

Dear Reader: This paper is still a work-in-progress, as I continue to develop my arguments about the legal implications of coercion in maternity care and appropriate responses to address the problem. Thank you in advance for all comments and suggestions! ~LK

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

Elizabeth Kukura

I. Introduction

Pregnancy is a time filled with decision-making for the pregnant woman and her partner—ranging from major decisions about who will care for the infant and whether changes in housing or employment will be necessary to less consequential decisions about stroller choice, diapering method, and nursery design. Countless books and articles provide prospective parents with advice about their choices in baby names, feeding methods, and parenting philosophy.¹ For many women, however, the decisions they face about their medical care throughout pregnancy and childbirth are more difficult to navigate. Most women do not have the medical knowledge necessary to anticipate and understand complications as they arise, at least without independent research. Doctors help guide women through unfamiliar terrain, explaining childbirth and the risks and benefits of different approaches to managing it, but patients often lack critical information about factors that may influence a physician's clinical recommendation—including professional philosophy, prior experience with malpractice claims, potential financial incentives, or hospital protocols and policies that impact physician behavior. Recognizing the complexities of pregnancy decision-making, some advocacy groups have organized to provide consumer education about women's rights during childbirth and the possible undisclosed risks and benefits of different courses of treatment.² Two states have even taken legislative action to mandate hospital disclosure of certain maternal health outcomes in order to empower better decision-making among pregnant women as they choose where and how to give birth.³ Nevertheless, for

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¹ Jennifer Senior, TEDTalk, "For Parents, Happiness is a Very High Bar," Mar. 2014 (discussing the vast array of parenting books on bookstore shelves),

https://www.ted.com/talks/jennifer_senior_for_parents_happiness_is_a_very_high_bar?language=en.

² See, e.g., Childbirth Connection, "What to Ask...A Physician Who May Provide Your Maternity Care,"

<http://www.childbirthconnection.org/resources/?referrer=https://www.google.com/>; CHOICES IN CHILDBIRTH, THE GUIDE TO A HEALTHY BIRTH, <http://choicesinchildbirth.org/our-work/education/guide-to-a-healthy-birth/>.

³ N.Y. PUB. HEALTH L. § 2803-j(2)(a-m) (2015) ("Each hospital's informational leaflet must provide the annual percentage of the following maternity related procedures performed at the hospital: cesarean sections (primary, repeat and total); successful vaginal deliveries by women who have had previous cesarean sections; deliveries by midwives; use of electronic fetal monitoring; use of forceps; breech births delivered vaginally; use of analgesia; use of anesthesia; induction of labor; augmentation of labor; episiotomies; and whether birthing rooms and rooming-in is available at the facility."); MASS. GEN. LAWS ch. 111, § 70E (2009) ("Every maternity patient, at the time of pre-admission, shall receive complete information from an admitting hospital on its annual rate of primary caesarian

some women, maternity care decision-making continues to be fraught with doubt, fear, and sometimes, conflict.

One version of this occurs when a physician and patient disagree about the appropriate course of treatment during labor and delivery, with the patient declining to follow her care provider's recommendation. Although such conflict is most commonly associated with cesarean surgery, there are various other decision points during childbirth where a physician and patient may disagree regarding a clinical recommendation. These include the decision to induce labor artificially using drugs, the prophylactic administration of antibiotics after a positive Group B Strep test, the use of continuous electronic fetal monitoring to measure fetal heart tones, which limits the woman's mobility during labor, and the use of a surgical incision to widen the birth canal—called an episiotomy. The reasons for a woman's resistance to her doctor's preferred approach vary but may include religious objections, fear, negative experiences during a previous birth, preference for unmedicated delivery, or concern about the risks associated with the recommended course of treatment. In some cases, additional counseling and better communication between the provider and patient can help overcome the disagreement, leading either to a woman's consent to treatment or the identification of an alternative approach. When the disagreement persists, however, women may find themselves in a standoff with their doctors, leading to heightened conflict. Of particular concern are situations where physicians threaten to use state power to compel a woman to consent to the recommended course of treatment—either by seeking a court order or by reporting the patient to the state child welfare authorities for neglect or abuse of the baby she will soon deliver.

Although various legal scholars have examined the use of court orders to compel pregnant women to undergo medical treatment,⁴ examining constitutional questions related to religious liberty and reproductive freedom, the position of health care providers in such situations has garnered much less attention. This paper contributes to the existing scholarship by considering how the specter of state involvement acts coercively to impact maternity care decision-making. It examines the legal and ethical implications for health care providers as they

sections, annual rate of repeat caesarian sections, annual rate of total caesarian sections, annual percentage of women who have had a caesarian section who have had a subsequent successful vaginal birth, annual percentage of deliveries in birthing rooms and labor-delivery-recovery or labor-delivery-recovery-postpartum rooms, annual percentage of deliveries by certified nurse-midwives, annual percentage which were continuously externally monitored only, annual percentage which were continuously internally monitored only, annual percentage which were monitored both internally and externally, annual percentages utilizing intravenous, inductions, augmentation, forceps, episiotomies, spinals, epidurals and general anesthesia, and its annual percentage of women breast-feeding upon discharge from said hospital.”).

⁴ See, e.g., Eric M. Levine, *The Constitutionality of Court Ordered Cesarean Surgery: A Threshold Question*, 4 ALB. L.J. SCI. & TECH. 229 (1994); Lisa C. Ikemoto, *The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law*, 53 OHIO ST. L.J. 1205 (1992); Joel J. Finer, *Toward Guidelines for Compelling Cesarean Surgery: Of Rights, Responsibility, and Decisional Authority*, 76 MINN. L. REV. 239 (1991); Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951 (1986); Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9 (1987). Others have criticized the way that pregnancy seems to create exceptions to established legal norms governing consent and the right to refuse unwanted medical treatment. [CITE]

navigate birth conflicts and make decisions about what kind of counseling they provide to their patients, how they approach the informed consent process, and how they exercise their judgment as medical experts. It considers how coercion may creep into provider-patient interactions, how bias influences and exacerbates coercion in health care settings, and what legal and ethical norms have developed to prevent coercion from influencing women's reproductive decision-making. The paper uses the example of health care providers relying on health-based justifications to threaten or secure involvement of child welfare authorities in order to examine how coercing consent through threats of state involvement violates physicians' legal and ethical responsibilities and may also have broader negative public health implications. In doing so, the paper challenges the pregnancy exceptionalism that tolerates coercion in the provider-patient relationship and identifies types of changes required to ensure meaningful protection of a woman's right to control her medical treatment when giving birth.

II. Making Legal Threats During Birth

When a pregnant patient declines to follow medical advice, her physician may resort to coercive tactics to secure the woman's consent to treatment.⁵ Such tactics may include seeking judicial intervention to compel the recommended treatment, enforcing institution-wide policies that restrict access to particular types of health care,⁶ applying pressure by withholding treatment or using emotional scare tactics, or threatening involvement of child welfare authorities.⁷ Cases involving maternity care provider coercion rarely make it to court and even more rarely are they reflected in written case law. Of those existing reported cases, most involve situations where a hospital and its physician initiate legal proceedings seeking permission to perform a cesarean over the woman's objection; after the birth, the woman appeals the court order or challenges it in federal court, resulting in a written opinion. The highest appellate court that has heard a challenge to a court-ordered cesarean vacated the order and held that the woman had the right to make treatment decisions for herself and her fetus, including refusing the cesarean.⁸ Nevertheless, the D.C. Court of Appeals left open the possibility that in "extremely rare and truly exceptional" cases, "a conflicting state interest may be so compelling that the patient's wishes must yield."⁹ Some courts have subsequently enforced a pregnant woman's right to refuse

⁵ See Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 Nw. U.L. Rev. 451, 469 (2000) ("It is only in the context of pregnancy that doctors assert the right to compel their patients to heed medical advice.").

⁶ See Elizabeth Kukura, *Obstetric Violence, forthcoming*, at Part II.A.2.b (discussing restrictions on vaginal birth after cesarean as a form of coercion in maternity care); Elizabeth Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN STATE L. REV. 955 (2010).

⁷ For a general discussion of coercion during childbirth as a form of obstetric violence, see Kukura, *Obstetric Violence*, *supra* note 6, at Part II.A.2.

⁸ *In re A.C.*, 573 A.2d 1235 (D.C. App. 1990) (physicians obtained court order to perform cesarean against cancer-stricken patient's wishes but fetus was stillborn and the woman died two days later).

⁹ *Id.* at 1252.

treatment¹⁰ but others have rejected the *In re A.C.*'s court reasoning and granted orders compelling cesareans.¹¹ In a notable 1996 case, a laboring woman left the hospital after she learned that administrators planned to seek a court order compelling a cesarean; the sheriff and State Attorney subsequently removed her from her home for a judicial hearing at the hospital, during which the judge ordered a cesarean be performed, even though the woman reported she could feel the fetus progressing into the birth canal without complication.¹² A federal district court later rejected Pemberton's claims of negligence, false imprisonment, and violation of her constitutional rights.¹³

The prospect of medical authorities using judicial power to force women to submit to major abdominal surgery against their will has, appropriately, drawn the attention of legal scholars.¹⁴ Given the tendency of courts to locate the authority to compel a cesarean in the Supreme Court's recognition in *Roe v. Wade* of a compelling state interest in protecting potential life, the pregnancy treatment cases have inspired analysis of a woman's liberty and privacy rights in childbirth and critique of the comparison between compelled treatment in pregnancy and abortion rights.¹⁵ Other situations where health care providers threaten to involve the state in order to secure a woman's consent have received much less attention, despite the potential for harm to women, babies, and families and the serious constitutional and public health concerns such threats raise. In particular, threatening to report a woman to child welfare authorities if she

¹⁰ See, e.g., *In re Baby Boy Doe*, 632 N.E.2d 326, 332 (Ill. App. Ct. 1994) (affirming that a "woman's right to refuse invasive medical treatment...is not diminished during pregnancy"); *In re Fetus Brown*, 689 N.E.2d 397, 405 (Ill. App. Ct. 1997) (holding that the State may not override a pregnant woman's competent treatment decision in order to save the life of a viable fetus); *Burton v. State*, 49 So.3d 263, 265 (Fla. Dist. Ct. App. 2010) (vacating order for forced bed rest on the basis of the woman's "fundamental constitutional right to refuse medical intervention"). No appellate court has upheld a court order compelling a cesarean since 1981. Farah Diaz-Tello, *When the Invisible Hand Wields a Scalpel: Maternity Care in the Market Economy*, 18 CUNY L. REV. 197, 213 (2015).

¹¹ Lisa Collier Cool, *Could You Be Forced to Have a C-Section?*, *Baby Talk*, May 2005, http://advocatesforpregnantwomen.org/articles/forced_c-section.htm; What Are Mothers' Rights During Childbirth?, MSNBC.com, May 19, 2004, <http://www.msnbc.msn.com/id/5012918/> (discussing the Pennsylvania court's order granting Wilkes-Barre General Hospital guardianship of Amber Marlowe's fetus in order to perform cesarean against Marlowe's will). Doctors had informed Marlowe—who had previously delivered six children vaginally, all nearly 12 pounds each—that her baby was large and would require a cesarean delivery, which she did not believe was necessary; after the hospital obtained a court order, she went to another area hospital and vaginally delivered a healthy eleven-pound baby. *Id.*

¹² *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr.*, 66 F. Supp.2d 1247, 1249 (N.D. Fla. 1999). Laura Pemberton had previously had a cesarean performed using a vertical incision, which increased the risk of uterine rupture associated with subsequent vaginal deliveries. She had decided to deliver at home after being unable to find a physician who would support her decision to attempt a vaginal delivery, which she reasoned was safer than an elective repeat cesarean given her desire to have more children in the future. See Laura Pemberton, *Address at National Advocates for Pregnant Women's National Summit to Ensure the Health and Humanity of Pregnant and Birthing Women* (Jan. 18-21, 2007) (audio recording on file with NAPW). Pemberton later moved to another state and subsequently delivered four more children vaginally, including twins.

¹³ *Pemberton*, 66 F. Supp. 2d at 1247.

¹⁴ See *supra* note 4.

¹⁵ April L. Cherry, *Roe's Legacy: The Nonconsensual Treatment of Pregnant Women and Implications for Female Citizenship*, 6 U. PA. J. CONST. L. 723 (2004); Oberman, *supra* note 5, at 475-76; Lynn M. Paltrow & Jeanne Flavin, *Pregnant, and No Civil Rights*, N.Y. TIMES, Nov. 7, 2014, http://www.nytimes.com/2014/11/08/opinion/pregnant-and-no-civil-rights.html?_r=0. See also Kukura, *Obstetric Violence*, *supra* note 6, at Part IV.

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

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

A. Coercing Consent with Child Welfare Threats

Federal law requires that all states maintain procedures to investigate suspected cases of child maltreatment.¹⁶ Beginning in the 1970s, states established Child Protective Services (CPS) agencies to fulfil this mandate, with partial funding from the federal government.¹⁷ State and federal law define child abuse and neglect, as well as set forth guidelines regarding the reporting of suspected abuse and neglect to the proper authorities.¹⁸ Generally, an individual is required to report suspected maltreatment when he or she “knows or has reasonable cause to believe or suspect that a child has been subjected to abuse or neglect.”¹⁹ Health care providers and other professionals are subject to heightened standards regarding mandatory reporting of potential maltreatment they encounter in their work with children and families.²⁰

A recent Florida case illustrates certain concerns and dynamics that are often present in situations of coerced decision-making in childbirth. In 2014, doctors for Jennifer Goodall threatened possible intervention by child welfare authorities in their attempt to convince Goodall, a mother of three who was nearly 39 weeks pregnant, to consent to an elective cesarean surgery for her impending birth. After three previous cesarean surgeries, Goodall had considered the risks of both VBAC and repeat cesarean and decided to pursue a vaginal delivery in order to avoid the potential complications of another surgery and minimize her recovery time.²¹ After

¹⁶ Child Abuse Prevention and Treatment Act (CAPTA) of 1974, P.L. 93-247 (requiring states “to prevent, identify and treat child abuse and neglect”).

¹⁷ Administration for Children & Families, Child Welfare Information Gateway, U.S. Dept. Health & Hum Servs., <https://www.childwelfare.gov/topics/systemwide/laws-policies/state/>. States use different names and acronyms to refer to their CPS agencies, including Department of Children and Families (DCF), Department of Children and Family Services (DCFS), or the Department of Social Services (DSS).

¹⁸ See “Definitions of Child Abuse and Neglect,” Child Welfare Information Gateway, at 4, <https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/define/> (discussing standards for reporting of child abuse and neglect). Federal law defines child abuse and neglect as “[a]ny recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm.” CAPTA Reauthorization Act of 2010 (P.L. 111-320) § 5101, Note (§ 3).

¹⁹ “Definitions of Child Abuse and Neglect,” *supra* note 18, at 4.

²⁰ “Mandatory Reporters of Child Abuse and Neglect,” Child Welfare Information Gateway, <https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/manda/>.

²¹ Research suggests that a fourth cesarean surgery carries a one in eight change of major complications. “Florida Hospital Says It Will Force Pregnant Woman to Have Cesarean Surgery,” Press Release, Nat’l Advocates for Pregnant Women, July 25, 2014,

several conversations with her care providers in which Goodall indicated her familiarity with the risks and benefits of each delivery method, she understood her doctors to be willing to attend her VBAC.²²

However, towards the end pregnancy, her case was referred to the hospital ethics committee. When she was one day short of 39 weeks pregnant, she received a letter hand-delivered to her home from the Chief Financial Officer of Bayfront Health Port Charlotte (BHPC).²³ The letter indicated the Goodall's maternity care providers intended to report her to the Department of Children and Family Services and petition for a court order to perform a cesarean.²⁴ In addition, the letter stated that if Goodall presented at the hospital, "a Cesarean section will be performed with or without your consent."²⁵ The hospital also recommended that she seek care from another physician who would support her decision to VBAC,²⁶ even though BHPC was the only hospital in the area that serves patients who want to deliver vaginally after a cesarean.²⁷

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

http://advocatesforpregnantwomen.org/blog/2014/07/press_release_florida_hospital.php ["Goodall Press Release"]. The American College of Obstetricians and Gynecologists says that 60-80% of women who attempt VBAC are successful. *Id.* Uterine rupture occurs in approximately 0.7% to 0.9% of VBAC attempts. *Am. Coll. Obstetricians & Gynecologists, ACOG Practice Bulletin No. 115: Vaginal Birth After Previous Cesarean Delivery*, 116 *OBSTETRICS & GYNECOLOGY*, no. 2, at 2 tbl. 1, Aug. 2010, *reaff'd* 2013 ["ACOG Practice Bulletin"]. The risk of neonatal brain damage resulting from uterine rupture is even smaller—approximately 1 in 2,000. Mona Lydon-Rochelle et al., *Risk of Uterine Rupture During Labor Among Women with a Prior Cesarean Delivery*, 345 *NEW ENG. J. MED.* 3 (2001). For more information about research on the safety of VBAC and the resulting impact on hospital policies restricting or encouraging VBAC for low-risk women, see Elizabeth Kukura, *Contested Care: The Limitations of Evidence-Based Maternity Care Reform*, 31 *BERKELEY J. GENDER L. & JUST.* 241, 260-61, 267-70 (2016).

²² See Declaration of Jennifer Goodall, *Goodall v. Comprehensive Women's Health Center, et al.*, Case No. 2:14-cv-299-FtM-38CM, ¶¶ 3-5 (filed in M.D. Fla. July 14, 2014) ["Goodall Declaration"]. Throughout her prenatal care and the later legal proceedings, Goodall expressed her "absolute[] consent to such surgery if there is a complication that arises during my labor that requires this surgical intervention." *Id.* at ¶ 5.

²³ Letter from Bayfront Health Medical Group CFO Cheryl Tibbett to Jennifer Goodall dated July 10, 2014, attached as Exhibit 1 to Declaration of Jennifer Goodall, *Goodall v. Comprehensive Women's Health Care, et al.*, Case No. 2:14-cv-299-FtM-38CM (filed M.D. Fla. July 14, 2014) ["Bayfront Letter"]; Complaint of Jennifer Goodall, *Goodall v. Comprehensive Women's Health Care, et al.*, Case No. 2:14-cv-299-FtM-38CM, ¶ 21 (filed M.D. Fla. July 14, 2014) ["Goodall Complaint"].

²⁴ Bayfront Letter, *supra* note 23, at 1.

²⁵ *Id.* at 2. This statement begs the question of why it intended to "begin a process for an Expedited Judicial Intervention Concerning Medical Treatment Procedures," if the hospital intended to perform a cesarean with or without Goodall's consent should she seek further care there.

²⁶ *Id.* at 2.

²⁷ Goodall Complaint, *supra* note 23, at ¶ 22.

children.”²⁸ She argued that “state action must withstand strict scrutiny when it threatens to come between parents and their children.”²⁹ Intrusions upon family privacy in the interests of child welfare are limited to those circumstances recognized by state statute, which does not contemplate child welfare jurisdiction over the medical decisions of competent adults acting on their own behalf.³⁰ Nor does mandatory reporting by health professionals extend to conflicts over medical treatment during childbirth.³¹ In addition to various constitutional violations, Goodall also brought claims of intentional and negligent infliction of emotional distress on the basis that “she, a nearly full-term pregnant woman soon to deliver,” “experienced great fear and worry” upon receiving the hospital’s treats of forced surgery and child welfare involvement in her family’s life.³²

The federal court declined to issue a TRO, finding that Goodall had no “right to compel a physician or medical facility to perform a medical procedure in the manner she wishes against their best medical judgment.”³³ This statement reflects a deep misunderstanding about the difference between a VBAC and a cesarean, seeming to equate the physiological process of labor resulting in vaginal delivery with a major abdominal surgery.³⁴ This inaccurate comparison misrepresents the degree of intervention required in each birth, as well as the resulting hardship (or lack thereof) on the parties involved.³⁵ In doing so, the court suggests that a vaginal delivery

²⁸ Pl. Memorandum of Law in Support of Motion for Temporary Restraining Order and Complaint for Preliminary Injunction, Declaratory Judgment, and Damages, *Goodall v. Comprehensive Women’s Health Center, et al.*, Case No. 2:14-cv-299-FtM-38CM, at 14 (filed M.D. Fla. July 14, 2014) [“Goodall Brief”], citing *Troxel v. Granville*, 530 U.S. 57, 65 (2000) (“The liberty interest...of parents in the care, custody, and control of their children...is perhaps the oldest of the fundamental liberty interests recognized by this Court.”). *See also* *Meyer v. Nebraska*, 262 U.S. 390 (1923); *Moriarty v. Bradt*, 177 N.J. 84, 101 (2003) (“The right to rear one’s children...has been identified as a fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment.”); *Moore v. East Cleveland*, 431 U.S. 494, 503-04 (1977) (“Our decisions establish that the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation’s history and tradition.”); *Santosky v. Kramer*, 455 U.S. 745, 753 (1982) (noting a “historical recognition that freedom of personal choice in matters of family life is a fundamental liberty interest protected by the Fourteenth Amendment”).

²⁹ Goodall Brief, *supra* note 28, at 14.

³⁰ *Id.* (citing Fla. Stat. § 39.001 et seq.).

³¹ Fla. Stat. §§ 39.01, 39.201 (laying out requirements for mandatory reporting of child abuse, neglect, or abandonment without any mention of reporting pregnant women who disagree with their physicians’ recommendations). *See also* Goodall Brief, *supra* note 28, at 14 (noting absence of “indication that the Legislature has granted the DCFS jurisdiction over fetuses in addition to children”). Goodall also suggested that reporting her to DCFS “may even trigger an abrogation of reporter immunity,” resulting in civil and criminal liability. *Id.* (citing Fla. Stat. § 39.205(9), which makes a knowingly and willing false report of child abuse, abandonment, or neglect a third-degree felony).

³² Goodall Complaint, *supra* note 23, ¶¶ 4, 48.

³³ Opinion and Order, *Goodall v. Comprehensive Women’s Health Center, et al.*, Case No. 2:14-cv-299-FtM-38CM, July 18, 20140.

³⁴ *See* Goodall Press Release, *supra* note 21, at 2 (“The process of labor and delivery isn’t a procedure; our client is the one trying to avoid a compelled medical procedure.”).

³⁵ The misleading comparison between the burdens of vaginal and cesarean delivery reflects the high degree of medicalization of childbirth in modern maternity care, such that few hospital-based vaginal deliveries are free from medical intervention—even though many routine interventions offered to laboring women are not evidence-based. [CITE] *See* Diaz-Tello, *Maternity Care in the Market Economy*, *supra* note 10, at 199 (noting that “childbirth has been medicalized to the point where vaginal delivery, the physiological process by which a fetus is expelled from

saddles a physician with serious burden—though one left unidentified and unquantified—elevating that supposed burden above the very real burden a woman suffers after undergoing an unwanted cesarean.³⁶ The court did not address Goodall's arguments that the hospital's threat to report her to the child welfare authorities was a wrongful attempt to "coerce Ms. Goodall into acquiescence" or constituted a form of patient abandonment.³⁷

No court has ruled on the question of whether a cesarean refusal can constitute a valid basis for a finding of child neglect or abuse. The closest a court has come to doing so arose out of a case before the New Jersey Appellate Division.³⁸ In 2006, a pregnant woman went to Saint Barnabas Hospital in New Jersey in labor and was presented with a variety of consent forms to sign upon her admission. She consented to administration of IV fluids, antibiotics, oxygen, fetal heart rate monitoring, an episiotomy, and an epidural, but she declined to consent at the outset to other invasive treatment, including a cesarean or fetal scalp stimulation.³⁹ Her health care providers urged her to sign the cesarean consent form "in the event of an emergency," despite the fact that there was no medical need for a cesarean—and the fact that declining to consent upon admission would not preclude her from choosing a cesarean should the medical circumstances later change.⁴⁰ She experienced continued pressure from her care providers, who also questioned her competence to refuse treatment and referred her to the hospital psychiatrist, who concluded that she was competent to determine her own course of treatment.⁴¹ V.M. eventually delivered a healthy baby vaginally without complications.⁴² Nevertheless, the hospital reported her to the Division of Youth and Family Services (DYFS) based on her refusal to provide advance consent to a cesarean.⁴³ DYFS removed the newborn from her case, along with the woman's four-year-old child, and placed them in foster care—later securing termination of her parental rights, a decision that was upheld on appeal.⁴⁴

the body, is now treated as a 'procedure' that facilities may decide to offer...or not,...transform[ing] a fundamental right—the right to forego an invasive surgery—into a request that a medical facility can grant or deny.”)

³⁶ Hospitals and doctors who maintain VBAC-restrictive policies generally justify them by citing fear of medical malpractice liability and the increased cost of practicing obstetrics due to high malpractice awards for birth complications. Even if liability exposure were a valid basis on which to force patients to accept unwanted medical treatment, Goodall argued that her “willingness to consent to surgery if she is advised that any condition indicating need for surgery arises during labor, as well as to memorialize in writing her understanding of the potential risks and benefits of [trial of labor after cesarean] and repeat cesarean surgery...will serve to protect any interest the hospital has with respect to limiting exposure to medicolegal liability.” Goodall Brief, *supra* note 28, at 24.

³⁷ Goodall Brief, *supra* note 28, at 14.

³⁸ N.J. Div. of Youth & Family Serv. v. VM, 974 A.2d 448, 450 (N.J. Super. Ct. App. Div.), *cert. denied*, 983 A.2d 1113 (N.J. 2009).

³⁹ *Id.*

⁴⁰ *Id.* at 449 (“Despite the medical opinion that the fetus demonstrated signs of distress and that the procedure was necessary to avoid imminent danger to the fetus, the child was born by vaginal delivery without incident.”).

⁴¹ Brief for National Advocates for Pregnant Women et al. as Amici Curiae Supporting Respondents, N.J. Div. of Youth and Family Services v. V.M., 974 A.2d 448, at 4-5 (N.J. Super. Ct. App. Div. 2009)(No. A-4627-06T4). The psychiatrist “concluded that V.M. was not psychotic and had the capacity for informed consent with regard to the c-section.” V.M., 974 A.2d at 451.

⁴² *Id.* at 449.

⁴³ *Id.*

⁴⁴ *Id.* at 450.

Although the appellate court ultimately affirmed the Family Court's decision to terminate V.M.'s parental rights, the panel that heard her case disagreed about whether it was appropriate to consider a cesarean refusal as evidence of parental neglect.⁴⁵ The per curiam opinion recognized that the Family Court judge based his finding of neglect in part on V.M.'s cesarean refusal but pointed to other grounds for an adverse finding based on the investigation conducted by DYFS after the baby's birth.⁴⁶ The court cites hospital records that refer to V.M. as "combative," "uncooperative," "erratic," "noncompliant," "irrational," and "inappropriate," which the court may have found compelling in light of evidence about her previous diagnosis of mental illness.⁴⁷ However, such adjectives could also describe many women in the midst of childbirth, especially under conditions where a woman perceives herself as being threatened by her health care providers. By relying on other grounds to affirm the termination of V.M.'s parental rights, the court dodges the need to address whether a cesarean refusal itself is a valid and sufficient basis for a neglect finding against a mother. Although the appellate court technically avoided answering this question, it is clear that her cesarean refusal triggered the subsequent investigation by child welfare authorities that led to the permanent removal of her children from her custody.

A pregnant woman choosing between a vaginal and cesarean delivery, or someone considering other possible medical interventions available to her during childbirth, must balance the risks and benefits of different courses of treatment. The experience of V.M. adds an additional factor to this risk-balancing exercise: possible intervention by child welfare authorities and the loss of one's child. This risk is not lost on women, particularly poor women, women of color, and young women, who are more likely to have experienced state—and sometimes public—scrutiny of their reproductive decision-making.⁴⁸

Consumer organizations dedicated to improving maternity care in the United States regularly receive reports from women across the country who have experienced mistreatment at the hands of their health care providers while pregnant or giving birth.⁴⁹ Included in their stories are accounts of being threatened with child welfare intervention if they did not consent to treatment. For example, a Texas woman who declined a labor induction reported that "[the doctor] said if I didn't go through with the induction today that he would do everything in his

⁴⁵ Compare V.M., 974 A.2d 448 (per curiam) (declining to review whether cesarean refusal should be considered in assessing neglect) with V.M., 974 A.2d at 450 (Carchman, P.J.A.D., concurring) (determining that consideration of cesarean refusal is improper as "beyond the legislative scope of the child-protective statutes").

⁴⁶ *Id.* at 449.

⁴⁷ *Id.* at 450-51.

⁴⁸ CITES about welfare reform/public benefits, Hyde, bypass, abortion/pregnancy shaming.

⁴⁹ See Improving Birth, "Global Momentum Towards Respectful Care" (Sept. 25, 2014), <http://improvingbirth.org/2014/09/respectful-care/> (discussing Improving Birth's #BreakTheSilence campaign, which was designed to "giv[e] mothers around the country a forum to voice the abuse and trauma they have experienced in childbirth"). Improving Birth identifies itself as the "largest U.S. consumer advocacy organization for better maternity care." Improving Birth, "Improving Birth/Consumers Welcome Recognition by Medical Community of Disrespect and Abuse in Childbirth" (Aug. 19, 2015), <http://improvingbirth.org/2015/08/consumers-respond/>.

power to make sure CPS would take my children.”⁵⁰ When she told the physician assistant (PA) that she preferred to go into labor on her own without the aid of medication to start contractions, the doctor “was very upset with me and [said] that [she] wasn’t to leave until [she] saw him or they’d have to call CPS.”⁵¹ The PA was “incredibly sympathetic” and agreed to send the woman home to wait for labor to start but warned the woman that “he would definitely follow up on his threat.”⁵² The pregnant woman’s desire to forego induction “seemed to infuriate [the doctor],” resulting in verbal abuse of the woman and her husband, as the doctor “yell[ed] at the top of his lungs about what a horribly selfish and dangerous parent [she] was.”⁵³ When she offered that she could not be induced immediately because she had to make arrangements for her children, the doctor “told [her] that if [she] didn’t walk over the hospital right now he’d call the police. He followed his threat by picking up his phone.”⁵⁴

Another woman told *Improving Birth* how when she asked for clarification about the need for a cesarean, the “nurse said in a very strict tone that I needed to cooperate, otherwise I could have my baby taken away. She pointed out that I was a young mother.”⁵⁵ Rinat Dray, an Orthodox Jewish mother of two whose doctor disagreed with her decision to attempt a vaginal delivery after two prior cesareans “told her that she would be committing the equivalent of child abuse and that her baby would be taken away from her” if she did not consent to the cesarean.⁵⁶ Child welfare threats during birth—tacitly supported by the V.M. decision—have a potential chilling effect that reaches beyond individual cases of coercion, as women share their birth stories with other women, who then perceive the potential for state intervention as one more risk to fear during childbirth. Threats made in one delivery room are likely to influence other women to submit to unwanted treatment or decline to ask relevant, appropriate questions of a care provider out of fear of similar consequences.⁵⁷ For example, a New York woman recounted how the doctors wanted to give her newborn broad-spectrum antibiotics because the woman’s Group B Strep status was unknown; although they did not discuss benefits, risks, and possible alternatives with her, she “consented because [she] was afraid if [she] did not, they would call Child Protective Services.”⁵⁸

⁵⁰ Brief of Human Rights in Childbirth et al. as Amicus Curiae in Support of Plaintiff Rinat Dray, *Dray v. Staten Island Univ. Hosp., et al.*, No. 500510/14, at 27 (N.Y. Sup. Ct. Kings Cty Dec. 23, 2014) [hereinafter “Dray Amicus Brief”]. A selection of written testimonies by women who suffered mistreatment at the hands of their health care providers was included as an appendix to an amicus brief filed by the organization Human Rights in Childbirth in a compelled cesarean case litigated in New York.

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.* at A-18.

⁵⁵ *Id.* at 27

⁵⁶ Gorelik Affidavit, *Dray v. Staten Island Univ. Hosp.*, No. 500510/14, ¶ 8 (filed Nov. 24, 2014). In her case, the threat did not have its desired effect of securing her consent to the cesarean, but the hospital lawyer ultimately advised the physician that a court order was unnecessary and the physician could simply override her competent consent refusal.

⁵⁷ See Diaz-Tello, *Maternity Care in the Market Economy*, *supra* note 10, at 199 (“The use of the iron fist of the law is rare when health care providers find that the invisible hand works just as well.”).

⁵⁸ *Id.* at A-29.

CPS reporting triggers an investigation that subjects the entire family to state surveillance. It may open other aspects of the family members' private lives to heightened scrutiny—including housing arrangements, family relationships, education, and nutrition—leading to the removal of children from their families and termination of parental rights, even if the circumstances prompting the original report are ultimately found to be baseless.⁵⁹ Intervention by child welfare authorities can have devastating consequences for parents and children. Once a child has been removed, the legal process to secure reunification is often long and arduous⁶⁰; this poses particularly serious consequences for mothers and newborns whose opportunities for early bonding and breastfeeding are interrupted by the removal. But even absent an actual removal of a newborn from the family, threatening to report a pregnant woman to the child welfare authorities for disagreeing with her care provider's treatment recommendation can cause harm by stripping the woman of her decision-making autonomy and increasing the risk of adverse health outcomes for both woman and baby.

B. Potential Consequences of Coerced Decision-Making During Birth

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

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

⁵⁹ See Josh Gupta-Kagan, *Toward a Public Health Legal Structure for Child Welfare*, 92 NEB. L. REV. 897 (2014).

⁶⁰ See I-Team: Family Separated After Family Court Closes Early, <http://www.nbcnewyork.com/investigations/228256391.html> (discussing family court delays that prolong the separation of parents and children). The consequences of such separations include the interruption of breastfeeding and the ongoing traumatization of young children. *Id.* (discussing one child's fear of the doorbell after a baseless separation from her mother and four-day-long placement in foster care).

coercion during childbirth for individual women and their families, as well as for the medical system and public health more generally.

1. Impact on Individual Women and Families

a. Physical Harm

Medically unnecessary interventions, especially those involving surgery, increase the risk of complications for women and babies.⁶¹ Women who have cesareans are more likely to experience death, emergency hysterectomy, blood clots and stroke, surgical injury such as bladder and uterine lacerations, hemorrhage, infection, and intense and prolonged postpartum pain.⁶² They are also more likely to suffer chronic pelvic pain and bowel obstruction than women who have vaginal births.⁶³ Cesareans require longer hospitalizations and more healing time; rehospitalization in the 60 days following a cesarean is almost twice as common as after a vaginal birth.⁶⁴ Research shows that cesareans also increase the risk of problems with future reproduction and are associated with involuntary infertility, cesarean scar ectopic pregnancy, placenta previa, placenta accreta, future deliveries with low birthweight babies, preterm babies, and stillbirths.⁶⁵ A history of multiple cesareans is associated with cumulative abdominal adhesion formation and increases the risk of adverse reproductive effects.⁶⁶ This disproportionately affects religious women whose desire for large families is rooted in their faith.⁶⁷

Babies may also suffer an increased risk of physical harm as a result of the coerced medical treatment provided to their mothers. Babies born by cesarean are more likely to

⁶¹ Research shows that the increase in cesareans in the United States has not improved birth outcomes. Joint Commission, *Specifications Manual for Joint Commission National Quality Measures, Perinatal Care/Cesarean Section* (2013), <https://manual.jointcommission.org/releases/TJC2013A/MIF0167.html>. See also CAROL SAKALA & MAUREEN P. CORRY, EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE 42 (October 2008) (“Recent analysis substantiate the World Health Organization’s recommendation that optimal national cesarean rates are in the range of 5 percent to 10 percent of all births and that rates above 15 percent are likely to do more harm than good.”), www.childbirthconnection.org/pdfs/evidence-based-maternity-care.pdf. Evidence-based research has begun to document the extent to which cesareans are often unnecessary, performed in non-emergent situations without clinical indication. *Id.* at 41-48.

⁶² CAROL SAKALA, CHILD BIRTH CONNECTION, VAGINAL OR CESAREAN BIRTH?: A SYSTEMATIC REVIEW TO DETERMINE WHAT IS AT STAKE FOR MOTHERS AND BABIES (2006), <http://www.pqcnc.org/>. See also Anne K. Daltveit et al., *Cesarean Delivery and Subsequent Pregnancies*, 111 *OBSTETRICS & GYNECOLOGY* 1327 (2008); Catherine Deneux-Tharoux et al., *Postpartum Maternal Mortality and Cesarean Delivery*, 108 *OBSTETRICS & GYNECOLOGY* 541 (2006).

⁶³ SAKALA, SYSTEMATIC REVIEW, *supra* note 62.

⁶⁴ WILLIAMS *OBSTETRICS* 592 (22nd ed. 2005).

⁶⁵ SAKALA, SYSTEMATIC REVIEW, *supra* note 62. See also Robyn Kennare et al., *Risks of Adverse Outcomes in the Next Birth After a First Cesarean Delivery*, 109 *J. OBSTETRICS & GYNECOLOGY* 270, 272 (2007); Jeffrey L. Ecker & Fredric D. Frigoletto, *Cesarean Delivery and the Risk-Benefit Calculus*, 356 *NEW ENG. J. MED.* 9, 885 (2007).

⁶⁶ SAKALA, SYSTEMATIC REVIEW, *supra* note 62.

⁶⁷ See TINA CASSIDY, *BIRTH: THE SURPRISING HISTORY OF HOW WE ARE BORN* 108 (reprint ed. 2006) (describing an increase in potentially life-threatening placental abnormalities in Mormon women who have previously given birth by cesarean).

experience respiratory problems, surgical injuries, and asthma in childhood and adulthood.⁶⁸ They also have higher rates of failure to establish breastfeeding.⁶⁹

Apart from cesareans, other unwanted interventions increase the risk of physical harm to women. Research has linked episiotomies with increased perineal injury, stitches, pain and tenderness, length of healing, the likelihood of leaking stool or gas, and pain with intercourse.⁷⁰ Interventions such as continuous electronic fetal monitoring, induction, and epidural can prompt the need for additional procedures, leading to injury. Researchers refer to the “cascade of secondary interventions” that are required to monitor and treat the side effects of the original interventions.⁷¹ For example, one study found that among first-time mothers who labored, 47% experienced an induction, and of those who were induced, 78% had an epidural; among women who had both an induction and an epidural, 31% ultimately had a cesarean.⁷² By contrast, women who experienced either an induction or an epidural—but not both—had cesareans 19-20% of the time.⁷³ Research shows that various interventions are routinely performed without evidence to support their safety and efficacy, or in situations lacking a clinical indication for the treatment, reflecting the degree to which childbirth in the United States has become a high-tech, procedure-intensive experience for a significant majority of women.⁷⁴ Medical intervention can be life-saving and injury-preventing in circumstances where complications arise, but intervention poses risk. When women are coerced into accepting medical treatment they do not want, their risk of physical harm—and in some instances, harm to their babies—increases, with the potential for serious, lasting consequences.

b. Emotional Harm

Coerced medical treatment can also cause emotional harm in the form of fear, trauma, depression, and impaired recovery and adjustment to parenthood. After she was informed that her hospital intended to seek a court-ordered cesarean and a child welfare investigation, Jennifer Goodall described her feelings of “deep distress, concern, and fear for myself and my pregnancy

⁶⁸ SAKALA, SYSTEMATIC REVIEW, *supra* note 62; SAKALA & CORRY, EVIDENCE-BASED MATERNITY CARE, *supra* note 61, at 44. *See also* James M. Alexander et al., *Fetal Injury Associated with Cesarean Delivery*, 108 OBSTETRICS & GYNECOLOGY 885 (2006); Anne K. Hansen et al., *Risk of Respiratory Morbidity in Term Infants Delivered by Elective Cesarean Section: Cohort Study*, 336 BRIT. MED. J. 85 (2008); March of Dimes, *Analysis Shows Possible Link Between Rise in C-Sections and Increase in Late Preterm Birth* (Dec. 16, 2008), http://208.74.202.108/24497_25161.asp; Astrid Sevelsted et al., *Cesarean Section and Chronic Immune Disorders*, PEDIATRICS (2015).

⁶⁹ SAKALA, SYSTEMATIC REVIEW, *supra* note 62.

⁷⁰ SAKALA & CORRY, EVIDENCE-BASED MATERNITY CARE, *supra* note 61, at 49.

⁷¹ *Id.* at 28.

⁷² Eugene R. Declercq, et al., LISTENING TO MOTHERS III: REPORT OF THE THIRD NATIONAL U.S. SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES, CHILDBIRTH CONNECTION, 24 (May 2013) [“Listening to Mothers III”], http://transform.childbirthconnection.org/wp-content/uploads/2013/06/LTM-III_Pregnancyand-Birth.pdf.

⁷³ *Id.*

⁷⁴ *See* Kukura, *Contested Care*, *supra* note 21, at Part I.C.

and my family.”⁷⁵ As Goodall experienced, emotional harm may occur at the time of the coercive conduct or it may manifest later in the pregnancy or postpartum period.

Mental health professionals have increasingly recognized birth trauma as a condition that interferes with postpartum well-being, often requiring counseling or other treatment.⁷⁶ Trauma during childbirth can lead to Post Traumatic Stress Disorder (PTSD), postpartum depression, poor bonding and attachment, and difficulty with breastfeeding.⁷⁷ A 2009 study of women during the postpartum period found that up to 9% of respondents met the clinical criteria for PTSD.⁷⁸ Research shows a strong association between coercion and postpartum PTSD. Researchers at the University of North Dakota found that 34% of women reported symptoms of PTSD related to their birth experience, concluding that the “strongest predictor of developing PTSD after labor was not a history of trauma, but rather the level of coercion the woman experienced during their labor and delivery.”⁷⁹ Longer-term emotional distress resulting from birth trauma may result in feelings of powerlessness and the desire to avoid anything associated with the birth.⁸⁰

In general, women who give birth by cesarean are more likely to have poor overall mental health and poor overall functioning than women who deliver vaginally.⁸¹ Women who have cesareans are more likely to report a poor birth experience and have less early contact with their babies, which impedes postpartum hormonal adjustment and lactation.⁸² Immediate skin-to-skin contact between mother and baby also helps regulate newborn body temperature, reduces newborn crying, improves breastfeeding effectiveness, and results in more affectionate maternal behaviors.⁸³ Although not all women and babies are able to breastfeed, women who breastfeed experience a lower incidence of premenopausal breast cancer, ovarian cancer, retained

⁷⁵ Goodall Declaration, *supra* note 22, at ¶ 11 (“I am now very near giving birth without an attending physician and am afraid to go to Bayfront Health Port Charlotte.”).

⁷⁶ See Penny Simkin, “Birth Trauma: Definition and Statistics,” Prevention and Treatment of Traumatic Childbirth (PATTCh), <http://pattch.org/resource-guide/traumatic-births-and-ptsd-definition-and-statistics/>.

⁷⁷ Improving Birth, “Global Momentum Towards Respectful Care” (Sept. 25, 2014) (describing the PTSD Kimberly Turbin suffered after her forced episiotomy, in addition to physical complications from the cutting itself), <http://improvingbirth.org/2014/09/respectful-care/>. See also Dray Amicus Brief, *supra* note 50, at 34-35 (recounting specific birth stories of women who experienced trauma and suffered flashbacks and nightmares about giving birth).

⁷⁸ Cheryl Tatano Beck et al., *Posttraumatic Stress Disorder in New Mothers: Results from a Two-Stage U.S. National Survey*, 38 BIRTH: ISSUES IN PERINATAL CARE 216, 217 (2011).

⁷⁹ Improving Birth, “Caught on Video: Improving Birth Breaks the Silence on Abuse of Women in Maternity Care” (Aug. 28, 2014) (study examined various risk factors, including history of physical and sexual abuse or domestic violence, low socioeconomic status, age, and education level), <https://improvingbirth.org/2014/08/vid/>. [add journal cite]

⁸⁰ JENNIFER BLOCK, PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE 14 (2007) (summarizing experience of woman who chose not to celebrate her child’s first birthday due to painful associations with the violence they experienced during childbirth).

⁸¹ SAKALA, SYSTEMATIC REVIEW, *supra* note 62. See also Jennifer Fenwick et al., *Women’s Experiences of Caesarean Section and Vaginal Birth After Caesarian: A Birthrites Initiative*, 9 INT’L J. NURSING PRACTICE 10, 12 (2003) (78% of women surveyed reported that their cesarean was both physically and emotionally traumatic).

⁸² SAKALA, SYSTEMATIC REVIEW, *supra* note 62, at 37 (discussing the functioning of natural oxytocin production to reduce postpartum hemorrhage and facilitate breastfeeding and bonding). See also Kukura, *Contested Care*, *supra* note 21, at 268-70 (discussing negative impact of cesarean on postpartum adjustment).

⁸³ SAKALA & CORRY, EVIDENCE-BASED MATERNITY CARE, *supra* note 61, at 55.

gestational weight gain, type-2 diabetes, and myocardial infarction.⁸⁴ Babies who breastfeed have a lower rate of infectious morbidity and less risk of childhood obesity, diabetes, leukemia, and sudden infant death syndrome.⁸⁵ Early breastfeeding is associated with greater breastfeeding success and longer duration of breastfeeding.⁸⁶

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

c. Financial Burden

Women who give birth by cesarean incur a greater financial burden as a result of the surgery, longer hospitalization, and in some instances, the costs associated with complications arising from the surgery. Even when comparing uncomplicated deliveries, the cost of a cesarean is significantly higher than the cost of a vaginal delivery. In 2011, the average hospital charge for an uncomplicated vaginal birth was \$10,657, while an uncomplicated cesarean cost \$17,859 on average.⁸⁷ These amounts exclude the cost of anesthesia, newborn care, or compensation for the services of an obstetrician or midwife.⁸⁸ Considering all childbirth costs together, both commercial payers compensate maternity care providers approximately 50% more for cesareans than vaginal deliveries.⁸⁹

Higher provider reimbursement rates for cesareans, along with longer hospitalizations and more ancillary procedures, create financial incentives to recommend cesareans even in the absence of medical necessity. Indeed, research suggests that such incentives do shape clinical decision-making, whether or not providers are conscious of the role that financial considerations play. Women with private, fee-for-service insurance have cesareans at higher rates than those who are insured by HMOs, Medicaid, or who are uninsured.⁹⁰ A California study revealed that for-profit hospitals were more likely to perform cesareans than not-for-profit hospitals, even for women experiencing low-risk pregnancies.⁹¹ Researchers concluded that a woman who delivers

⁸⁴ Alison Steube, *The Risks of Not Breastfeeding for Mothers and Infants*, 2 REV. OBSTET. GYNECOL. 222 (2009).

⁸⁵ *Id.*

⁸⁶ CITE

⁸⁷ CHILDBIRTH CONNECTION, AVERAGE FACILITY LABOR AND BIRTH CHARGE BY SITE AND METHOD OF BIRTH, UNITED STATES, 2009-2011, at 1 (2013) (average hospital charge for complicated cesarean is \$23,923), <http://transform.childbirthconnection.org/wp-content/uploads/2013/06/USCharges-chart-2009-2011.pdf>.

⁸⁸ *Id.*

⁸⁹ TRUVEN HEALTH ANALYTICS, THE COST OF HAVING A BABY IN THE UNITED STATES 8 (2013), <http://transform.childbirthconnection.org/wp-content/uploads/2013/01/Cost-of-Having-a-Baby-Executive-Summary.pdf>.

⁹⁰ Emmett B. Keeler & Mollyann Brodie, *Economic Incentives in the Choice between Vaginal Delivery and Cesarean Section*, 71 THE MILBANK QUARTERLY 365 (1993).

⁹¹ Nathanael Johnson, *For-profit Hospitals Performing More C-sections*, CALIFORNIA WATCH (Sept. 11, 2010), <http://californiawatch.org/health-and-welfare/profit-hospitals-performing-more-c-sections-4069>. Other studies have linked differences in cesarean rates with the profit orientation of the hospital where a woman gives birth. See, e.g.,

at a for-profit hospital is 17% more likely to give birth by cesarean than women who obtain care at not-for-profit institutions.⁹²

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

Other non-cesarean medical intervention may also increase the financial burden associated with childbirth. Under fee-for-service reimbursement structures, various obstetric procedures—such as artificial induction, administration of IV fluids, bladder catheterization, rupture of membranes to release amniotic fluid, fetal monitoring, episiotomy, shaving pubic hair, epidural anesthesia, and forceps- or vacuum-assisted delivery—may all generate additional fees. When a woman feels pressure to accept a procedure that she does not otherwise want, she must also bear the increased costs associated with that procedure.

2. Impact on Medical System and Public Health

In addition to the negative impact on women and their families, coercion in the provider-patient relationship during childbirth poses a threat to the medical system and public health more broadly. The vast majority of women wish to give birth in a hospital, giving them access to any necessary medical care to ensure the health and safety of both mother and infant.⁹³ When women experience coercion by their maternity care providers—or hear other women recount threats wielded against them during pregnancy and childbirth—pregnant women lose trust in physicians, nurses, and hospitals.⁹⁴ Some will seek maternity care outside a hospital setting; in areas with midwifery access, women may be able to give birth in a freestanding birth center or at home with a trained attendant instead.⁹⁵ But in the many areas of the country where women have no options for midwifery care, they may decide to give birth at home unassisted—with a higher

Jonathan Gruber & Maria Owings, *Physician Financial Incentives and Cesarean Section Delivery*, 27 RAND J. ECON. 99 (1996) (analyzing the correlation between a fall in fertility over the 1970-1982 period and the rise of cesarean delivery as an offset to lost profit).

⁹² *Id.*

⁹³ [CITE # hospital/out-of-hospital births.] See also Goodall Declaration, *supra* note 22, at ¶ 12 (expressing a desire to give birth in a hospital attended by medical professionals who are trained to respond appropriately in the event of an emergency).

⁹⁴ After her hospital threatened legal action against her to force her to undergo a cesarean, Jennifer Goodall was “terrified to enter a hospital.” Jodi Jacobson, “Florida Hospital Demands Woman Undergo Forced C-Section,” *Rewire*, July 25, 2014, <https://rewire.news/article/2014/07/25/florida-hospital-demands-woman-undergo-forced-c-section/>.

⁹⁵ [Stats on CPM and birth center access.] See also Kukura, *Contested Care*, *supra* note 21, at 256-57; Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN’S L.J. 61, 64 (2004–2005) (discussing legal regulation that restricts access to midwifery in certain areas).

risk of adverse outcomes—move their families to a different state or region,⁹⁶ or forego future pregnancies out of fear.⁹⁷

The World Health Organization has recognized that “disrespectful, abusive or neglectful treatment...constitutes a violation of trust between women and their health-care providers and can also be a powerful disincentive for women to seek and use maternal health care services”⁹⁸ The violation of trust can also inhibit essential communication between a pregnant woman and her doctor, as women become less likely to disclose relevant sensitive information about their health and pregnancies, such as smoking, alcohol use, and drug use—both illicit drugs and legal medication.⁹⁹ When a woman feels safe to discuss issues that may impact fetal development and her own well-being, physicians can offer appropriate information, counseling, or treatment. Women who fail to disclose relevant information about their health miss opportunities to receive smoking cessation support, methadone treatment, or advice on how to safely continue taking medication for mental illness—increasing the risk of impaired fetal development, birth defects, and low birthweight.¹⁰⁰

Finally, threats to leverage state power in order to secure consent to medical treatment during pregnancy degrade the principle of informed consent. As discussed in Part III, *infra*, informed consent protects patient autonomy and ensures respect for the right of patients to direct the course of their own care. It is central to modern medical care and respect for the value of patient dignity. Recognized in law and enshrined in ethical guidance to medical professionals, informed consent works when providers take their obligations seriously and ensure that patient consent is obtained after full disclosure of the risks and benefits of the proposed treatment, as well as the risks and benefits of any alternatives.¹⁰¹ When a woman consents to treatment out of fear of losing her child to the state, informed consent is an empty promise.¹⁰² The potential for erosion of the principle of informed consent threatens medical ethics and could have far-reaching consequences beyond the maternity care context.

⁹⁶ [CITE Laura Pemberton]

⁹⁷ It is possible that some threats by hospitals and physicians are made with the purpose of reducing their liability risk by encouraging the patient to go elsewhere for care. See Diaz-Tello, *Maternity Care in the Market Economy*, *supra* note 10, at 216 (discussing threats of legal process as liability-minimizing tool that “mak[es] the prospect of delivering at that facility so frightful that the pregnant person goes elsewhere”).

⁹⁸ WORLD HEALTH ORG., WHO STATEMENT: THE PREVENTION AND ELIMINATION OF DISRESPECT AND ABUSE DURING FACILITY-BASED CHILDBIRTH, 1 (2014) [“WHO Statement”].

⁹⁹ [CITE NAPW amicus; Tennessee findings]

¹⁰⁰ [CITE risks of non-disclosure]

¹⁰¹ See Kukura, *Obstetric Violence*, *supra* note 6, at Part IV.A (discussing the limitations on legal enforcement of the right to informed consent and the need for providers to uphold the principle even in the absence of possible legal sanction).

¹⁰² See 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 RIGHTS L. REP. 538, 540-41 (2010) (“If the repercussions for failure to consent to cesarean section are so severe that children can be taken from their mothers, what is the purpose of a consent form?”).

C. Data Gaps

Analyzing the problem of child welfare threats—and coercion more generally—during childbirth is complicated by a lack of data on the occurrence of such threats. Identifying when, where, and how health care providers threaten state action against pregnant women is likely hindered by the shame some women feel resulting from birth trauma, but the bigger obstacle is how few people are asking the right questions.¹⁰³ This reflects the dearth of data on the broader phenomenon of obstetric violence, where a lack of research on the issue impedes efforts to assess the scope of the problem and develop effective interventions.¹⁰⁴ Nevertheless, existing research and data collection suggest that child welfare threats and other forms of coercion during birth are sufficiently prevalent to be taken seriously.

The few studies that have considered women's experiences of coercion during childbirth show that provider pressure to agree to medical treatment is not uncommon. A 2013 study found that 25% of women who had experienced labor induction or cesarean felt pressure by their health care provider to accept those interventions.¹⁰⁵ A 2014 study reported that women who experienced pressure to consent to a cesarean were more than five times more likely to have one, more than six times more likely to have one without a medical basis, and almost seven times more likely to have an unplanned cesarean.¹⁰⁶ Reflecting the extent to which health care providers are able to assert their preferences upon their patients, 20% of women who were induced and 38% of women who had cesareans reported to researchers that their care provider made the “final decision” about their treatment.¹⁰⁷ Together, this research suggests that provider coercion contributes to the high rates of medical intervention in U.S. maternity care. It also supports the conclusion that a significant number of women bear the increased risks of cesarean surgery without medical necessity and contrary to their wishes.

Other research suggests that provider preferences have a significant influence on women's decision-making during childbirth; specifically, the manner in which a health care provider presents risks and whether he or she is perceived to support a particular course of treatment shapes women's ultimate decisions. One study compared good candidates for VBAC

¹⁰³ See Dray Amicus Brief, *supra* note 50, at 34-36 (describing types of emotional suffering that women may experience after traumatic births, including humiliation, degradation, and shame). Some women are reluctant to support mistreatment during children out of fear that complaining will be perceived as ungratefulness about the birth of the baby, reflecting the oft-repeated sentiment that “a healthy baby is all that matters,” even in the face of birth-related injuries suffered by the mother. See Kukura, *Obstetric Violence*, *supra* note 6, at Part II.C.2 (discussing social expectations of self-sacrificing mothers and the disregard of maternal birth injuries in the presence of a healthy baby).

¹⁰⁴ See Kukura, *Obstetric Violence*, *supra* note 6, at Part II.B.1.

¹⁰⁵ Eugene R. Declercq, et al., LISTENING TO MOTHERS III: REPORT OF THE THIRD NATIONAL U.S. SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES, CHILDBIRTH CONNECTION, 35 (May 2013) [“Listening to Mothers III”], http://transform.childbirthconnection.org/wp-content/uploads/2013/06/LTM-III_Pregnancyand-Birth.pdf.

¹⁰⁶ Judy Jou et al., *Patient-Perceived Pressure from Clinicians for Labor Induction and Cesarean Delivery: A Population-Based Survey of U.S. Women*, Health Serv. Res. (Sept. 2014).

¹⁰⁷ LISTENING TO MOTHERS III, *supra* note 105, at 38.

who chose a repeat cesarean with those who chose a trial of labor, finding that maternity care providers strongly influence women's choice of delivery method, distinct from the actual risk presented in individual situations.¹⁰⁸ Researchers suggested that the repeat cesarean rate among study subjects could have decreased from 70.4% to 25.5% if their health care providers had exhibited support for VBAC.¹⁰⁹ Another study concluded that women were extremely likely to choose repeat cesarean if they understood it to be their doctor's preferred approach, with only 4% of women who perceived a physician preference for surgery actually attempting a VBAC.¹¹⁰

Not all women are impacted by provider coercion to the same degree. First, certain women are more likely to be threatened with state intervention in their medical decision-making. Young women, women of color, and poor women, who may already live with a high degree of state surveillance in order to receive public benefits, are more likely to receive child welfare threats and to face difficult decisions about whether to accept unwanted treatment—and the increased risk of complications—in order to avoid the risk of losing their children.¹¹¹

Second, certain women are more likely to succumb to provider pressure due to their vulnerability. Although research suggests that provider preferences may influence all women, regardless of background or status, it is likely that women with fewer resources, weaker support networks, and less perception of power in the treatment relationship will agree to unwanted treatment in the face of coercion. This includes uninsured women and Medicaid recipients who do not have a preexisting relationship with the treating doctor, women without resources to hire a doula for emotional support throughout childbirth, young women, immigrant women, and women who have no or limited English language skills. The disproportionate risk of coercion faced by such women is supported by global research on maternal health, which suggests that certain categories of women may be more vulnerable to mistreatment by their health care providers—especially young women, poor women, unmarried women, women with HIV, and women who belong to racial, ethnic, and religious minorities.¹¹²

There are reasons to think that coercion in maternity care will continue to be a problem and may even increase in frequency. First, the high degree of medicalization in modern maternity care means that there are a variety of decision points during labor and delivery when intervention may be recommended by a health care provider without a strong evidence basis

¹⁰⁸ Torri D. Metz et al., *How Do Good Candidates for Trial of Labor After Cesarean (TO-LAC) Who Undergo Elective Repeat Cesarean Differ from Those Who Chose TOLAC?*, 208(6) AM. J. OBSTETRICS & GYNECOLOGY 458.e4-e5 (2013).

¹⁰⁹ *Id.*

¹¹⁰ Sarah Bernstein et al., *Trial of Labor After Previous Cesarean Section Versus Repeat Cesarean Section: Are Patients Making an Informed Decision?*, AM J. OBSTETRICS & GYNECOLOGY, Supplement to Jan. 2012, at S21.

¹¹¹ [CITE - racism in child welfare system]

¹¹² WHO Statement, *supra* note 98, at 1. See also Jenna Murray de López, "Birth is Like a Battle of the Ancient Maya": Obstetric Violence in South East Mexico, at 17 (undated manuscript, on file with author) (reporting results of qualitative anthropological study of obstetric violence that suggested women's experiences of violence, and the frequency of such violations, "are informed by their status and treatment in the wider society"). [add Argentina paper]

supporting its use.¹¹³ Of all hospital procedures performed on individuals aged 18-44 in 2005, 49% were obstetric procedures.¹¹⁴ Six of the fifteen most common hospital procedures for the entire population are associated with childbirth.¹¹⁵ Indeed, the most common operating room procedure is cesarean surgery; in 2013, 32.7% of all babies in the United States were born by cesarean.¹¹⁶

Second, and relatedly, growing concern about record-high cesarean rates and the number of medically unnecessary inductions and surgeries performed each year have focused more public attention on maternal health and birthing rights.¹¹⁷ Indeed, a growing consumer advocacy movement is engaging the public in education and advocacy about the over-medicalization of childbirth in the United States and encouraging women to share their negative birth experiences.¹¹⁸ Armed with more information about common childbirth interventions, more women are likely to question or challenge their doctors about the necessity of medical intervention, leading to more conflict between pregnant women and their health care providers. As birth conflicts become even more common, it is likely that more providers will consider it necessary to resort to threats of judicial or child welfare intervention in order to convince patients to follow their treatment advice.

III. Legal and Ethical Responsibilities of Maternity Care Providers

Making child welfare threats and other coercive tactics used to secure a pregnant woman's agreement to treatment violate physician's legal and ethical responsibilities. Although health care providers are generally under no legal obligation to begin treating an individual who presents seeking care,¹¹⁹ once they do undertake to provide health care services, the law requires them to provide care for patients in an existing treatment relationship.¹²⁰ As they treat patients, physicians are bound by certain legal and ethical obligations. These obligations shape the provider-patient relationship, as well as clinical decision-making about the patient's course of treatment. Before administering medical care, a physician must obtain the patient's informed consent to the treatment. Failure to do so may result in a legal claim by the patient under tort law, although the legal requirements for proving a violation of informed consent are sufficiently onerous that routine violations are unlikely to result in successful claims. Nevertheless, this legal

¹¹³ See Kukura, *Contested Care*, *supra* note 21, at 258-60 (discussing the introduction of childbirth interventions without adequate study and regional variations in cesarean rates that suggest "a pattern of almost random decision making" for the use of cesarean surgery).

¹¹⁴ SAKALA & CORRY, EVIDENCE-BASED MATERNITY CARE, *supra* note 61, at 11.

¹¹⁵ *Id.* at 11-12.

¹¹⁶ JOYCE A. MARTIN ET AL., NAT'L VITAL STATISTICS SYSTEMS, BIRTH: FINAL DATA FOR 2013 7 (2015) (reporting that 32.7% of babies born in the U.S. in 2013 were by cesarean).

¹¹⁷ Articles decrying cesarean rate; ACOG statement

¹¹⁸ See Kukura, *Obstetric Violence*, *supra* note 6, at II.B.1 (discussing the recent founding of three organizations to address obstetric violence in a four-year period, joining established groups advocating for maternity care reform).

¹¹⁹ CITE case law on duties to treat. Exception in certain circumstances, such as EMTALA.

¹²⁰ The law recognizes a small number of circumstances under which the treatment relationship may be ended without violating this legal duty. CITE

duty applies to physicians across medical practice areas and establishes standards that are fundamental to patient counseling and treatment. In addition to the legal requirement to obtain informed consent, physicians' conduct is also guided by ethical standards issued by the professional medical associations relevant to their area of practice. In some instances, such professional standard-setting results in enforceable rules; elsewhere, the policy statements and ethical guidance of professional organizations are merely advisory but, under certain circumstances, can be considered as evidence of the standard of care governing physician conduct in legal proceedings. This section will explore the legal doctrine of informed consent and the guidance of the two most important professional associations relevant to address obstetric practice.

A. *Informed Consent*

Informed consent doctrine has shaped modern medical care, transforming the way physicians interact with their patients and view their role in medical decision-making. It evolved to protect patient autonomy and to ensure patients can conduct their own medical decision-making.¹²¹ In contrast to the historical approach to medical decision-making, which reflected paternalistic assumptions that the doctor knows best and should be the decision-maker on behalf of the patient, the requirement of informed consent recognizes that physicians' greater knowledge and expertise demand added protection for the patient as the less powerful player in the treatment relationship.¹²²

Justice Cardozo expressed the basic principle underlying informed consent in *Schloendorff v. Society of New York Hospital*, stating: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."¹²³ The requirement of informed consent imposes a duty on physicians to "volunteer...the information the patient needs for intelligent decision."¹²⁴ In other words, it is not simply enough to answer patients' questions; the physician must proactively provide information to inform patient decision-making. Some jurisdictions have developed a patient-based model of informed consent, which requires disclosure of the information relevant to the patient's decision about medical treatment,¹²⁵ in contrast to a physician-based model of informed consent, which requires disclosure of information "a reasonable medical practitioner of the same school, in the same or similar

¹²¹ Julie Gantz, *State Statutory Preclusion of Wrongful Birth Relief: A Troubling Re-Writing of a Woman's Right to Choose and the Doctor-Patient Relationship*, 4 VA. J SOC. POL'Y & L. 795, 799 (discussing the evolution from physician control and autonomy to norm of information disclosure as "a fundamental ethical requirement").

¹²² See Sylvia A. Law, *Childbirth: An Opportunity for Choice That Should Be Supported*, 32 N.Y.U. REV. L. & SOC. CHANGE 345, 363-65 (2008) (discussing the tradition of paternalism and disrespect for women's choices in reproductive health care, especially childbirth).

¹²³ *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

¹²⁴ *Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir. 1972) ("Physicians and hospitals have patients of widely divergent socio-economic backgrounds, and a rule which presumes a high degree of sophistication which many members of society lack is likely to breed gross iniquities.").

¹²⁵ See *Canterbury v. Spence*, 464 F.2d at 772 (shifting the emphasis of informed consent law to the individualized needs of the patient).

circumstances, would have disclosed.”¹²⁶ A patient-based model of informed consent encourages physicians to consider the individual characteristics of the patient, including any personal, family, religious, or other considerations that might bear on what information that person needs in order to make an informed choice about medical care.

The U.S. Supreme Court has recognized that a competent person has a constitutionally-protected liberty interest in refusing unwanted medical treatment.¹²⁷ In its reasoning, the Court noted that courts had recognized the “right to refuse treatment either solely on the common law right to informed consent or on both the common law right and a constitutional privacy right.”¹²⁸ Drawing on common law precedent to locate the constitutional right in the Fourteenth Amendment’s substantive due process protections, the Court held that “[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person.”¹²⁹

The doctrine of informed consent applies across the medical profession with no exceptions for childbirth-related medical care. The American Medical Association (AMA) states unequivocally that “[i]nformed consent is a basic policy in both ethics and law that physicians must honor, unless the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent.”¹³⁰ Informed consent requires the physician “to present the medical facts accurately to the patient or to the individual responsible for the patient’s care and to make recommendations for management in accordance with good medical practice.”¹³¹ This means that patients have the right to be informed about a proposed treatment, including its purpose, risks, and benefits, as well as the potential risks and benefits of any alternative courses of treatment, including the decision to decline care.¹³²

In order for the right to informed consent to be meaningful, courts must recognize its necessary corollary—the right to informed refusal of medical treatment. When a physician properly discloses the risks, benefits, and alternatives to a proposed course of treatment but is unwilling to respect a patient’s refusal of treatment after such disclosure, any “consent” obtained from the patient cannot be considered true informed consent. Some courts recognize that health care providers should not be held liable in tort for good-faith compliance with a competent patient’s informed refusal of treatment, even if a preventable adverse outcome results.¹³³ But

¹²⁶ Guebard v. Jabaay, 452 N.E.2d 751, 755 (Ill. App. Ct. 1983). See generally Jaime Staples King & Benjamin Moulton, *Rethinking Informed Consent: The Case For Shared Medical Decision-Making*, 32 AM. J.L. & MED. 480-83 (2006) (examining the physician-based and patient-based models of informed consent); Richard A. Heinemann, *Pushing the Limits of Informed Consent: Johnson v. Kokemoor and Physician-Specific Disclosure*, 1997 WIS. L. REV. 1079, 1082 (1997) (noting that approximately half of states apply a reasonable medical practitioner standard – update).

¹²⁷ Cruzan v. Dir., Mo. Dep’t of Health, 497 U.S. 261, 278 (1990).

¹²⁸ *Id.* at 271.

¹²⁹ *Id.* at 269 (quoting Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891)).

¹³⁰ American Medical Association, *Opinion 8.08 – Informed Consent, as published in* 14 AM. MED. ASSN. J. ETHICS 555, 555 (July 2012) [“AMA Opinion 8.08”], <http://journalofethics.ama-assn.org/2012/07/pdf/coet1-1207.pdf>.

¹³¹ AMA Opinion 8.08, *supra* note 130, at 555.

¹³² American Medical Association, *Informed Consent* (Mar. 7, 2005), <http://www.leg.state.nv.us/Session/77th2013/Exhibits/Senate/HHS/SHHS1054M.pdf>.

¹³³ See *In re Dubreuil*, 629 So. 2d 819, 823 (Fla. 1993). Add non-pregnant cites (see Dray order).

elsewhere, courts have been unwilling to hold providers liable for violations of informed consent where the violation involves a physician overriding a pregnant woman's informed refusal.¹³⁴ In such cases, courts often import reasoning from a separate area of the law—abortion jurisprudence—to assert the state's interest in protecting potential life, as recognized in constitutional doctrine on abortion.¹³⁵ This unwillingness to recognize informed treatment refusals presents an ongoing obstacle to faithful adherence to the legal requirement of informed consent.¹³⁶

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

B. Professional Ethical Guidelines

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

In 1987, the ACOG Ethics Committee published Opinion No. 55 on informed consent and the use of force against pregnant women.¹³⁷ Acting after the prominent case of Angela Carder, whose court-ordered cesarean was subsequently vacated by the D.C. Court of Appeals, as discussed in Part II.A, the Ethics Committee clarified that “resort to the courts is almost never justified.”¹³⁸ It expressed concern that judicial action interferes with the doctor-patient relationship and infringes women's rights, noting that “inappropriate reliance on judicial authority” to force treatment can result in “undesirable societal consequences, such as criminalization of noncompliance with medical recommendations.”¹³⁹ The Ethics Committee called on obstetricians to “refrain from performing procedures that are unwanted by a pregnant

¹³⁴ See Order, *Dray v. Staten Island Univ. Hosp., et al.*, No. 500510/14, at X (N.Y. Sup. Ct. Kings Cty DATE).

¹³⁵ See Kukura, *Obstetric Violence*, *supra* note 6, at Part IV.C (analyzing the flawed analogy between compelled treatment in pregnancy and abortion rights).

¹³⁶ See Dray Amicus Brief, *supra* note 50, at 7-8, 21-25 (discussing the need for courts to consistently recognize an informed refusal of treatment as part of informed consent and enforce liability against providers who violate an informed refusal).

¹³⁷ AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS COMMITTEE ON ETHICS, OPINION NO. 55, PATIENT CHOICE: MATERNAL-FETAL CONFLICT (1987), *published at* 1 WOMEN'S HEALTH ISSUES 13-15 (1990).

¹³⁸ *Id.*

¹³⁹ *Id.*

woman.”¹⁴⁰ Although the statement does not expressly condemn the use of other coercive tactics to secure consent to treatment, it makes clear that ACOG opposes the use of judicial intervention to force medical treatment on pregnant women.

Several decades later, the ACOG Ethics Committee released Committee Opinion No. 321, “Maternal Decision Making, Ethics, and the Law,” which stated that “[p]regnant women’s autonomy decisions should be respected.”¹⁴¹ The Committee directed that “[c]oncerns about the impact of maternal decisions on fetal well-being should be discussed in the context of medical evidence and understood within the context of each woman’s broad social network, cultural beliefs, and values.”¹⁴² This updated guidance refers to the “destructive effect” that court orders to compel treatment can have on the provider-patient relationship.¹⁴³ It reinforces ACOG’s view that coercion in the form of judicial intervention is generally inappropriate in the treatment context, stating that “judicial authority should not be used to implement treatment regimens aimed at protecting the fetus, for such actions violate the pregnant woman’s autonomy.”¹⁴⁴ Despite this strong warning, the Committee again leaves a narrow exception to the rule against compelled treatment, noting, however, that it “cannot currently imagine” what type of “extraordinary circumstances” would justify leveraging judicial power on behalf of the fetus.¹⁴⁵ Subsequently, in updated VBAC guidelines, issued in 2010, ACOG affirmed that “patients should be allowed to accept increased levels of risk,” out of respect for patient autonomy. This means that it is for patients to decide whether or not to have a cesarean, even for women who are not considered optimal candidates for a trial of labor under the ACOG guidelines.¹⁴⁶

Although ACOG’s guidelines are not linked to an enforcement mechanism, they may constitute evidence of the applicable standard of ethical conduct in a proceeding to determine whether a physician has committed professional misconduct.¹⁴⁷ They also “establish a profession’s collective vision of appropriate care and thus serve as a tacit indictment of practices that significant diverge from these standards.”¹⁴⁸

Shortly after the ACOG Ethics Committee released Opinion No. 55, the AMA Board of Trustees issued a policy statement that judicial involvement in medical decision-making during childbirth “is inappropriate when a woman has made an informed refusal of treatment designed to benefit her fetus.”¹⁴⁹ The Board stated that the physician’s duty is to provide the relevant

¹⁴⁰ *Id.*

¹⁴¹ AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS COMMITTEE ON ETHICS, COMMITTEE OPINION NO. 321: MATERNAL DECISION MAKING, ETHICS, AND THE LAW (2005).

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Id.* (noting that “the use of the courts to resolve these conflicts is *almost* never warranted” (emphasis added)).

¹⁴⁶ Am. Coll. Obstetricians & Gynecologists, *ACOG Practice Bulletin No. 115: Vaginal Birth After Previous Cesarean Delivery*, 116 *OBSTETRICS & GYNECOLOGY*, no. 2, at 8 Aug. 2010, *reaff’d* 2013.

¹⁴⁷ See David Orentlicher, *The Influence of a Professional Organization on Physician Behavior*, 57 *ALB. L. REV.* 583, 592 (1994).

¹⁴⁸ Oberman, *supra* note 5, at 491.

¹⁴⁹ Board of Trustees Report, *Legal Intervention During Pregnancy*, 264 *J. AM. L. MED. ASSOC.* 2663, 2670 (1990).

information, “not to dictate the woman’s decision.”¹⁵⁰ The AMA Board’s statement left open the possibility of an “exceptional circumstance” when it might be appropriate for a maternity care provider to secure judicial intervention; however such an exception was limited to cases where the treatment “poses an insignificant or no health risk to the woman (such as oral administration of a drug which would cause no ill effects in her own body), entails minimal invasion of her bodily integrity and would clearly prevent substantial and irreversible harm to her fetus.”¹⁵¹ Though not enforceable on its own, the statement advocates a high bar for judicial intervention. The AMA Board statement does not discuss child welfare threats as a form of coercion against laboring women, but the same logic regarding judicial intervention would presumably apply to provider threats to leverage state power against a pregnant woman in the form of child welfare investigation and removal.

Outside of the pregnancy-specific context, the AMA’s Council on Ethical and Judicial Affairs (“AMA Council”) recognizes a patient’s right to refuse medical treatment, even if the result of such refusal is an avoidable death.¹⁵² The AMA Council’s Code of Ethics takes the view that personal values and circumstances lead different patients to reach different decisions.¹⁵³ In this regard, courts have cited the Code of Ethics when recognizing a patient’s right to refuse life-saving treatment.¹⁵⁴ The Code of Ethics also includes provisions regarding the right of patients to receive information and the patient’s right to make her own decisions regarding a treating physician’s recommendation.¹⁵⁵ In Opinion No. 10.01, which addresses the fundamental elements of the patient-physician relationship, the AMA also identifies the patient’s “right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.”¹⁵⁶ Violating the Code of Ethics may lead to discipline by the AMA and by county and state medical societies; further, some states incorporate the AMA Code of Ethics into their medical practice acts, creating the possibility for official discipline for physicians who violate the Code.¹⁵⁷

Both ACOG and the AMA have published general guidance to their members on the meaning of informed consent. In its Opinion No. 108, entitled *Ethical Dimensions of Informed Consent*, ACOG confirms that informed consent “respects a patient’s moral right to bodily

¹⁵⁰ *Id.*

¹⁵¹ *Id.* at 2663, 2670 (“the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances”).

¹⁵² AMA COUNCIL ON ETHICAL AND JUDICIAL AFF., AM. MED. ASS’N CODE OF MEDICAL ETHICS - CURRENT OPINIONS WITH ANNOTATIONS, 8.08, at 134-35 (1998-1999) (“The patient should make his or her own determination on treatment.”).

¹⁵³ *Id.* (“Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment.”).

¹⁵⁴ See *In re Fetus Brown*, 689 N.E.2d 397 (Ill. App. Ct. 1997). [add]

¹⁵⁵ AM. MED. ASS’N, CODE OF MEDICAL ETHICS OPINION 10.01—FUNDAMENTAL ELEMENTS OF THE PATIENT-PHYSICIAN RELATIONSHIP (2009) (noting that “[t]he practice of medicine...is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering”), <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.shtml>.

¹⁵⁶ *Id.* at (3).

¹⁵⁷ Orentlicher, *supra* note 147, at X.

integrity [and] to self-determination regarding sexuality and reproductive capacities.”¹⁵⁸ The AMA’s Code of Medical Ethics recognizes that “[t]he patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice.”¹⁵⁹ It identifies the physician’s “ethical obligation to help the patient make choices...consistent with good medical practice.”¹⁶⁰ The AMA advises physicians on the substantive aspects of informed consent, calling on physicians to discuss the risks and benefits of a proposed treatment, any alternatives regardless of cost or insurance coverage, the risks and benefits of any alternative treatments, and the risks and benefits of foregoing treatment.¹⁶¹ In doing so, it also reminds physicians the process of securing informed consent is not only an ethical obligation but also a legal requirement in all fifty states.¹⁶²

The public statements of leading professional medical organizations reinforce the importance of physician’s legal duty to obtain informed consent and provide necessary ethical guidance to physicians caring for a patient who refuses medical treatment. The obligation to respect patient autonomy and abide by a patient’s informed refusal applies in maternity care just as in other aspects of medical practice. Although pregnancy care is complicated by concern for fetal well-being, these expert bodies cannot identify a circumstance in which it would be appropriate to use judicial authority to override a woman’s cesarean refusal—arguably the most invasive medical intervention into childbirth. The use of child welfare threats to secure consent to treatment should be considered akin to obtaining a court-ordered cesarean, as such threats attempt to leverage state power to force a woman’s consent to medical care. In this way, child welfare threats to coerce consent violate health care providers’ legal and ethical obligations.

IV. Recommendations

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

¹⁵⁸ AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, ETHICAL DIMENSIONS OF INFORMED CONSENT, COMMITTEE OPINION NO. 108 (1992).

¹⁵⁹ AMA Opinion 8.08, *supra* note 130, at 555.

¹⁶⁰ *Id.*

¹⁶¹ AM. MED. ASS’N. INFORMED CONSENT, PATIENT PHYSICIAN RELATIONSHIP (2009), <http://www.amaassn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.shtml>.

¹⁶² *Id.*

A. Education and Training

Curbing the use of coercive tactics by maternity care providers requires targeted education, both within the field of medicine and among other stakeholders. Such education should include at least two different aspects of the problem. First, doctors and nurses working in maternity care settings, along with the hospital administrators who oversee their care, need to be familiar with the latest scientific research on VBAC, cesareans, and other forms of medical intervention during childbirth, such as medical induction, episiotomy, and the use of continuous electronic fetal monitoring. Research suggests that the incorporation of medical research results into practice is a slow process, sometimes taking up to two decades before clinical practice is adjusted to reflect the best available evidence.¹⁶³ All providers, whether still in training or several decades into their careers, should be familiar with evidence-based maternity care practices, especially those more recent research results that contradict conventional wisdom about the safety of certain practices and support fewer interventions into the labor and delivery process.¹⁶⁴ Familiarity with evidence-based maternity care practices may help reduce conflict over treatment decisions in situations where a physician applies a traditional interventionist framework and a patient relies on more recent research about the risks associated with an interventionist approach. The need for ongoing education regarding evidence-based practices should include members of hospital legal and risk management departments, who may be accustomed to operating under the assumption that performing a cesarean—even over a woman's objection—is safer than vaginal delivery, despite evidence to the contrary.¹⁶⁵

Second, medical education should include training about the harms associated with coercion in maternity care. This includes the heightened risk of PTSD and other birth trauma that is associated with women feeling coerced by their health care providers during childbirth.¹⁶⁶ It also includes the potential harm to provider-patient trust and physicians' ability to provide care effectively. Such efforts to train health care providers and hospital administrators about issues related to maternity care decision-making would complement ongoing consumer education by non-profit advocacy groups dedicated to improving childbirth experiences and reducing adverse health outcomes in maternity care.

¹⁶³ U.S. DEP'T OF HEALTH & HUMAN SERVS., AGENCY FOR HEALTHCARE RESEARCH & QUALITY, TRANSLATING RESEARCH INTO PRACTICE (TRIP)-II, at 1 (Mar. 2001), <http://archive.ahrq.gov/research/findings/factsheets/translating/tripfac/trip2fac.html>.

¹⁶⁴ See Kukura, *Contested Care*, *supra* note 21, at X (discussing best available research on induction, EFM, VBAC, episiotomy [fill in]).

¹⁶⁵ Should research reveal that *actual* reporting to child welfare authorities is occurring with some degree of frequency—as opposed to simply *threatening* to report a woman for refusing treatment—training for child welfare agencies about evidence-based maternity care and the ethical dimensions of maternity care decision-making might also be necessary.

¹⁶⁶ See Part II.B.2.b, *supra*.

B. Data Collection

A significant obstacle to ending the use of coercive means to obtain consent during childbirth is the incomplete nature of data collection regarding maternity care practices and childbirth experiences. The United States lacks comprehensive data on obstetric practices and even on maternal health outcomes, which impedes efforts both inside and outside the field of medicine to improve maternity care.¹⁶⁷ Medical coding practices that fail to distinguish between scheduled cesareans, emergency cesareans, and post-induction cesareans, or between spontaneous and induced vaginal births, prevent researchers and maternity care consumers from reaching a robust understanding of the risks and benefits of interventions like medical induction and cesarean surgery.¹⁶⁸

There is also a need for more qualitative research on women's birth experiences in order to understand how women feel coerced into accepting unwanted medical treatment and the frequency with which this occurs. In 2002, the non-profit organization Childbirth Connection conducted a survey of women's birth experiences, which for the first time documented the frequency of many practices that had not previously been recorded.¹⁶⁹ Childbirth Connection has subsequently updated the survey twice, in 2006 and 2013, enabling them to track trends over that time period and also ask more nuanced questions informed by the results of previous surveys.¹⁷⁰ The Listening to Mothers surveys capture a more complete account of various childbirth interventions than had previously been available and have provided several useful data points about pregnant women's medical decision-making and their experience of coercion by their health care providers.¹⁷¹ But this is just one study and as such, leaves much ground uncovered. The outpouring of testimonials collected by birth-oriented consumer advocacy groups suggest there are aspects of maternity care that remain woefully underexplored, including the use of coercive tactics to secure consent to treatment.¹⁷² In particular, research is needed on the specific

¹⁶⁷ See AMNESTY INT'L, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA, at 86-88 (2010) (discussing the lack of consistent reporting on maternal mortality and other childbirth outcomes in the United States); SAKALA & CORRY, EVIDENCE-BASED MATERNITY CARE, *supra* note 61, at 68-70 (calling for a standardized system of measuring maternity care performance and reporting mechanisms to identify "current practices of overuse, underuse, and unjustified practice variation"). See also Elizabeth Kukura, *Giving Birth Under the ACA: Analyzing the Use of Law as a Tool to Improve Health Care*, 94 NEB. L. REV. 799, 850 & n.299 (2016) (discussing introduction of new diagnostic codes across various medical specialties).

¹⁶⁸ See Peter B. Angood et al., *Blueprint for Action: Steps Toward a High-Quality, High-Value Maternity Care System*, 20 WOMEN'S HEALTH ISSUES S18, S26 (2010) (identifying the need for separate billing codes for cesareans and vaginal deliveries under different conditions).

¹⁶⁹ EUGENE R. DECLERCQ, ET AL., LISTENING TO MOTHERS: REPORT OF THE FIRST NATIONAL U.S. SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES (Oct. 2002), http://www.nationalpartnership.org/research-library/maternal-health/listening-to-mothers-i_2002.pdf.

¹⁷⁰ Listening to Mothers Reports and Surveys, <http://www.nationalpartnership.org/issues/health/maternity/listening-to-mothers.html?referrer=http://www.childbirthconnection.org/resources/> (discussing the three initial surveys and two follow-up surveys directed to initial participants). In 2014, Childbirth Connection became a program of the National Partnership for Women & Families. See *About Us*, Childbirth Connection, <http://www.childbirthconnection.org/aboutus.asp>.

¹⁷¹ See Part II.A *supra*.

¹⁷² CITE Improving Birth, Dray Amicus Brief, *supra* note 50, at X.

experiences of poor women, women of color, young women, immigrant women, and other women who may be especially vulnerable to coercion by health care providers. The collection of more empirical and narrative data about women's birth experiences will bolster the work of advocates seeking to create cultural change within maternity care settings.

C. Administrative Complaints

A third approach to tackling inappropriate child welfare threats and other coercive means of securing a pregnant woman's consent to medical treatment focuses on the use of administrative mechanisms to lodge complaints about the improper conduct of health care providers. Depending on the circumstances, patients may have several different opportunities to make a formal complaint. First, each hospital has a review board that conducts oversight of staff and affiliates who work within the hospital, and receives complaints from patients treated at that hospital. Although some women have reported dismissive and disheartening responses from hospital administrators with whom they have shared their stories of mistreatment by maternity care providers, it is critically important that hospitals continue to hear about the quality of care provided within its walls.¹⁷³ Advocates should work with hospitals and medical practices to improve the way patient complaints are investigated and addressed, with more transparency and accountability for inappropriate provider behavior.¹⁷⁴ In particular, hospitals should be encouraged to understand how taking action to reduce birth conflicts and improve provider-patient communication is likely to result in fewer malpractice lawsuits.¹⁷⁵

Women should also consider filing complaints with oversight bodies outside the hospital. This might include a third-party administered complaint system through accrediting bodies like the Joint Commission, which is responsible for hospital oversight,¹⁷⁶ or the Commission for the Accreditation of Birth Centers,¹⁷⁷ which oversees freestanding birth centers. Affected patients should also consider filing a formal complaint with the appropriate state licensing agency alleging misconduct on the part of doctors and nurses who improperly use coercive tactics to secure consent to medical treatment. They can draw on the clinical and ethical guidelines of the ACOG and the AMA, especially the AMA Code of Ethics, to encourage a more faithful adherence of medical practitioners to such professional standards. Even if such complaints fail to result in discipline or sanction by the oversight board, the process of receiving and reviewing such complaints will help educate members of the state licensing agency and create heightened

¹⁷³ See Dray Amicus Brief, *supra* note 50, at X.

¹⁷⁴ See Diaz-Tello, *supra* note 10, at 225 (calling on consumer groups to advocate with health care facilities to develop accountability mechanisms for threatening and other inappropriate conduct by health care providers).

¹⁷⁵ See Kukura, *Obstetric Violence*, *supra* note 6, at Part II.C.1.c (discussing research that links poor provider-patient communication and lack of trust with the decision to bring a malpractice claim).

¹⁷⁶ THE JOINT COMMISSION, REPORT A PATIENT SAFETY EVENT, http://www.jointcommission.org/report_a_complaint.aspx.

¹⁷⁷ THE COMMISSION FOR THE ACCREDITATION OF BIRTH CENTERS, HOW TO REPORT A COMPLAINT ABOUT A BIRTH CENTER, <https://www.birthcenteraccreditation.org/find-accredited-birthcenters/how-to-report-a-complaint-about-a-birth-center/>

awareness of coercion as a matter of integrity for the medical system. Consumer advocacy groups have a role to play in helping educate women about their options for filing administrative complaints and providing resources to assist them in doing so. To that end, education, data collection, and enhanced use of administrative mechanisms are interconnected strategies: more formal complaints will help educate stakeholders with power to influence clinical practice, such as hospital administrators, state regulators, and even physicians themselves; and better data collection about the nature and frequency of coercion in maternity care decision-making will help educate care providers about the problem and prepare those providing oversight to respond appropriately.

V. Conclusion

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

There are some hopeful indications that the medical system can correct improper coercive conduct by health care providers, such as reforms instituted to deliver more patient-centered care, many of which were part of the Affordable Care Act. In addition, growing concern about the U.S.' high cesarean rate among medical professionals themselves may be leading providers to adopt a more hands-off approach to labor and delivery for low-risk women, one which finds support in the medical research literature.¹⁷⁸ These reasons for cautious optimism should inform future research and advocacy to eliminate the improper use of child welfare threats and other coercive tactics employed to secure a woman's consent to treatment.

¹⁷⁸ CITE new guidelines on second stage labor, ACOG statements about VBAC and cesarean rate.