[142] However, the new framework has allowed for some successful claims to be brought in cases of obstetric mistreatment.[143] These laws have the potential to shift power dynamics between providers and patients in births in favor of greater patient

136. Dawn Thompson, Heather Thompson, Cristen Pascucci & Amanda Hardy Hillman, *Letter to American College of Obstetricians and Gynecologists*, IMPROVING BIRTH (Sept. 4, 2015), https://improvingbirth.org/wp-content/uploads/2015/09/9.04.15-Ltr-to-ACOG.pdf [https://perma.cc/LVH8-EMG5].

137. Kukura, *Obstetric Violence*, supra note 17, at 798.

138. Borges, *supra* note 7, at 858; *see also* Herring*, Identifying the Wrong*, *supra* note 28, at 70; Diaz-Tello, *supra* note 34, at 61–62.

139. Organic Law on the Right of Women to a Life Free of Violence, art. 15(13)*, translated in* Rogelio Pérez D'Gregorio, *Obstetric Violence: A New Legal Term Introduced in Venezuela*, 111 INT'L J. GYNECOLOGY & OBSTETRICS 201, 201 (2010).

140. Diaz-Tello, *supra* note 34, at 61–62. The penalty for obstetric violence in Venezuela is a fine and professional disciplinary proceeding. *Id.*

141. *Id*. at 62; Borges, *supra* note 7, at 830.

142. Diaz-Tello, *supra* note 34, at 62. In Argentina, courts "continue to rely on malpractice analysis." *Id*. In Mexico, "authorities are reticent to criminally charge physicians." *Id*.

143. *Id*. Complaints to human rights commissions "have recently yielded positive results," such as "restitution for women and agreements by the state to improve infrastructure and disseminate maternity care standards." *Id.*

autonomy and respect.

II. THE PROPOSAL: A LEGISLATED AFFIRMATIVE CONSENT STANDARD

In response to the epidemic of violations of consent in childbirth and the lack of legal protections available, this Article proposes a legislated affirmative consent standard. The standard would seek to codify medical ethical requirements for consent in childbirth into law. It would require written or oral affirmative consent for each new medical procedure performed in childbirth. Absence of active agreement would constitute refusal. As in medicine more broadly, there would be a narrow exception for time-sensitive emergency situations that threaten "serious harm or death if the intervention is not immediately provided" where a provider failed to ask for consent.[144] This exception would never overcome an express *refusal* of care by a competent patient, even in an emergency. Violation of the standard would carry civil penalties including licensure sanctions and potentially, in egregious cases, criminal penalties.[145]

Unlike existing informed consent doctrine, the proposed standard does not require that the provider give any particular information about a recommended procedure. It only requires consent before the provider may proceed. While medicine and law often emphasize the *informed* part of informed consent, this proposal advocates a renewed focus on the *consent* piece alone, urging that regardless of how informed a patient is, their consent should still matter. Thus, the affirmative consent standard proposed here solely requires consent before proceeding.

However, the information piece of informed consent would still be covered under existing informed consent doctrine and medical ethics. In this way, an affirmative consent standard could have trickle-down effects on the doctrine of informed consent during childbirth. By making express that physicians must obtain consent before undertaking a given procedure, courts would have less leeway to dismiss claims brought under breach of informed consent. It would be harder for courts to conclude that consent for a given procedure was simply not necessary under the circumstances, as they have been inclined to do.[146] Once a court determines that such consent was indicated, then they will necessarily have to undertake an examination of whether that consent was informed, i.e., what information on benefits, risks, and alternatives was provided prior to that consent.

144. STEPHEN WEAR, INFORMED CONSENT: PATIENT AUTONOMY AND CLINICIAN BENEFICENCE WITHIN HEALTH CARE 10 (2d ed. 1998).

145. Professor Karen Brennan has explored the application of criminal penalties to obstetric violence in some detail, arguing that some obstetric violence should be criminal and noting that some offenses may already be covered by criminal laws such as battery. Karen Brennan, *Reflections on Criminalising Obstetric Violence: A Feminist Perspective*, *in* CHILDBIRTH, VULNERABILITY AND THE LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL 226, 232–34 (Camilla Pickles & Jonathan Herring eds., 2020).

146. *See infra* Section II.A.iv.

As a result, the standards for how much information must be given to birthing people could become more robust.[147]

Unlike in criminal sexual assault law, conduct alone would not be sufficient to establish affirmative consent in childbirth. Affirmative consent standards in sexual assault law vary across states,[148] but they often allow for consent to be communicated either verbally or with affirmative conduct.[149] The totality of circumstances test is used in states like New Jersey, which allows for "all the surrounding circumstances" to be considered in determining whether affirmative consent was present.[150] In medicine, where the relationship is professional and procedures are documented, receiving *verbal* consent for each procedure is reasonable.

Critically, the proposed affirmative consent standard would necessarily include a waiver of liability for providers where a poor outcome resulted from a patient's refusal of a particular intervention. This would not act as a blanket waiver of liability, but it would shift the burden onto the patient to show that any procedure declined was not the cause of the poor outcome.

Finally, the proposed affirmative consent standard must include language prohibiting criminal or civil liability for birthing people for the choice to decline recommended treatment during pregnancy. Recent years have seen an escalation of criminal prosecutions of people for conduct during pregnancy that allegedly results in harm to the fetus, including declining recommended medical care.[151] Such prosecutions overwhelmingly target poor women and women of color.[152] For example, Melissa Rowland was charged with first degree murder by the state of Utah after she initially declined a cesarean section for her twin pregnancy.[153] Although she underwent a cesarean section in the end, one of the twins was

147. For an in-depth examination of the relationship between information and autonomy in childbirth, *see generally*, Lisa Forsberg, *Childbirth, Consent, and Information About Options and Risks*, *in* CHILDBIRTH, VULNERABILITY AND THE LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL 161 (Camilla Pickles & Jonathan Herring eds., 2020).

148. Tuerkheimer, *supra* note 5, at 449–51.

149. *Id.*

150. *Id.* at 449 n.35.

151. *See* Jeanne Flavin & Lynn M. Paltrow, *Punishing Pregnant Drug-Using Women: Defying Law, Medicine, and Common Sense*, 29 J. ADDICTIVE DISEASES 231, 233 (2010). Through 2017, over 1,000 cases of criminal charges against women for prenatal conduct have been documented, over half of which occurred between 2007 and 2017. *See* Priscilla A. Ocen, *Birthing Injustice: Pregnancy as a Status Offense*, 85 GEO. WASH. L. REV. 1163, 1174 (2017) [hereinafter Ocen]. Recently, the Eighth Circuit upheld the first ever federal manslaughter charge against a pregnant person for drug use while pregnant that allegedly resulted in the death of the baby after birth. *Criminal Law — Criminalization of Pregnancy — Eighth Circuit Upholds Manslaughter Charge against Pregnant Woman for Death of Baby Based on Prenatal Drug Use —* United States v. Flute, *929 F.3d 584 (8th Cir. 2019)*, 133 HARV. L. REV. 1087, 1087–88 (2020).

152. Flavin & Paltrow, *supra* note 151.

153. Howard Minkoff & Lynn M. Paltrow, *Melissa Rowland and the Rights of Pregnant Women*, 104 OBSTETRICS & GYNECOLOGY 1234, 1234 (2004). Rowland pled guilty to lesser child endangerment charges in exchange for the state dropping the murder charge. *Id.*

stillborn and the death was attributed to the delay in the birth.[154] On the civil side, hospitals and providers have used refusal of recommended care to win orders to take custody of the infant after delivery.[155] A law upholding affirmative consent would not prohibit courts from finding people liable for any harm to the fetus resulting from their medical decisions.[156] Under an affirmative consent regime, protection from criminal and civil liability for birthing people is thus essential to uphold actual choice and ensure prosecutors do not seek manslaughter, assault, child endangerment, or other such charges against parents who experience a poor outcome after declining a recommended treatment.

This Part assesses how an affirmative consent standard would interact with existing consent standards in law and medicine. It shows that affirmative consent is in line with existing ethical standards for consent and refusal in childbirth. However, existing law does not uphold these ethical standards.

A. Affirmative Consent Versus Informed Consent

Many providers may reflexively respond that a new standard is not needed—informed consent *is* affirmative consent. Indeed, when informed consent is implemented according to professional ethical guidelines, it requires that a patient agree to each new procedure, and it upholds patient refusal of care under any circumstance, including while pregnant.[157] But these providers would be confusing the *ethical* standard of informed consent, as laid out in professional guidelines, with the *legal* standard of informed consent.[158] Ethical standards of informed consent are not legally enforceable. They do not protect patients when

154. *Id.*

155. *Id.* at 1235. In one such example, hospital administrators asked for and received orders granting them custody to a fetus before, during, and after delivery, as well as to perform a court-ordered cesarean section, in a case where a Pennsylvania woman refused a cesarean section allegedly necessitated by macrosomia, or a big baby. *Id.* The mother fled the hospital and delivered the baby vaginally elsewhere, with no complications. *Id.* (citing *Wyoming Valley Health Care System Hospital Inc. and Baby Doe v. Jane Dow and John Doe*, Ct. Com. Pl, Luzerne County, Pennsylvania, Civil Action No. 3-E 2004, Special Injunction Order and Appointment of Guardian, Judge, MT Council January 14, 2004).

156. This is evident from cases like that of Melissa Rowland's, see *supra* text accompanying notes 153–154, where criminal liability attached to her decision to decline care even though the decision itself was respected.

157. *See, e.g.*, Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion on Refusal of Medically Recommended Treatment During Pregnancy, No. 664*, 124 OBSTETRICS & GYNECOLOGY e175, e176–77 (2016) [hereinafter ACOG, *Refusal of Treatment*], Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion on Informed Consent*, No., 114 OBSTETRICS & GYNECOLOGY 401, 406 (2009) [hereinafter ACOG, *Informed Consent*]. Obstetric textbooks also advise that where patient and provider decisions diverge, no matter how significantly, the patient should be the final decisionmaker. *See, e.g.*, CHARLES R.B. BECKMANN, FRANK W. LING, BARBARA M. BARZANKSY, WILLIAM N.P HERBERT, DOUGLAS W. LAUBE & ROGER P. SMITH, OBSTETRICS AND GYNECOLOGY 25 (6th ed. 2010); Gordon M. Stirrat, *Ethical Dilemmas in Obstetrics and Gynaecology*, in DEWHURST'S TEXTBOOK OF OBSTETRICS AND GYNAECOLOGY 658, 664 (D. Keith Edmonds ed., 7th ed. 2007).

158. ACOG, *Informed Consent*, *supra* note 157, at 6.

providers act without consent. As this Section will explore, the law has a watered-down notion of informed consent that emphasizes the type of information given to the patient, along with whether the patient would have made a different decision if given additional information.[159] When the patient is *pregnant*, current law is inconsistent as to whether the patient can decline medical recommendations.[160] A legislated affirmative consent standard would close the gap between the ethical standard of informed consent and the legal one.

1. Ethical Standards

Affirmative consent in childbirth is in line with predominant professional and ethical standards of care for healthcare providers.[161] However, these standards have failed to prevent frequent violations of bodily autonomy in childbirth. They are not upheld by professional agencies, regulatory bodies, or the courts. Once they are violated, there is no recourse. The proposed affirmative consent standard would convert those ethical standards into legal ones, such that they are enforceable when violated.

The dominant medical ethical framework in childbirth requires that the birthing person's medical provider discuss each recommended procedure with them. Under this framework, the birthing person has full authority to agree to or refuse the procedure under any circumstances. The American College of Obstetricians and Gynecologists (ACOG)'s Committee on Ethics has issued a series of opinions on consent and refusal in childbirth.[162] It declared that "[p]regnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment to maintain life."[163] The Committee emphasized the "primacy" of maternal interests when the interests of the pregnant patient and the fetus are seen to "diverge," and "discourage[d]" obstetrician-gynecologists "in the strongest possible terms" from using "duress, manipulation, coercion, physical force, or threats, including threats to involve the courts or child protective services, to motivate women toward a specific clinical decision."[164] The Committee's opinions urge that even in the most severe cases, "the patient should be reassured that her wishes will be respected when treatment recommendations are refused."[165] Should a bad outcome occur as a result of patient refusal of recommended treatment, "resources and counseling should be

159. Heather Joy Baker, *We Don't Want to Scare the Ladies: An Investigation of Maternal Rights and Informed Consent throughout the Birth Process*, 31 WOMEN'S RTS. L. REP. 538, 543–45 (2010).
160. *See id.* at 543–55.
161. *See, e.g.*, ACOG, *Refusal of Treatment*, *supra* note 157, at 75–76; ACOG, *Informed Consent*, *supra* note 157, at 40.
162. *See, e.g.*, ACOG, *Refusal of Treatment, supra* note 157; ACOG, *Informed Consent*, *supra* note 157.
163. ACOG*, Refusal of Treatment*, *supra* note 157, at e177.
164. *Id.* at e176–77.
165. *Id.* at e176.

made available" to the patient.[166]

In part, these standards have failed to prevent obstetric violence because of seemingly inconsistent ethical or professional standards that providers use to justify violating consent. Namely, the concepts of physician beneficence, patient capacity, and conscientious refusal of care by providers are regularly invoked as "[l]imits of [i]nformed [c]onsent."[167] Physician beneficence refers to the duty of providers to act in the patient's best interest.[168] Obstetricians have contended that the physician's duty of beneficence to the fetus broadly justifies overriding a pregnant person's refusal whenever the "procedure [is] intended to enhance or preserve fetal well-being."[169] Providers invoke patient capacity on behalf of both the pregnant patient and fetus. The capacity of patients to consent in labor is constructed as less than fully certain, and providers argue that patients who are not fully informed cannot give meaningful consent or refusal.[170] Where the fetus is considered a second patient, the fetus's incapacity to consent fuels the beneficence argument.[171] Providers also use conscientious refusal of care to functionally deny patients the ability to consent to or refuse care. When a patient refuses a physician's recommendation for an intervention, the physician could be forced to care for the patient under circumstances they consider unethical or outside the standard of care. Using this logic, providers will refuse—or threaten to refuse—care to pregnant patients who decline recommended treatment. Cloaked as ethical considerations by conscientious providers seeking to serve their patients to their best ability, these principles place the comfort of providers above the physical autonomy of patients.

In response to this provider-centric reasoning, ACOG has clarified in its recent ethical opinions that beneficence, patients' capacity to consent, and conscientious refusal of care should not be used to deny patient autonomy. In their guidelines on "Refusal of Medically Recommended Treatment During Pregnancy," ACOG explains that "[i]t is not ethically defensible to evoke [provider] conscience as a justification to attempt to coerce a patient into accepting care that she does not desire."[172] With regards to beneficence, the opinion emphasizes that while the physician may have "beneficence-based *motivations* toward the fetus of a woman who presents for obstetric care," the physician has an

166. *Id.*
167. ACOG, *Informed Consent*, *supra* note 157, at 406.
168. WEAR, *supra* note 144, at 33.
169. Neha A. Deshpande & Corrina M. Oxford, *Management of Pregnant Patients Who Refuse Medically Indicated Cesarean Delivery*, 5 REV. OBSTETRICS & GYNECOLOGY e144, e145 (2012).
170. WEAR, *supra* note 144, at 9.
171. *See, e.g.*, William J. Sullivan & M. Joanne Douglas, *Medicine, Ethics, and the Law*, *in* ANESTHESIA AND THE FETUS 365, 371 (Yehuda Ginosar, Felicity Reynolds, Steven Halpern, Carl P. Weiner eds., 2013) (advising physicians facing perceived maternal-fetal conflict to "[a]pply ethical principles: Do societal justice, fetal beneficence, and fetal non-maleficence overturn maternal autonomy and maternal justice?").
172. ACOG, *Refusal of Treatment, supra* note 157, at e176.

ultimate "beneficence-based *obligation* to the pregnant woman who is the patient."[173] Finally, with regard to patient decision-making capacity, the Committee urges that a physician "should not infer from a patient's decision to refuse treatment that the patient's capacity to make medical decisions . . . is diminished."[174] Rather, "[p]atients are, by law, presumed to be decisionally capable unless formally determined otherwise."[175] Furthermore, the extent to which a patient has been informed, even under emergency circumstances, does not limit the right to consent: "a patient retains the right to make an uninformed refusal."[176]

Despite formally supporting patient consent and autonomy, professional ethical standards have failed to prevent violations during pregnancy and birth. This is because these ethical standards are not enforced by law. As discussed *supra* in Section I.C, courts routinely fail to offer a remedy for these ethical violations and even uphold and commit such violations through court-ordered interventions.[177] Aside from the evidence of frequent violations of ethical informed consent guidelines reported by birthing people,[178] studies about providers' views of their ethical role with regard to informed consent in childbirth show that they are at odds with professional ethical guidelines.[179] The legal doctrine of informed consent, as discussed in the next Section, does not capture the standards described by professional ethical guidelines. Courts and juries have sided with providers who believe themselves to know better than the ethical guidelines, legitimizing and normalizing the physician's role as the final decision maker in pregnancy and birth.[180] As discussed *supra* in Section I.C, regulatory bodies rarely intervene to control provider behavior even where it violates medical standards of practice and do not get involved over scruples about professional ethics. As it stands, the professional ethical guidelines are purely optional and are not reflected in the law's

173. *Id.* at e177.
174. *Id.* at e180.
175. *Id.*
176. *Id*. "Even if the patient has not been fully informed, a decisionally capable adult patient's refusal of emergent care should be respected." *Id.*
177. *See also infra* Section II.A.iv (discussing current informed consent laws and judicial decisions).
178. *See supra* Section I.B.
179. In one such study, though formally ascribing to the idea that pregnant people should have autonomy, doctors and midwives generally agreed that "the needs of the woman may be overridden for the safety of the fetus." Sue Kruske, Kate Young, Bec Jenkinson & Ann Catchlove, *Maternity Care Providers' Perceptions of Women's Autonomy and the Law*, BMC PREGNANCY & CHILDBIRTH 1, 1 (Apr. 2013). *See also* Jenkinson et al., *supra* note 25, at 12 (describing clinicians' "line in the sand" or boundaries for supporting women's autonomy).
180. *See* Veronika E.B. Kolder, Janet Gallagher & Michael T. Parsons, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1195 (1987). When asked by medical providers to override patient consent, courts consistently issue court orders. In one study of court-ordered cesarean sections, researchers found that 88 percent of court orders were granted within six hours, while 19 percent were granted within one hour of the request being made by providers. *Id*.

treatment of informed consent in childbirth.

2. Common Law Informed Consent

Under common law, the legal doctrine of informed consent has its origins in the concept of the doctor's "fiduciary relationship" to the patient, along with the principle of self-determination.[181] The patient chooses and places their trust in the fiduciary physician to use their specialized knowledge and expertise to act on the patient's behalf.[182] This forms a special relationship of trust and care between a doctor and patient that requires that the doctor "disclose to the patient all pertinent facts regarding the patient's condition and the treatment that the physician is recommending."[183] The duty to disclose has been elaborated in case law, which holds that physicians must disclose information that a reasonable person in the patient's situation would consider material in deciding whether to undertake the procedure.[184]

Fiduciary relationships naturally allow for abuse because the fiduciary has power over the entrustor.[185] As a result, roles that traditionally carry fiduciary duties, such as attorneys and accountants, typically include "carefully tailored rules that limit [the fiduciary's] ability to inappropriately exploit the power they have."[186] However, the law has largely declined to hold physicians accountable as fiduciaries.[187] In order to recover under informed consent doctrine where the physician did not offer complete information, the patient must show that a prudent patient under similar circumstances would have made a different decision had they received more information.[188] So long as a physician performs procedures that

181. Leslie J. Miller, *Informed Consent: I*, 244 JAMA 2100, 2100 (1980).

182. Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 458 (2000).

183. Miller, *supra* note 181.

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

185. Oberman, *supra* note 182, at 458.

186. *Id.*

187. *Id.* at 459. Professor Oberman notes that fiduciary duties are mentioned in the medical malpractice context, but, so long as the physician performed in accordance with the medical standard of care, the duties are considered satisfied. *Id.* Professor Elizabeth Kukura compellingly argues that holding providers responsible as fiduciaries could be an effective approach to combatting obstetric violence. Kukura, *Obstetric Violence*, *supra* note 17, at 791–92. She notes that where physicians elevate fetal interests over the pregnant person's, they are breaching their duty to act in the interests of their patient. *Id.* at 791. When a physician "fail[s] to disclose to his patient his belief that he has an independent obligation to the fetus as a second patient—and that he may use his authority to force her to receive treatment against her will based on that perceived obligation—[it] could be considered a violation of fiduciary duty, as he has prioritized other interests above the interests of the patient for whom he has been entrusted to care." *Id.*

188. Roughly half of all states continue to adhere to a "reasonable medical practitioner standard," which requires providers to offer information that a reasonable practitioner would consider necessary under the circumstances. Baker, *supra* note 159, at 544 (internal quotation marks omitted). The remaining states have adopted a "reasonable patient standard," which centers the informational requirement on what a reasonable patient would want to know under the

align with the medical standard of care,[189] the duties are considered satisfied, regardless of whether the interest of the patient was served or their wishes followed.[190]

Self-determination, autonomy, and bodily integrity are also implicated in the legal doctrine of informed consent.[191] The "logical corollary of the doctrine of informed consent" is the right "to refuse treatment."[192] A legally competent patient has the "right to decide what is to be done to his body and cannot be compelled to accept treatment that he does not wish."[193] Such competence under the law is "presumed" absent extreme circumstances, such as "gross mental deficits or incapacity."[194] Accordingly, the tort law doctrine of informed consent was initially articulated by then-Judge Cardozo as the rule that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[195]

Under common law, the right of an individual to refuse medical treatment has similarly been upheld even when that refusal results in harm to a third party.[196] In *McFall v. Shimp*, a plaintiff suffering from cancer required a bone marrow transplant to survive.[197] After an extensive search, the plaintiff's cousin was revealed as the only available match.[198] The cousin refused to go forward with the donation, and the plaintiff sued for a court order to compel the cousin to donate. The court framed the issue as whether, "in order to save the life of one of its members by the only means available, [society may] infringe upon ones [sic] absolute right to his 'bodily security'?"[199] In declining to "forc[e] submission to the medical procedure,"[200] the court drew on common law doctrines rejecting a duty to rescue.[201] Though it described the defendant's decision as "morally

---

circumstances. *Id.* at 544–45.

189. The medical standard of care is not set by professional guidelines. Abrams, *Illusion of Autonomy*, *supra* note 19, at 42. Rather, it is determined by how medicine is actually practiced, as evidenced by expert testimony. *Id*. "Obstetric medical practitioners themselves set the standards of care" and tort law then "gives a heightened deference to the customs of the medical community." *Id.* Thus, if the custom of the medical community is to not ask for consent under particular circumstances or to always perform particular procedures in a certain situation, and these standards are accepted by "most women," then they will be upheld in court. *Id.*
190. Oberman, *supra* note 182, at 459–69.
191. Miller, *supra* note 181, at 2100.
192. Cruzan v. Dir., Missouri Dep't of Health, 497 U.S. 261, 270 (1990).
193. Miller, *supra* note 181, at 2100.
194. WEAR, *supra* note 144, at 10.
195. Schloendorff v. Soc'y of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914).
196. *See* Oberman, *supra* note 182, at 468.
197. 10 Pa. D. & C.3d 90 (Allegheny Cnty. Ct. 1978).
198. *Id.* at 90; *see also* Oberman, *supra* note 182, at 468 (identifying the defendant as the plaintiff's cousin).
199. *McFall*, 10 Pa. D. & C.3d at 90–91.
200. *Id.* at 92.
201. *See id.* at 91 (holding that the common law recognizes a rule "which provides that one human

indefensible," the court reasoned that society and the state's role was to prevent people from harming others, not to compel individuals to aid others at their own expense.[202] Doing so "would change every concept and principle upon which our society is founded" and would "impose a rule which would know no limits."[203]

3. Constitutional Law

There is also a constitutional right to informed consent, but it is unclear how the right applies in late pregnancy. In *Cruzan v. Director, Missouri Department of Health*,[204] the Supreme Court recognized informed consent and refusal of medical treatment to be a constitutional right under the Fourteenth Amendment.[205] The Court recognized that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment," even life-saving care.[206] The constitutional right to privacy may also be implicated in the right to refuse treatment.[207]

However, *Roe v. Wade*[208] may place a limit on a constitutional right to choose medical treatment in pregnancy. In *Roe*, the Court recognized a legitimate state interest in the "potential [fetal] life" starting at the point of fetal viability, which at the time was usually placed at twenty-eight weeks.[209] Advances in medicine have moved up the date of viability to around twenty-four weeks.[210] In

being is under no legal compulsion to give aid or to take action or to save another human being's life or to rescue").

202. *See id.* at 91–92 (recognizing no principle in American law that compels the individual to prioritize society's needs over their own).

203. *Id.* Proponents of compelled medical treatment in childbirth would likely distinguish this situation from pregnancy by arguing that, unlike the defendant in *McFall*, by declining to abort a pregnancy before the point of viability, the pregnant person implicitly established an obligation toward the fetus and waived their rights to bodily autonomy. *See, e.g.*, Joel Jay Finer, *Toward Guidelines for Compelling Cesarean Surgery: Of Rights, Responsibility, and Decisional Authenticity*, 76 MINN. L. REV. 239, 259 (1991). This view is not grounded in the law, nor articulated by medical ethics or the medical profession. *See supra* Part II.A. However, if it were, such a legal waiver should require delineating the nature of the legal obligation to the fetus and the extent to which it compromises medical decision-making. In addition, informed notice to pre-viability pregnant patients and full access to abortion would be necessary in order for remaining pregnant past viability to be considered a voluntary and knowing waiver of legal rights. *See* Brady v. United States, 397 U.S. 742, 748 (1970) (establishing the standard for valid waiver constitutional rights as "voluntary [and] knowing"). Even then, the ethics of legal waivers would be questionable should the pregnant patient's health later be at risk. *Cf.* Roe v. Wade, 410 U.S. 113, 163–64 (1973) (permitting state regulation of abortion after viability "except when it is necessary to preserve the life or health of the mother"). This is so far from the reality in which pregnancy exists to date that such arguments only strengthen the case for decisional autonomy.

204. 497 U.S. 261 (1990).

205. *Id.* at 278.

206. *Id.*

207. *See id.* at 271.

208. 410 U.S. 113 (1973).

209. *Id.* at 163–64.

210. Am. Coll. of Obstetricians & Gynecologists, *Obstetric Care Consensus: Periviable Birth*, 130

the case of abortion, the Court held that states could regulate or even prohibit abortion entirely after viability, unless it was necessary for the life or health of the pregnant person.[211] *Roe* also enshrined a model in which the physician, rather than the patient, is the primary decisionmaker regarding whether an abortion is "medical[ly]" indicated, rather than the patient.[212]

What *Roe* means for declining medical care during birth is unclear.[213] The state may be able to enact legislation that limits pregnant people's ability to decline medical care in the third trimester based on an interest in fetal life.[214] In the absence of such regulation, a legally competent pregnant person would presumably retain the ability to decline care under both the common law informed consent doctrine and the Fourteenth Amendment.[215] However, despite the absence of state regulations limiting such rights in pregnancy, courts have relied on *Roe* to deny birthing people the constitutional right to decline medical care. In *Pemberton v. Tallahassee Memorial Regional Medical Center, Inc.*,[216] a woman in labor seeking a vaginal birth after a prior delivery by cesarean (VBAC) left the hospital to birth at home after being denied the option of vaginal birth in the hospital.[217] The hospital sought a court order, which the court granted.[218] Law enforcement went to Pemberton's home and brought her to the hospital against her will.[219] There, the doctors performed a forced cesarean section.[220] The court found that there was a 4–6 percent risk of a serious complication, and that such risk to the fetus was unacceptable.[221] Citing *Roe*, the court held that Pemberton's constitutional rights "clearly did not outweigh the interests of the State of Florida in preserving the life of the unborn child."[222] In justifying its decision under *Roe*, the court reasoned that "[b]earing an unwanted child is surely a greater intrusion on the mother's constitutional interests than undergoing a cesarean section to

---

OBSTETRICS & GYNECOLOGY e187, e188–89 (2017).

211. *See Roe*, 410 U.S. at 163–64.
212. *Id.* at 164 ("[T]he abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.").
213. *See* Margo Kaplan, *"A Special Class of Persons": Pregnant Women's Right to Refuse Medical Treatment After* Gonzales v. Carhart, 13 U. PA. J. CONST. L. 145, 167–69 (2010).
214. *Id.*
215. *See* Oberman, *supra* note 182, at 475–76.
216. 66 F. Supp. 2d 1247 (N.D. Fla. 1999). The American College of Obstetricians and Gynecologists guidelines note that "[m]ost women with one previous cesarean delivery . . . are candidates for and should be counseled about and offered [VBAC]." They further recommend that "[g]iven the overall data, it is reasonable to consider women with two previous low-transverse cesarean deliveries to be candidates for [VBAC]." Am. Coll. of Obstetricians & Gynecologists, *Practice Bulletin No. 205*, 133 OBSTETRICS & GYNECOLOGY 110, 113 (2019).
217. *Id.* at 1249.
218. *Id.* at 1250.
219. *Id.*
220. *Id.*
221. *Id.* at 1253, nn.14–15.
222. *Id.* at 1251.

deliver a child that the mother affirmatively desires to deliver."[223]

The 2007 Supreme Court case *Gonzales v. Carhart*[224] may have further endangered a right to medical autonomy in childbirth.[225] In upholding a ban on intact dilation and evacuation abortion, *Carhart* identified new legitimate state interests in fetal health, such as "expressing respect for fetal life" and "preventing a woman from exercising informed consent where her decision would harm the fetus and might subsequently cause her to feel remorse."[226] Together, these interests allow the state to interfere even when the pregnant person's health is at stake and establish a rationale that could easily be used to compel medical treatment in pregnancy.[227]

Despite the strong right to informed consent and refusal of treatment upheld in *Cruzan,* the constitutional right to decline care during birth was weakened by *Roe* and *Carhart*. Bringing constitutional legal challenges to violations during birth thus continues to be an inadequate strategy for preventing such harms.

4. Consent in Action

Pinning down the legal standard of informed consent *as applied to pregnancy and birth* is not a simple task. Childbirth "remains vastly unexamined within the law," and the legal rights entailed are severely "undertheorized."[228] Different courts have reached opposing outcomes, and questions of consent to medical procedures in childbirth are often not addressed directly under doctrines of informed consent, but rather under a hodgepodge of state statutes, tort laws, and disparate interpretations of constitutional rights. Courts and providers frequently use fetal interests as a justification to apply "the informed consent doctrine . . . loosely with expectant mothers[,] . . . substitut[ing] their own judgment on the baby's behalf."[229] The existing legal regime supports routine obstetric practice in which informed consent, to the extent that it is offered by providers in childbirth, often consists of simply telling the patient what is going to happen next. Consent is regularly considered to have been "implied" simply by the patient's presence at the hospital. So long as the patient does not protest when "informed" of what is going to happen, consent has been obtained. In some cases, even when decisionally capable patients do protest, their consent is and can be overridden.

Several state court cases have denied pregnant people the ability to choose among health options. In one case, *Dray v. Staten Island University Hospital,* a New York woman seeking vaginal birth after cesarean (VBAC) declined the

223. *Id.*
224. 550 U.S. 124 (2007).
225. *See* Kaplan, *supra* note 213, at 148.
226. *Id.*
227. *Id.* at 149.
228. Abrams, *Distorted and Diminished*, *supra* note 96, at 1958.
229. Baker, *supra* note 159, at 546.

doctor's recommendation of cesarean section when she arrived at the hospital.[230] When she refused to submit even after extensive coercion, doctors chose to "overrid[e] [her] refusal to consent" and performed a forced cesarean section that caused a lacerated bladder complication.[231] Dray lost in district court. The judge ruled that by accepting care at that hospital, Dray implicitly agreed to the hospital policies, one of which allegedly allowed physicians to override pregnant patients' consent without a court order when the "potential benefits to the fetus of medically indicated treatment may justify" doing so.[232] The lower court decision was upheld on appeal.[233] In another case, *Jefferson v. Griffin Spalding City Hospital Authority*,[234] a Georgia court overruled a religious woman's decision to decline a cesarean section for placenta previa, a condition in which the placenta blocks fetal access to the birth canal.[235]

The District of Columbia, on the other hand, has affirmed informed consent in childbirth. In the case *In re A.C.*,[236] a woman on life support who was twenty-six-weeks pregnant declined a cesarean section that she was unlikely to survive.[237] The D.C. Circuit issued an order compelling a cesarean section,[238] against the decision of the woman herself, who, in her lucid moments, repeatedly mouthed "I don't want it done" to family and care providers.[239] Doctors performed a cesarean section, and both the mother and fetus died shortly after as a result.[240] On rehearing, an en banc D.C. Circuit overturned the panel's decision after the fact, determining that "in virtually all cases the question of what is to be done is to be decided by the patient—the pregnant woman—on behalf of herself and the fetus."[241]

An Illinois appellate court has also determined that pregnant people are the final decisionmakers during childbirth. In *In re Baby Boy Doe*,[242] a physician

230. 160 A.D.3d 614 (N.Y. App. Div. 2018).
231. *Id*. at 616.
232. *See* Molly Reddin, *New York Hospital's Secret Policy Led to Woman Being Given C-Section Against Her Will*, THE GUARDIAN (Oct. 5, 2017), https://www.theguardian.com/us-news/2017/oct/05/new-york-staten-island-university-hospital-c-section-ethics-medicine [https://perma.cc/2L56-ZC4M]. The actual existence of such a policy at the time of the incident is contested by the plaintiff. *See infra* note 233.
233. *See Dray,* 160 A.D.3d at 618–19. After a nurse testified that she was unaware of the hospital policy alleged, Dray filed for leave to amend her complaint, and the motion was granted. Dray v. Staten Island Univ. Hosp., No. 500510/2014, 2019 WL 233141, at *2 (N.Y. Sup. Ct. Jan. 15, 2019).
234. 274 S.E.2d 457 (Ga. 1981).
235. *Id.* at 458. Jefferson's placenta moved off of the birth canal in the third trimester and she had a vaginal birth in the end. *See* Susan Irwin & Brigitte Jordan, *Knowledge, Practice, and Power: Court-Ordered Cesarean Sections*, 3 MED. ANTHROPOLOGY Q. 319, 322 (1987).
236. 573 A.2d 1235 (D.C. 1990) (en banc).
237. *Id.* at 1240.
238. *In re A.C.*, 533 A.2d 611, 613 (D.C. 1987).
239. *In re A.C.*, 573 A.2d at 1241.
240. *Id.* at 1238.
241. *Id.* at 1237.
242. 632 N.E.2d 326 (Ill. App. Ct. 1994).

advised Mother Doe that her placenta was failing and that an immediate cesarean delivery was necessary to save the fetus's life.[243] On religious grounds, the patient declined the procedure, choosing instead to wait for labor to begin naturally.[244] Over the ensuing weeks, a series of emergency hearings were held as the state sought wardship over the fetus and a court-ordered cesarean section.[245] In these hearings, physicians testified that due to placental insufficiency, the condition of the child was deteriorating daily, making "the chances of the unborn child surviving natural childbirth . . . close to zero."[246] They stated that "[i]f the child were to somehow survive natural childbirth he would be retarded."[247] The court rejected the state's petitions and found that a pregnant person's "competent choice to refuse medical treatment as invasive as a cesarean section during pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus."[248] Mother Doe gave birth vaginally to a healthy baby boy roughly three weeks after the hearing.[249]

In addition to inconsistency on the question of refusal of treatment in childbirth, the law has been ambivalent as to whether information and an opportunity to consent must be offered for specific procedures during childbirth.[250] Courts have been more likely to consider patients to have given "implied [or implicit] consent" to care in childbirth simply by entering the hospital or engaging a particular care provider.[251] To reach this conclusion, the law often treats childbirth as a single medical event. For example, courts have held that a birthing person had "impliedly consented" to the administration of spinal anesthetic by entering a hospital during childbirth.[252] They have found no requirement to obtain consent where forceps were used in labor, as the use of forceps was not considered a separate surgical procedure from birth itself.[253] Courts have even held that by entering a hospital where residents are trained, birthing patients have impliedly consented to having residents perform procedures on them.[254]

Hospitals and providers have also argued that, upon signing the blanket consent form at the start of labor, a patient "voluntarily gives up the right to be so

243. *Id.* at 327.
244. *Id.*
245. *Id.* at 327–30.
246. *Id.* at 328.
247. *Id.*
248. *Id.* at 326.
249. *Id.* at 329.
250. *See* Jay M. Zitter, Annotation*, Malpractice: Physician's Duty, Under Consent Doctrine, To Obtain Patient's Consent to Treatment in Pregnancy or Childbirth Cases*, 89 A.L.R.4th 799 (1991).
251. *Id.* at §§ 2[a]–[b].
252. *Id.* (citing Hall v. United States, 136 F. Supp. 187, 193 (W.D. La. 1955)).
253. *See id.* (citing Charley v. Cameron, 528 P.2d 1205 (Kan. 1974); Sinclair v. Block, 633 A.2d 1137 (Pa. 1993)).
254. *Id.* (citing Henry v. Bronx Lebanon Med. Ctr., 53 A.D.2d 476 (N.Y. App. Div. 1976)).

informed and consents[] in advance."[255] These general consent forms, which patients sign upon arrival at the hospital and which use broad terms like the patient agrees to "all necessary treatment," have been used in some instances to find implied consent for particular medical procedures.[256] However, despite their general willingness to find implicit consent based on conduct, courts have largely rejected the notion that a blanket consent form itself creates a presumption of consent.[257]

The "implicit consent" framework sanctions a culture of non-consent in childbirth. By treating childbirth as a single event, during which any and all procedures performed have been consented to simply by presenting for care, implicit consent denies birthing people the right to make decisions about their care during the birthing process.[258] Under the implicit consent regime, "from the perspective of the hospital, [patients birthing in their facilities] had forfeited their rights to informed consent and refusal in order to give birth" there.[259] The notion that a patient has agreed to any treatment that a provider chooses for them by engaging a particular hospital or provider for care also operates on the faulty assumption that birthing people have access to a range of options, including out-of-hospital ones, from which to choose.[260] Because most pregnant people have no real choice but to go to a local hospital for care, "it is irresponsible for courts to infer a woman's informed consent from her presence in the hospital."[261]

In conclusion, current law does not consistently uphold consent in childbirth. Judicial decisions around informed consent in childbirth largely allow providers to perform procedures without providing information or even telling the patient, as well as to override consent in some states or situations. Providers' adherence to the ethical standard of informed consent, which requires giving information for each procedure, asking for consent or refusal, and respecting the decisions of the laboring patient, is entirely voluntary. Imposing an affirmative consent standard on childbirth would fill this gap in the law by taking existing ethical standards and making them legally enforceable.

B. Addressing the "Exceptional Circumstances" Argument

The case of a true obstetric emergency, where the fetus's life is in clear and

255. WEAR, *supra* note 144, at 10.
256. Baker, *supra* note 159, at 551.
257. *See* Wendy Woolery, *Informed Consent Issues throughout the Birthing Process*, 21 J. LEGAL MED. 241, 253–55 (2000).
258. *See* Cristen Pascucci, *Being Admitted to the Hospital or Signing Consent Forms is Not "Implied Consent,"* BIRTH MONOPOLY (Sept. 18, 2017), https://birthmonopoly.com/implied-consent/ [https://perma.cc/UC83-4TGW].
259. *Id.*
260. Baker, *supra* note 159, at 552–53.
261. *Id.* at 553.

immediate danger and the patient declines recommended care, is very rare.[262] None of the known case studies discussed in Parts I and II represent such a scenario (*Jefferson* may come closest, though the threat to the fetus was not imminent[263]). However, many who support pregnant autonomous decision-making overall, and would support an affirmative consent standard almost all of the time, still hold out for the "exceptional circumstance"—situations where it *is* clear that the fetus will die if the pregnant person does not consent; where the pregnant person, despite being legally competent, may *not* understand the risks to the fetus or themself in full; or where a pregnant person is not invested in the fetal outcome and the risks are understood but they decline care regardless.[264] As argued above, and as supported by the ethical guidelines of ACOG,[265] overriding a pregnant person's consent and bodily autonomy is never indicated given that pregnant people's bodies must be infringed upon significantly to "get to" the fetus.

However, for those who do not buy it—who believe that there is a state interest in potential fetal life, that the physician represents the fetal interest over the pregnant person, and that violating maternal bodily autonomy is the ethical choice, but only in the "exceptional circumstance"—*then the situations in which such violations can take place must be carefully-defined, narrow exceptions to the rule of affirmative consent*. Clear standards and procedures must be in place for when maternal consent can be violated, including the types of health scenarios that warrant violation, the quality of evidence needed to support a violation, the level of imminence necessary, and the authorities that must be involved. The situations in which such a violation of consent is warranted should be decided collectively, through recognized democratic processes of the legislature, and the violation of consent itself must be committed under the power of the state—not an individual medical provider. Before getting pregnant, choosing to carry a pregnancy to term, and entering labor, people should have information about the circumstances under which a patient's consent and refusal can be overridden. People need transparent information about when their consent may be overridden in order to make informed decisions about whether or not to become pregnant, or, once pregnant, whether to undergo labor with providers who may exercise the option to override

262. *See* Allison B. Wolf & Sonya Charles, *Childbirth Is Not an Emergency: Informed Consent in Labor and Delivery*, 11 INT'L J. FEMINIST APPROACHES TO BIOETHICS 23, 32 (2018).

263. Professor Joel Finer has argued that cases like *Jefferson v. Griffin Spalding City Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981), in which both the pregnant person's and the fetus's life are at significant risk without medical intervention, are the only cases in which court-ordered intervention should be compelled. Joel Jay Finer, *Toward Guidelines for Compelling Cesarean Surgery: Of Rights, Responsibility, and Decisional Authenticity*, 76 MINN. L. REV. 239, 241–42 (1991). Finer distinguishes these cases from those in which the fetus is at risk without medical intervention but the pregnant person is not, or where the pregnant person is at risk without medical intervention but the fetus is not, and argues these latter cases should not allow for compelled treatment by courts. *Id.*

264. *See supra* note 169, at 48–49 (advocating legal intervention to override maternal consent in "exceptional cases" based on factors such as the risk of fetal harm, patient decisional capacity, or lack of "willingness to care" for the baby).

265. *See supra* notes 162–66.

consent. The boundaries of any such exception to consent must be rigorously policed, with no provider allowed to violate consent outside of the expressly authorized exception. Affirmative consent should be the rule at all other times, and providers who violate consent without meeting the requirements for the exception should face state sanction.

Part of the problem with the current model is that the widely held "exceptional circumstance" belief is allowing ad hoc violation of pregnant people's consent, with no standards in place. Individual providers proposing to override consent may erroneously believe that they are facing the "exceptional circumstance." Judges, who frequently have little medical knowledge, are inclined to enforce compliance if the provider tells them the risk to the fetus is high. Even if one believes in state intervention in the "exceptional circumstance," appropriate protections should be put into place to ensure that such violations cannot take place under any and all circumstances. Legislated affirmative consent standards, with clear criteria for "exceptional circumstances," would serve that purpose.

III. AFFIRMATIVE CONSENT IN CHILDBIRTH: THE RATIONALE

This Part briefly explores a number of arguments in support of a legislated affirmative consent standard. It first argues that a special, heightened standard for consent in childbirth is warranted given the scale of the mistreatment and the use of special consent standards in other areas of medicine where patients are considered especially vulnerable to provider misconduct. Second, this Part urges that the inherent lack of evidence and medical uncertainty underlying most obstetric treatment decisions strengthens the case for affirmative consent. Next, Section C explores the analogies between sexual violence and obstetric violence, arguing that an affirmative consent standard makes sense in childbirth for some of the same reasons it has been applied to sexual relations. Section D argues that the assumption that the fetus is a "second patient"—with its own interests that are best represented by the provider during birth—misconstrues the actual interests and relationships involved in childbirth. Finally, the last Section argues that affirmative consent would reduce liability for providers by ensuring that birthing people make and are responsible for each decision during the birthing process.

A. A Heightened Standard for Consent Is Warranted

Obstetrics is unique from other areas of medicine in ways that support implementing a higher standard of consent. Its history is heavily gendered, marked by notoriously poor treatment of women through the ages and a deliberate effort to remove childbirth from the domain of midwives and place it under the control of physicians.[266] From a clinical perspective, the birthing process unfolds in real

266. *See e.g.*, HELEN KING, MIDWIFERY, OBSTETRICS AND THE RISE OF GYNAECOLOGY (1st ed. 2007).

time with an exceptional amount of decision-making by providers and patients. There is an acute lack of evidence underlying most obstetric practices,[267] with protocols varying widely between providers.[268] Finally, childbirth is more than just a set of medical procedures: it is a value-laden process entwined with sex, intimate relationships, procreation, and parenting—arenas recognized by the courts as fundamental to liberty.[269]

Heightened consent requirements exist in areas of medicine where patients are considered vulnerable to coercion. For example, sterilization carries heightened consent requirements under Medicaid in recognition of the "much-needed protection against coercive sterilization practices."[270] Affirmative consent has also been legislated in response to the epidemic of nonconsensual pelvic examinations performed by medical students on unconscious patients under anesthesia.[271] Though these consent standards differ from the procedure-by-procedure approach proposed in this Article, they validate the acceptance of heightened standards of consent in particular medical contexts where coercion is an issue.

---

267. *See* Jason D. Wright, Neha Pawar, Julie S. R. Gonzalez, Sharyn N. Lewin, William M. Burke, Lynn L. Simpson, Abigail S. Charles, Mary E. D'Alton & Thomas J. Herzog, *Scientific Evidence Underlying the American College of Obstetricians and Gynecologists' Practice Bulletins*, 118 OBSTETRICS & GYNECOLOGY 505 (2011) [hereinafter Wright et. al] (finding that two thirds of ACOG practice bulletins were based on "limited or inconsistent evidence" or "consensus and opinion"); *see also infra* Section III.B.

268. *See, e.g.*, Joyce K. Edmonds, Michele O'Hara, Sean P. Clarke & Neel T. Shah, *Variation in Cesarean Birth Rates by Labor and Delivery Nurses*, 46 J. OBSTETRIC GYNECOLOGIC & NEONATAL NURSING 486, 486 (2017) (finding that cesarean rates vary from 8 percent to 48 percent among nurses in a single hospital) [hereinafter Edmonds et al.]; Katy B. Kozhimannil, Michael R. Law & Beth A. Virnig, *Cesarean Delivery Rates Vary Tenfold Among US Hospitals: Reducing Variation May Address Quality and Cost Issues*, 32 HEALTH AFF. 527, 527 (2013) (finding total cesarean rates ranging from 7.1 percent to 69.9 percent between area hospitals); *see also* BRIGITTE JORDAN, BIRTH IN FOUR CULTURES (1993) 46, 48, 67–69 (finding that authoritative "medical" understandings and practices of childbirth are cultural and vary greatly between countries including Holland, Sweden, and the United States).

269. *See, e.g.*, Griswold v. Connecticut, 381 U.S. 479 (1965); Lawrence v. Texas, 539 U.S. 558 (2003).

270. Priscilla Huang, Candace Gibson & dfitzgerald, *NHeLP Comments: Comments on Sterilization Consent Form*, NAT'L HEALTH L. PROGRAM (Sept. 18, 2018), https://healthlaw.org/resource/nhelp-comments-comments-on-sterilization-consent-form/ [https://perma.cc/YLH9-DZYJ]. Heightened consent standards also exist in abortion, where opponents have often invoked the specter of coercive "abortionists" pressuring women into unwanted procedures in support of legislated consent standards in 34 states, 27 of which also require waiting periods. *See* Leslie Cannold, *Understanding and Responding to Anti-Choice Women-Centered Strategies*, 10 REPRODUCTIVE HEALTH MATTERS 171, 173 (2002); *Counseling and Waiting Periods for Abortion*, GUTTMACHER INSTITUTE (Feb 1, 2019) https://www.guttmacher.org/print/state-policy/explore/counseling-and-waiting-periods-abortion [https://perma.cc/W2K3-PPPC]; *see also* Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL'Y 223, 224–25 (2009) (examining the Supreme Court's treatment of informed consent in abortion).

271. Seven states currently ban the practice, and Massachusetts has a current bill proposed to do so. Sarah Betancourt, *Bills Bar Non-Consensual Pelvic Exams Under Anesthesia*, COMMONWEALTH (Apr. 18, 2019), https://commonwealthmagazine.org/health-care/bills-bar-nonconsensual-pelvic-exams-under-anesthesia/ [https://perma.cc/U9D7-6Z5A].

B. The Science Underlying Most Obstetric Recommendations in Birth Is Weak

The case for affirmative consent is strengthened by the lack of evidence available to support most obstetric practices. From a purely ethical standpoint of autonomy, this observation should be meaningless. Pregnant people, like any competent patients, should be able to decline any treatment option regardless of how strong the evidence is that underlies it.[272] However, when faced with the arguments made in favor of physician decision-making and compelled treatment in pregnancy, the lack of evidence underlying the decisions made in childbirth is of critical importance. The paucity of science in obstetric decision-making severely undermines the case for denying pregnant people choice in childbirth.[273] The fact that perceived risk to the fetus—the purported reason that justifies compelled treatment—is so often largely unsupported by reliable scientific evidence makes patient choice all the more necessary and appropriate.

Many obstetric recommendations are based on weak and inconsistent evidence. A review of the practice guidelines issued by ACOG indicates that two-thirds of obstetric and gynecological practices are based on "limited or inconsistent evidence" or "consensus and expert opinion."[274] The remaining third of the guidelines are based on "good and consistent scientific evidence.[275] In addition, ACOG's guidelines differ considerably from the guidelines issued by other professional associations. In a comparison with professional guidelines issued by the Royal College of Obstetricians and Gynecologists, the British counterpart to ACOG, researchers found that only 28 percent of the guidelines were the same, 56 percent were not comparable, and 16 percent of the recommendations were opposite.[276] Adherence to ACOG guidelines is considered

272. Professor Camilla Pickles argues that evidence-based guidelines can be tools to silence birthing people and deny them choice. Camilla Pickles, *Leaving Women Behind*, in CHILDBIRTH, VULNERABILITY AND THE LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL 140, 141–42 (Camilla Pickles & Jonathan Herring eds., 2020). Pickles notes that while evidence-based guidelines are often imposed on birthing people, sometimes with the force of law, birthing people cannot likewise enforce these guidelines under law to gain access to their benefits when providers choose not to adhere to evidence-based guidelines. *Id.* at 147–48.

273. *See* ACOG, *Refusal of Treatment*, *supra* note 157, at 178 (arguing that even the best available medical evidence is imperfect).

274. *See* Wright et al., *supra* note 267, at 505. The classification of the quality of evidence is performed by ACOG itself. *Id.* at 506.

275. *Id.* In obstetric guidelines alone, without gynecologic guidelines, only 25.5 percent of the guidelines were based on good or consistent scientific evidence, while 74.5 percent were based on low-quality evidence or opinion. *Id.* at 509.

276. Suneet P. Chauhan, Nancy W. Hendrix, Vincenzo Berghella & Danish Siddiqui, *Comparison of Two National Guidelines in Obstetrics: American Versus Royal College of Obstetricians and Gynecologists*, 27 AM. J. PERINATOLOGY 763, 766 (2010).

the "benchmark for quality" in the practice of US obstetrics,[277] shaping the recommendations pregnant patients will receive and the legal standards for informed consent and medical malpractice. One reason for the lack of high-quality evidence in obstetrics is the difficulty of randomized trials in childbirth, which are rarely performed on pregnant patients for ethical reasons.[278] The complexity and host of variables present in the pregnancy and childbirth processes also make controlled studies challenging.[279]

Another indicator of the arbitrariness of clinical decision-making in obstetrics is the fact that practices vary widely between individual providers and facilities.[280] The rates of variation between providers and hospitals are "not fully explained by the patient risk factors or preferences and [are] instead widely believed to be driven by differences in clinician practices."[281] Such variation means that the "biggest risk factor [for cesarean section] is 'the hospital a mother walks into to deliver her baby, and how busy it is.'"[282] In practice, this means that the particular recommendations that a given obstetric patient receives may vary widely depending on where the person seeks care and the provider that they see.[283] This significant element of chance concerning the proscribed treatment plan further weakens the argument that provider recommendations should be enforced on the pregnant person when they are resisted.

When a pregnant person refuses a medical recommendation in pregnancy or childbirth, it occurs in this context of scientific uncertainty and medical

277. Wright et al., supra note 267, at 505.

278. *See id.* at 510.

279. *See id.*

280. *See, e.g.*, Isabel A. Caceres, Mariana Arcaya, Eugene Declercq, Candice M. Belanoff, Vanitha Janakiraman, Bruce Cohen, Jeffrey Ecker, Lauren A. Smith & S.V. Subramanian, *Hospital Differences in Cesarean Deliveries in Massachusetts (US) 2004 – 2006: The Case Against a Case Mix Artifact*, 8 PLOS ONE, Mar. 2003, at 1, 4; Edmonds et al., *supra* note 268, at 490; Jourdan E. Triebwasser, Neil S. Kamdar, Elizabeth S. Langen, Michelle H. Moniz, Tanima Basu, John Syrjamaki, Alexandra C. Thomason, Roger D. Smith & Daniel M. Morgan, *Hospital Contribution to Variation in Rates of Vaginal Birth After Cesarean: A Michigan Value Collaborative Study*, Supplement to AM. J. OBSTET. GYNECOL. 904, 907 (2018).

281. Edmonds et al., *supra* note 268, at 486.

282. Tara Haelle, *Your Biggest C-Section Risk May Be Your Hospital*, CONSUMER REPS. (May 10, 2018), https://www.consumerreports.org/c-section/biggest-c-section-risk-may-be-your-hospital/ [https://perma.cc/S4MM-RUSR] (quoting Dr. Neel Shah).

283. In a number of cases of court-ordered intervention in childbirth, birthing people have successfully received their desired care at a different hospital that supported their choices. For instance, a Pennsylvania mother named Amber Marlowe was told her baby was too big for a vaginal birth, and that she needed a cesarean section. Baker, *supra* note 159, at 546. Marlowe had birthed six other children vaginally, many of whom were large babies. *Id.* When Marlowe refused a c-section, Pennsylvania's Wilkes-Barre General Hospital obtained a court order allowing it to perform a cesarean regardless and naming it the legal guardian of Marlowe's unborn child. *Id.* Marlowe fled to another area hospital where she birthed her healthy baby vaginally, with the support of the providers. *Id.* Cases like Marlowe's support the finding that patients can receive widely variable care and responses to their desired birthing choices depending on the provider they encounter.

heterogeneity.[284] "[P]arties may not agree on the best course of treatment due to differing assessments of success rates, side effect severity, and side effect likelihood. Accordingly, the birthing process yields many decision-making points on which professionals, patients—and even the state—may reasonably disagree."[285] But physicians, attorneys, and courts often present the decisions as carrying clear and certain risks, with only one possible path forward. The risk to the fetus and the pregnant person of a given medical procedure, and the separate and isolated "fetal interest" in the decision, are described as known quantities, when they are not. In one retrospective review of court-ordered cesarean sections, researchers found that the "prediction of harm to the fetus" made by the medical providers who petitioned for the court orders "was inaccurate" in over a third of the cases.[286] All of the orders were granted promptly by the courts, typically within hours of being requested.[287] The propensity of providers to present risk as known and certain, combined with the willingness of courts to enforce medical recommendations on pregnant patients, leads to particularly alarming results.

C. Obstetric Violence Is Analogous to Sexual Violence

The rationales for requiring affirmative consent in sex are similarly applicable in the birthing context. As in sex, a power relationship exists between the parties in the birthing context, obscuring the voluntariness of their actions. When violations of sexual consent occur, as with obstetric mistreatment, bodily integrity is at issue. Like sexual assault, obstetric mistreatment can include unwanted genital touching and penetration. At issue is a matter of control and choice—both in general and over the body. The roles and acts of the parties are heavily gendered, infused with implicit understandings about authority, submission, competency, and the right to control of the pregnant body by the parties. The political valence of obstetric violence mirrors that of sexual assault, as do the legal challenges facing survivors. For some people who experience it, the harms of obstetric violence resemble those often produced by sexual assault. This section addresses the arguments against affirmative consent standards in sex, finding that many of them do not apply in the context of birth.

Power. Affirmative consent has been promoted in sexual relations to reduce ambiguity regarding consent and because a power difference between parties can make it difficult to ascertain voluntariness.[288] Subjective perceptions of the parties, combined with a desire to proceed, can allow parties to cross lines without realizing it. Meanwhile, a power difference can render outright refusal difficult on the part of a less powerful party. Requiring that each party say "yes" before sexual

284. ACOG, *Refusal of Treatment*, *supra* note 157 (finding that "coercion is not only ethically impermissible but also medically inadvisable because of the realities of prognostic uncertainty and the limitations of medical knowledge").
285. Abrams, *Distorted and Diminished*, *supra* note 96, at 1959.
286. Kolder, *supra* note 180, at 1195.
287. *Id.*
288. *See* Humphrey, *supra* note 26, at 54–63.

activity can proceed forces a more explicit negotiation between the parties. While coercion based on the preexisting power relationship can still occur, affirmative consent standards endow the person whose consent is required with additional bargaining power.

Likewise, obstetric providers possess enormous power over their patients. The physician can choose which recommendations to offer and how conscientiously to give care. Keenly aware of this power, patients are eager to please in the hope of receiving good care. This can cause patients to stay silent or offer only vague protestations when unwanted procedures are performed. Unfamiliar with the medical environment or the birthing process, patients may be unaware of the option to decline procedures. Under the current framework, so long as a patient does not emphatically decline, a provider can carry out unwanted procedures while staying ignorant of the fact that they are violating consent.[289] As in the sexual context, requiring that a patient say "yes" before a given procedure may help correct for the power difference between providers and patients and reduce potential ambiguity regarding the agreement of the patient.[290] In this way, affirmative consent gives laboring people bargaining power under the law during childbirth—an endowment that arguably currently rests with providers.[291]

Violation. Obstetric violence, like sexual assault, takes away someone's control over their body. It can involve physical violation of regions of the body usually held private and associated with sexuality, as well as acts of restraint and humiliation by providers.[292] People who experience obstetric violence involving unwanted genital penetration routinely describe the violation as similar to rape or sexual assault.[293] In their study of traumatic birth experiences, Reed et al. document a number of such accounts.[294] Their respondents described feeling "…raped and mutilated," "… violated and damaged," and "…violated and scared and disgusting" as a result of provider actions.[295] Those who had previous sexual trauma analogized their traumatic birth experiences to their sexual violations. One

289. For example, in *Charley v. Cameron*, 528 P.2d 1205, 1207 (Kan. 1974), Mrs. Charley expressed a desire prenatally to avoid forceps in labor unless absolutely necessary. At the hospital where she birthed, forceps were used in 95 percent of first-time births where the patient had an epidural. *Id.* at 1207. During the birth, the physician picked up the forceps and moved to use them. Mrs. Charley said "forceps?" *Id.* at 1209. The doctor did not respond and proceeded to use the forceps. *Id.* The court found that Mrs. Charley "raised no objection to their use" and thus consented. *Id.* This kind of ambiguous consent scenario, common in obstetrics, could be prevented with the use of affirmative consent.

290. In the healthcare context, as in the sexual context, this clarity has major implications for any ensuing liability. *See* Humphrey, *supra* note 26, at 39.

291. *See* Robert H. Mnookin & Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950, 968–69 (1979) (describing how legal rules shape how claims would come out in court change the bargaining chips held by each party, granting parties an endowment in the bargaining process that can change the outcome of negotiations).

292. *See supra*, text accompanying notes 28–31, 54–66.

293. *See* Herring, *Identifying the Wrong,* supra note 28, at 81.

294. Reed et al., *supra* note 9, at 6.

295. *Id.*

participant described:

> The most terrifying part of the whole ordeal was being held down by 4 people and my genitals being touched and probed repeatedly without permission and no say in the matter, this is called rape, except when you are giving birth. My daughter's birth was more sexually traumatising than the childhood abuse I'd experienced…[296]

Another respondent explained:

> [M]y cervix was manually dilated forcefully after pleading for the Dr. to stop. This caused me to reexperience a previous rape. Later in my birth my Dr. performed a deep episiotomy after being told repeatedly that I did not want one… Images and fears from my past sexual abuse/assaults became constant in my mind after birth.[297]

These firsthand accounts reveal the way in which the embodied experience of obstetric violence can mirror that of rape or sexual assault for some survivors.

Gender. Obstetric violence unfolds in the midst of heavily gendered constructions of labor and birthing people. As with rape culture, these gendered constructs create an environment in which obstetric violence is normalized and excused.[298] Laboring women are portrayed as irrational and unreasonable.[299] Birth itself is approached as animalistic, and the people doing it as not fully human.[300] Women are constructed as a threat to their fetuses, and as deviant should they disobey authoritative physician orders.[301] There is also an undertone of punishment in birth: it is her fault for getting pregnant in the first place, so now she has to deal with the consequences. On the flip side, doctors are constructed as eminently rational, objective, and clear-headed.[302] Their own decision-making is seen as inherently calculated and reasonable.[303] Survivors of sexual assault have their sexuality scrutinized and questioned and are depicted as immoral and

296. *Id.* at 6–7.
297. *Id.* at 6.
298. *See Rape Culture*, MARSHALL WOMEN'S CTR., https://www.marshall.edu/wcenter/sexual-assault/rape-culture/ [https://perma.cc/4AL8-QREU].
299. *See, e.g.*, ROBBIE E. DAVIS-FLOYD, BIRTH AS AN AMERICAN RITE OF PASSAGE 50–51 (2d ed. 2003); *see also infra* note 301 (reciting negative descriptors providers used describing birthing people who declined recommended care).
300. *See* DAVIS-FLOYD, *supra* note 299 (discussing the construction of women and birth as "beast[ly] and "dangerously under the influence of nature").
301. One study of providers found that birthing people who declined recommended care were described by providers as "aggressive," "stupid," "crazy," "completely bonkers," "asking for trouble… naughty," "selfish," "ridiculous… she's nuts," "control freak," and "manipulative." Jenkinson et al., *supra* note 25, at 17. When pregnant patients declined care, providers' "most frequent judgment was to question whether women who declined recommended care were acting as good mothers." *Id.*
302. *Cf.* DAVIS-FLOYD, *supra* note 299, at 72.
303. *Id.* (describing obstetrics as a machine).

licentious for supposedly putting themselves in a situation where assault could occur. Similarly, survivors of obstetric violence have their motherhood scrutinized and questioned and are painted as depraved, uncaring, and selfish mothers for questioning the provider or challenging their authority. The stories of sexual and obstetric violence told by survivors are often distrusted and disbelieved.[304] In both sexual assault and obstetric violence, though in different ways, many consider the victim to be asking for it.

Lack of justice. In the sexual context, consent rules that permit silence and ambiguity to count as permission deepen the challenges survivors face in getting justice. Affirmative consent seeks to counter this ambiguity and ensure that assessment of what is permissible turns less on gendered scripts and more on whether actual permission was granted. It's not perfect—gendered constructions still mar sexual assault proceedings, and coercion can always be applied to get someone to say "yes."[305] However, having an affirmative consent rule changes the framework for the kinds of questions available to determine whether a violation occurred.

Likewise, in obstetric violence, turning the assessment away from questions of whether the treatment decision was most reasonable, was medically recommended, or was the best for the fetus over the pregnant person—and towards whether the pregnant person gave permission for the procedure to occur—would shift the framework in which these incidents are analyzed. It would move the conversation away from questions of moral blame and toward an inquiry more appropriately considerate of the rights and bodily autonomy of the birthing person.

Lasting harm. In addition to physical injuries, survivors of sexual assault can suffer lasting harm such as depression, post-traumatic stress disorder (PTSD), substance abuse, irritability, anger, and anxiety.[306] These symptoms carry accompanying economic costs, including healthcare costs and loss of productivity,[307] damage relationships,[308] and have a lasting impact on sexual

304. *See* Cohen Shabot, *We're Being Gaslighted*, *supra* note 34, at 14. Professor Cohen Shabot argues that that obstetric violence occurs in an epistemic framework of "gaslighting," in which women are routinely "disbelieved, distrusted, and (unjustifiably) questioned about their violent laboring experiences and, more pressingly, even being made to doubt their own experiences of violence." *Id.*

305. *See infra* Section IV.C.

306. Fiona Mason & Zoe Lodrick, *Psychological Consequences of Sexual Assault*, 27 BEST PRAC. & RSCH. CLINICAL OBSTETRICS & GYNAECOLOGY 27, 31 (2013). Sexual assault survivors evidence higher levels of post-traumatic stress disorder than survivors of other potentially traumatic events such as motor vehicle accidents or loss of a loved one. *See* Jane Shakespeare-Finch & Deanne Armstrong, *Trauma Type and Posttrauma Outcomes: Differences Between Survivors of Motor Vehicle Accidents, Sexual Assault, and Bereavement*, 15 J. LOSS & TRAUMA 69, 69 (2010).

307. A recent Center for Disease Control study estimated a lifetime cost of $122,461 per victim of rape attributable to healthcare costs, lost productivity, and criminal justice costs. Cora Peterson, Sarah DeGue, Curtis Florence & Colby N. Lokey, *Lifetime Economic Burden of Rape Among U.S. Adults*, 52 AM. J. PREVENTATIVE MED. 691, 691 (2017).

308. *See* Mason & Lodrick, *supra* note 306, at 31–32.

satisfaction.[309] People raped by someone they know experience more severe and lasting harm than those attacked by a stranger, an effect associated with the betrayal of trust inherent in the violation.[310] The emerging picture of obstetric violence indicates that survivors of such violence can likewise experience lasting harm as a result, often in the form of PTSD, anxiety, and depression.[311] Obstetric violence also includes a loss of trust when the healthcare provider who commits the violation betrays the patient's confidence.[312] Though research is still limited on the full extent of the harm associated with obstetric violence, it appears that it bears some similarity to the harm resulting from sexual violence.

Concerns about affirmative consent. Despite the similarity of the rationales for affirmative consent standards in sex and childbirth, many of the concerns raised by opponents of affirmative consent in the sphere of sexual relations are inapplicable in the context of healthcare. Unlike in sex, the provider-patient relationship in childbirth is a formal one with explicit expectations of communication and documentation. While affirmative consent standards in sex are criticized for being over-inclusive of common sexual behavior and therefore too aspirational,[313] affirmative consent in childbirth is in line with existing professional and ethical standards of care for healthcare providers.[314] Concerns that affirmative consent in sex will foster an "intensely repressive and sex-negative" moral order or "encourage weakness among those [it] protect[s]"[315] are also likely inapplicable in the healthcare environment. Few would argue that laboring patients, who require care and may lack the ability to leave the hospital setting, are disempowered by a standard that requires their verbal agreement to individual procedures.[316] In sum, the drawbacks that affirmative consent standards may pose in the context of sex are largely absent in birth.

D. The Physician Does Not Represent the Fetal Interest

Outside of childbirth, there is relative comfort with the grant of final decision-making to the patient due to largely accepted principles of self-determination, autonomy, and bodily integrity.[317] But in childbirth, the presence

309. *Id.*
310. *Id.* at 30.
311. *See* Reed et al., *supra* note 9, at 6; Horsch & Garthus-Niegel, *supra* note 9, at 51–53.
312. Herring, *Identifying the Wrong*, *supra* note 28, at 74.
313. Janet Halley, *The Move to Affirmative Consent*, 42 J. WOMEN CULTURE & SOC'Y 257, 277 (2016).
314. *See, e.g.*, Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion on Refusal of Medically Recommended Treatment During Pregnancy, No. 664,* 127 OBSTETRICS & GYNECOLOGY e175, e176 (2016).
315. Halley*, supra* note 313, at 259.
316. For concerns about the practicability of affirmative consent in birth, including what constitutes a new procedure, see *infra* Section IV.B.
317. *See generally* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 278 (1990); Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (1914).

of the fetus, combined with the belief that the physician is more informed than the pregnant person, leads many to conclude that the doctor is the best decision maker in such situations. Part of this view rests on the belief that there is a separate and distinct fetal interest at stake and that the doctor necessarily represents that interest, while the pregnant person does not.[318] But the idea that the presence of the fetus fundamentally changes the calculation with regard to autonomous medical decision-making does not withstand scrutiny. Much of the same reasoning that supports the patient as the optimal decision maker in nonpregnant situations applies equally in childbirth.

First, "maternal" and fetal interests cannot be distinguished or reliably identified.[319] At the root of the debates around pregnant people's decision-making is the construction of a conflict of interest between the pregnant parent's interest and the fetus's, often described as the "maternal-fetal conflict."[320] This narrative gained credence with the advent of medical technologies, such as ultrasound, amniocentesis, fetal heart monitoring, and fetal surgery, that "contributed to a perception that the fetus is a separate entity" from the pregnant patient.[321] Though the fetus itself never approaches the doctor for care nor agrees to a care relationship, doctors have nevertheless unilaterally adopted fetuses as a "second patient" when treating pregnant people.[322]

In the words of Professor Michelle Oberman, disagreements about treatment "are not maternal-fetal conflicts at all, but rather maternal-doctor conflicts."[323] As Oberman describes, physicians generate these conflicts by inserting their own preferences into the treatment plan:

> [The conflict] begins when doctors project their own estimations of the optimal course of action onto their pregnant patients. When a pregnant woman resists medical advice, the doctor often invests the fetus with interests and rights that directly coincide with his own personal treatment preferences. The pregnant woman's interests are then rendered in direct opposition to those attributed by the doctor to her fetus.[324]

---

318. *See* Oberman, *supra* note 182, at 472.
319. The term "maternal" is used interchangeably here with gender-neutral language because of the gendered framing that infuses the discussion of the interests of the pregnant person (including notions of self-sacrifice, undervaluing of women's lives and autonomy, etc.). *See, e.g.*, *supra* text accompanying notes 32–37.
320. Oberman, *supra* note 182, at 454.
321. *Id.* at 471–72; Susan Goldberg, *Medical Choices During Pregnancy: Whose Decision is it Anyway*, 41 RUTGERS L. REV. 591, 591 & n.1 (1989) [hereinafter Goldberg].
322. Oberman, *supra* note 182, at 472. Oberman draws the parallel to a minor child, noting that a physician would not be able to establish a physician-patient relationship with a child absent consent from the parent or guardian. *Id.* Only through filing a report with a state agency and meeting designated legal standards for medical neglect could a physician overcome such consent and treat a child without parental consent. *Id.*
323. Oberman, *supra* note 182, at 454.
324. *Id.* In childbirth, where multiple care decisions build off of one another, a physician may even

Where a separate and distinct fetal interest is constructed, the conclusion is often that there should be a "balancing" of fetal and maternal interests when they "conflict." But because the doctor is the one who decides what the fetal interest is in the first place and how it relates to the plan of care, acting in the fetal interest is functionally equivalent to the physician dictating care decisions.[325] Rather than serving as a "neutral" third party, adjudicating between maternal and fetal interests, the physician is de facto aligned with the fetus, whose interests the physician has constructed.[326] The idea of "balancing" is therefore a fallacy: where fetal interests are decided and followed against the wishes of the pregnant person, the living pregnant individual's legally recognized rights and physical body are fully violated.[327] The physician making such a determination, who claims a fiduciary duty to both the pregnant person and the fetus, has not only abandoned but has undermined the fiduciary duty to the pregnant person.[328]

Tort law further entrenches this inequity in care between the fetus and the birthing person. The unequal compensation regime, in which fetal harm results in large damage verdicts while harm to the birthing person yields minimal claims, drives "fetal-focused consequentialist decision-making."[329] Doctors are keenly aware that "[h]ealthy babies negate maternal harms" when it comes to liability and are thus incentivized to sacrifice the birthing person's interests to even a minor perceived fetal risk.[330] In tort law, "judicial reasoning suggests that the only *real* harm that a woman can suffer is a harmed child; anything else that a woman might endure is de minimis, at best, and acceptable at worst."[331]

Even if one grants the existence of a "second patient" in the fetus, with separate interests that conflict with the pregnant person's, the pregnant patient is still the best decision maker of the three parties involved: doctor, patient, and fetus.[332] Where a birthing person's medical preferences diverge from the doctor's, the person is often "characterized as stubborn, perhaps reckless, and their medical preferences are framed as emotional wants or desires, rather than medical preferences."[333] But typically, the birthing person has a set of reasons for their preferences that involve their unique set of circumstances.[334] The pregnant person,

---

be responsible for creating the situation that has caused a particular treatment conflict to arise. Earlier care decisions, also made by the physician, may create risks that generate need for further treatment, which is subsequently declined by the patient. In such scenarios, the physician's role in the apparent conflict of interests is even more ambiguous. *Id.*

325. *Id.*
326. *Id.*
327. *Id.*; Goldberg, *supra* note 321, at 595.
328. Oberman, *supra* note 182, at 477.
329. Abrams, *Distorted and Diminished*, *supra* note 97, at 1960.
330. *Id.*
331. *Id.* at 1989 (emphasis in original).
332. *See, e.g.*, Baker, *supra* note 159, at 548 (challenging the notion that physicians are better advocates for a fetus than "the child's own mother").
333. Abrams, *Distorted and Diminished*, *supra* note 96, at 1994.
334. The reasons women provide for declining certain medical care include: "[W]anting to avoid

who has an actual stake in the life of the fetus—and in their own life—is a better representative of the fetus than the physician.[335] The decisions made in childbirth "will have a lasting effect on the mother's body, her infant's life, and her family's ability to recover from this pregnancy and carry future children to term."[336] In terms of establishing an appropriate "balancing" of interests, the pregnant person is more likely to have the relevant personalized information and actual stake in the fetus's life necessary to make the best overall decisions.

E. Affirmative Consent Can Reduce Physician Liability

Obstetric liability casts a long shadow over the issue of consent in childbirth. A 2015 survey of obstetricians and gynecologists indicated that 73.6 percent were sued in their career, with an average of 2.59 claims per respondent.[337] Correctly or not, physicians believe that they will be liable if a poor fetal outcome results from a patient's refusal of care.[338] Some physicians self-report that this has led them to increase the number of cesarean sections they perform.[339] This type of "defensive medicine" can drive providers to recommend more interventions and to push more forcefully for those interventions because they fear liability should a bad outcome occur.[340] Affirmative consent would reduce the decision-making burden on physicians and limit their liability. This section will first address instances where patients affirmatively consent to the recommended course of care, and then discuss cases in which a patient refuses recommended care.

Affirmative consent as a practice is likely to reduce liability for physicians throughout care, even where a patient accepts all recommendations. To the extent that physicians are currently liable regardless of patient consent, it is because they are the primary decision makers in the care. When physicians act without informing the patient of the reasoning for their decisions or asking for their

---

specific experiences encountered in a previous birth; reduced recovery time from vaginal birth over [cesarean section], especially in the context of caring responsibilities for older children; desire to maximise the likelihood of a normal birth; belief that vaginal birth would enable easier and swifter bonding with the new baby; wanting baby to be born when it was ready (rather than labour being induced), and wanting future pregnancies not to be complicated by multiple previous [cesarean sections]." Jenkinson et al., *supra* note 25, at 10–11 (based on interviews with women who had declined recommended care during childbirth).

335. *See* Baker, *supra* note 159, at 548.

336. *Id.*

337. Andrea M. Carpentieri, James J. Lumalcuri, Jennie Shaw & Gerald F. Joseph Jr., *Overview of the 2015 American Congress of Obstetricians and Gynecologists' Survey on Professional Liability*, PROTECT PATIENTS NOW (Nov. 3, 2015) at 3, https://protectpatientsnow.org/wp-content/uploads/2016/02/ACOG2015PLSurveyNationalSummary11315.pdf [https://perma.cc/DB9X-V2UW].

338. *Id.*

339. *Id.*

340. *See* Baker, *supra* note 159, at 548–50 (describing defensive medicine as "the deviation from sound medical practice to avoid the threat of malpractice litigation" in which "doctors order tests and procedures based on self-preservation rather than medical necessity" (citation omitted).

consent, they are liable when something goes wrong. Patients are less likely to sue when they participate in care decisions along the way.[341] If a patient is given a genuine opportunity to decline a given course of care but chooses to accept it, they will be less inclined to blame the provider should there be a poor outcome.[342] Furthermore, relationship building is at the heart of reducing liability for providers,[343] and affirmative consent would contribute to that relationship building by requiring increased communication and contact between providers and patients. From a formal legal perspective, affirmative consent ensures a record of each step of the choices made by the patient. A clear record of consent makes it harder for patients to establish liability.

In cases where patients decline recommended care, the proposed affirmative consent legislation must provide for a legislated waiver of liability for the provider. Responsibility for the outcome goes hand-in-hand with the autonomy of decision-making. Patients should be informed when they decline care that they are waiving the provider's liability for that decision should a bad outcome result. In the case that a bad outcome were to occur after a patient declined a care recommendation, the burden would be on the patient to show that their decision to decline the treatment was not the cause of the outcome.

IV. CRITIQUES AND LIMITATIONS OF AFFIRMATIVE CONSENT IN CHILDBIRTH

A. Patients Want Doctors to Decide for Them

Recent decades have brought significant pushback on ideas of unfettered patient autonomy.[344] Such critiques center around the notion that people accessing care "want to be fixed and reassured, not educated and forced to make decisions about matters with which they are quite unfamiliar."[345] There is some evidence to support this claim in medicine at large.[346] However, it is at least possible that this is not the case with childbirth, which is not primarily a medical condition for most people, and involves a host of values and preferences—more so than most other

341. *See, e.g.*, Elizabeth M. Schoenfeld, Shelby Mader, Connor Houghton, Robert Wenger, Marc Probst, David Schoenfeld, Peter Lindenauer & Kathleen Mazor, *The Effect of Shared Decisionmaking on Patients' Likelihood of Filing a Complaint or Lawsuit: A Simulation Study*, 74 ANNALS EMERGENCY MED. 126, 126 (2019) (finding participants in a simulated study who engaged in shared decision-making to be 80 percent less likely to want a lawyer than those who did not).

342. *Id.*

343. *See* Aaron E. Carroll, *To Be Sued Less, Doctors Should Be Talking to Patients More*, N.Y. TIMES (June 1, 2015) https://www.nytimes.com/2015/06/02/upshot/to-be-sued-less-doctors-should-talk-to-patients-more.html [https://perma.cc/Q386-7YP6] (collecting studies on the link between liability and patient-provider trust and communication).

344. WEAR, *supra* note 144, at 3.

345. *Id.*

346. *Id.*

medical care.[347] Birth is a protracted process with more depth to the experience than most medical procedures. Many people approach the birthing process as a life event with hopes and aspirations beyond the medical outcome. And qualitative studies of people's birth experiences consistently show that control over the process ranks highly in birth satisfaction.[348]

Even if patients eschew complicated medical decision-making and want the provider to decide for them, affirmative consent does not unduly interfere with that process. It simply requires providers to meet ethical standards for consent by seeking agreement to each procedure. There is no information requirement beyond that already in place; patients who prefer simply to be given care without too much decision-making can easily say "yes" to the recommended treatment.

B. Practicability

Some may believe that birth is an emergency so there is no time to get affirmative consent. This argument is belied by the fact that some physicians and hospitals likely fully implement ethical informed consent according to professional guidelines.[349] In addition, the midwifery model of care already applies an affirmative consent standard.[350] Despite media portrayal of childbirth as an emergency, labor and birth typically unfold over the course of many hours, with ample time for informed choice along the way. The vast majority of decisions in childbirth are not made under urgent conditions,[351] and informed choice can still be offered when things are happening quickly.[352] Even if there are a narrow handful of situations that present a time-sensitive emergency wherein affirmative consent is impracticable, these should operate as carefully defined exceptions to the rule of affirmative consent—like in other areas of medicine—and should not

347. Wolf & Charles, *supra* note 262, at 32 (noting that the idea "that all decisions made in labor are medical in nature—is [] highly doubtful. In the context of labor, many, if not most, decisions are really value judgments based on weighing and balancing the perceived risks and benefits of using (or not) certain interventions" as opposed to technical medical decisions).

348. *See, e.g.*, Katie Cook & Colleen Loomis, *The Impact of Choice and Control on Women's Childbirth Experiences*, 21 J. PERINATAL ED. 158, 165–66 (2012); A.M. Hardin & E.B. Buckner, *Characteristics of a Positive Experience for Women Who Have Unmedicated Childbirth*, 13 J. PERINATAL ED. 10, 14 (2004).

349. *Cf. supra* text accompanying footnotes 81–94. Though studies on mistreatment do not expressly track the rates of providers who provide respectful care and ask for consent, the fact that roughly two-thirds of pregnant people do not report misconduct suggests that many providers in many births abide by ethical guidelines and ask for consent.

350. *Statement of Values and Ethics*, MIDWIVES ALLIANCE OF NORTH AMERICA (Aug. 2010) https://mana.org/sites/default/files/pdfs/MANAStatementValuesEthicsColor.pdf [https://perma.cc/R68V-EXWV]; *Midwives Model of Care*, MIDWIVES ALLIANCE OF NORTH AMERICA, https://mana.org/about-midwives/midwifery-model [https://perma.cc/2F62-XPLB].

351. *See, e.g.*, Wolf & Charles, *supra* note 347 (cataloguing various procedures in low-risk childbirth and arguing that these procedures are not emergencies and require informed consent either prior to labor or at the time).

352. WEAR, *supra* note 144, at 156 (demonstrating the particular requirements to avoid the need for consent to argue that even in many emergency situations, consent is still required).

dictate a lack of consent throughout the process.

Time-sensitive childbirth situations can be analogized to other areas of medicine where treatment decisions must be made quickly, such as emergency medicine. In emergency medicine, informed consent for each procedure is still the norm, barring exceptional circumstances.[353] The criteria for avoiding informed consent due to an emergency are:

> (1) there must be a clear, immediate, and serious threat to life and limb; (2) the treatment that will be provided without informed consent should be . . . one that is in keeping with the standard of practice; and (3) the time it would take to offer an informed consent would significantly increase the patient's risk of mortality and morbidity.[354]

An exception to obtaining affirmative consent in childbirth of similar scope would be reasonable and would cover a narrow range of emergent situations, such as shoulder dystocia or hemorrhage, so long as the birthing person did not express treatment preferences contrary to the routine course of care.

Although there is time to get consent during labor, there could be questions about what constitutes a new procedure requiring fresh consent. These questions, in particular, would need to be clarified for an affirmative consent standard to be effective. However, there is plenty of precedent available in obstetrics upon which to build in determining when affirmative consent is required. As discussed above, many providers already implement fully informed consent according to ethical guidelines[355] and have developed principles around when to obtain patient consent. Charting systems for providers already lay out discrete procedures to be charted, guiding providers as to which actions constitute a new procedure. Determining when to obtain affirmative consent is a surmountable issue and would involve clarifying existing protocols and procedures to accommodate affirmative consent.

International efforts to ensure both proper information and affirmative consent throughout the birthing process are illustrative. Notably, in response to national outcry over obstetric violence, the National Health Service of England (NHSE), in collaboration with Birth Rights UK, the Royal College of Obstetricians and Gynecologists, and the British Intrapartum Care Society, is currently developing an app called IDECIDE to assist with informed consent during the birthing process.[356] This "consent tool" will guide providers and patients through informed decision-making for various procedures in labor,

353. *Id.* (pointing out the few, specific exceptions to requiring consent).
354. *Id.* at 157.
355. *See supra* Section II.A.i.
356. *IDECIDE – A New Consent Tool Is On Its Way…*, Birthrights (Jan. 30, 2020), https://www.birthrights.org.uk/2020/01/30/idecide-a-new-consent-tool-is-on-its-way/ [https://perma.cc/7GT5-ZMFZ] (stating that the initial pilot is expected to be ready by summer 2020).

including facilitating individualized discussions of the patient's situation.[357] It is designed to be used even in "the most urgent and stressful situations" and will allow for more or less information and engagement to be offered depending on the time-sensitivity of decision-making.[358] The tool is being designed with the dual purpose of ensuring sufficient information and active, affirmative consent during the labor process for birthing people and alleviating liability concerns for providers.[359]

C. Providers Can Coerce People into Affirmatively Consenting

The potential for provider coercion is the strongest critique of the affirmative consent standard and raises real concerns. Affirmative consent will not overcome the power dynamics in the birthing room. That being said, coerced consent is already a problem. Under the current legal framework, birthing people have little leg to stand on in the face of this conduct because the law is uncertain as to their very ability to make decisions during birth. It is at least possible that a defined affirmative consent standard could alleviate, rather than aggravate, this existing problem.

Coercive consent is a real risk, and any improvements resulting from an affirmative consent standard would be limited by the extent to which providers can manipulate patients into saying "yes." If past conduct is any indicator, providers may simply resort to even more aggressive, coercive, and manipulative techniques to "obtain" the necessary consent. The information given to patients could becoming increasingly skewed in favor of the provider's preferred treatment plan, to proactively head off the possibility that a birthing person would not consent. For example, providers could routinely pull the "dead baby card," insisting to patients that their baby could die if they do not follow the prescribed treatment,[360] or threaten to withdraw care if a birthing person will not comply, even when risks are nominal. Or providers could opt to limit the options they present to birthing people, presenting only false choices between options of which the provider approves. Birthing people could face emotional and physical abuse designed to extract their consent. In the current power relationship, in which providers have the upper hand and birthing people are dependent on them for care,

357. *Id.*

358. *Id.*

359. *See, e.g.*, *Our Mission*, MOTHERBOARD, https://www.motherboardbirth.com/about-us [https://perma.cc/5GZQ-2X7D] (exploring another website being used as a tool for providers and patients to ensure a positive and consensual birthing process).

360. The "dead baby card" is a common reference used to describe how providers sometimes respond when a birthing person "hesitates to comply with a command, or refuses a treatment." *See, e.g.*, Ashley M. Kim, *The Vulnerability of Mothers*, RADICAL MOTHERHOOD: MEDIUM (Oct. 19, 2020), https://medium.com/radical-motherhood/the-vulnerability-of-mothers-39755ff20f0c [https://perma.cc/R6BY-NQPB]. In these cases, providers may respond by suggesting that the baby will die even when the risk is very low, or that "[w]e could do it your way, . . . but you want your baby to live, right?" to manipulate the patient's own sense of loyalty to the fetus. *Id.*

information, physical support, anesthesia, and access to their newborn baby after birth, affirmative consent has the potential to increase the extent to which providers use this kind of coercion.

However, once affirmative consent became law, the norms and standards for obtaining consent would likely begin to shift. The law would clarify providers' designated role in the process, as well as the birthing person's definite status as the decision maker. Furthermore, advocates for pregnant people would have more fodder for their arguments that decisions lie with the birthing person rather than the provider. The burden of liability on the provider would be lessened, reducing their incentives to coerce consent. It is at least possible that, within this new framework, there would be greater potential for reducing the coercive role of providers and for advocating for improvements in the birthing process.

D. Pregnant People Could Be Held Liable for Their Choices

Another risk of affirmative consent is that it could contribute to increasing criminalization of pregnant people for poor outcomes.[361] This is why a legislated consent standard must include clear language prohibiting criminal or civil liability for birthing people for their medical treatment decisions. Without this protection in place, in an affirmative consent regime, if a birthing person declined a medical recommendation and the baby died as a result, the state could easily choose to prosecute this death as manslaughter. Already, courts have upheld manslaughter charges for pregnant conduct that was found to be reckless and resulted in harm to the fetus.[362] Absent language preventing liability for medical decision-making, increased criminal and civil action against pregnant people thus seems like a possible unintended consequence of pursuing affirmative consent to its logical conclusion.

With a prohibition on liability for birthing people in place, the question remains whether an affirmative consent standard would impact criminalization for acts other than medical decision-making, such as drug use or self-harm. A legislated affirmative consent regime may have no effect on this type of criminalization. But it also may strengthen the idea that pregnant people should not be held criminally liable for acts that risk harm to the fetus, thereby potentially helping curb such criminalization. While affirmative consent will not do away with criminalization of pregnancy, it could help clarify that pregnant people have bodily autonomy and are in charge of medical decision-making during pregnancy.

361. *See, e.g.*, Cortney E. Lollar*, Criminalizing Pregnancy,* 92 IND. L.J. 947, 948–49 (2017) (exploring cases where birthing people were arrested when their babies were born with drugs in their systems). *See also* Ocen, *supra* note 151.

362. *See* United States v. Flute: *Eight Circuit Upholds Manslaughter Charge Against Pregnant Woman for Death of Baby Based on Prenatal Drug Use*, 133 HARV. L. REV. 1087, 1087–88 (2020). *See also* Minkoff & Paltrow, *supra* note 153 (discussing case in which a mother who declined a cesarean section and whose fetus was stillborn was charged with murder).

CONCLUSION

There remains a dearth of analysis around the legal treatment of childbirth, and the current law fails to prevent widespread mistreatment of birthing people during labor. Courts have upheld this mistreatment, and professional standard setting has not stemmed it. There is a need for more research and new legal tools to address the problem of obstetric violence. In exploring solutions, it is critical to note that the issues facing birthing people are not fully captured by discrete incidents of egregious misconduct. They are instead grounded in an ongoing relationship of power and coercion that is currently largely sanctioned societally and legally. For a legal approach to succeed in significantly reforming obstetrics and eliminating obstetric violence, it needs to endow birthing people with more power within the provider-patient relationship and address the step-by-step decision-making that occurs in labor.

Affirmative consent in childbirth is a potential mechanism to shift the power relationship between providers and patients, clarify communication, and reduce the incidence of unwanted procedures. Such an approach would mirror legal approaches to other forms of gender-based violence, like sexual assault, in setting heightened standards that seek to correct for existing power imbalances. It would take existing professional ethical standards and enshrine them into law, guaranteeing birthing people the kind of autonomy they deserve. An emphasis on consent over information-giving would grant birthing people the additional bargaining power needed to receive more fulsome explanations of their birthing options and to say "no" when it matters. Of course, the potential of an affirmative consent standard would be limited by the ability of providers to manipulate and coerce patients into consenting. However, once the law is clear that the decision to consent or refuse belongs to the birthing person, affirmative consent could give birthing people leverage to push back on such techniques. If affirmative consent was the background rule, providers would be pushed to develop more comprehensive decision-making tools and ways of explaining procedures that would better serve patients—whose consent they are currently required to neither ask for nor receive before proceeding—and would keep patients' experiences and outcomes at the center of the birthing process.