Exhibit A

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

RINAT DRAY,

Plaintiff,

- against -

Index No. 500510/14

Hon. Laura Lee Jacobson

STATEN ISLAND UNIVERSITY HOSPITAL, LEONID GORELIK, METROPOLITAN OB-GYN ASSOCIATES, P.C., and JAMES DUCEY,

Defendants.

BRIEF OF HUMAN RIGHTS IN CHILDBIRTH ET AL. AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF RINAT DRAY

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STATEMENT OF INTEREST

Amici curiae ("Amici") are four organizations – Human Rights in Childbirth, Birth Rights Bar Association, ImprovingBirth.org, and The International Cesarean Awareness Network, Inc. – that advocate for maternity care that respects birthing women's legal and human rights. Amici are interested in this case because Appellant's experience echoes the voices of many other women who have related to Amici that violations of the fundamental rights to informed consent and bodily autonomy are systemic and widespread in maternity care; that the violations lead to emotional and physical harms, as well as a loss of trust in the maternity care system; and that most women lack access to any meaningful system of accountability. This Court's decision will impact maternity care and the treatment of birthing women in the state of New York and, due to media attention, the United States. Together, Amici offer the Court a substantive understanding of the frequent dearth of informed consent in maternity care, a detailed explanation of why the resulting harms justify damages, and the possibilities for positive systemic changes in the medico-legal system of checks and balances that could result from a decision in Appellant's case. The interests of individual *amici* are fully set forth in the Affirmation in Support of the Amici's Motion for Leave to File Brief as *Amici Curiae*, filed with this brief.

SUMMARY OF THE ARGUMENT

Informed consent and its necessary corollary, the right to refuse treatment, are the basic human rights to physical autonomy and bodily integrity in the healthcare setting. All competent patients have the right to be recognized as the authority in decisions about their care. Healthcare providers have a corresponding

legal and ethical duty to inform, advise, and respect patients in decisions about their care.

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

Pregnant women, like most patients, typically acquiesce to their providers' clinical recommendations; informed consent and refusal is tested only when patients disagree with those recommendations. Surprisingly, many women are unsure if they actually have the right to refuse care during pregnancy and childbirth. Sometimes, when they try to exercise this right, those they hired to provide care proceed as if the right to informed consent is suspended during labor and birth. Women may sign a "consent" form in such circumstances, but without the right to refuse care, their power to consent to care is meaningless.

Consumer advocacy organizations, like the Amici represented here, have emerged in response to widespread reports of disrespect and abuse in maternity care, including violations of informed consent. These organizations hear from women who report that their right to consent was infringed during childbirth. When they seek a legal declaration that their treatment was unacceptable, they are often told that they "have no damages" and reminded that their babies are healthy. A vicious cycle ensues: because no one expects women's rights to be legally enforced, they become in fact unenforceable. What is most extraordinary about Rinat Dray is not that she was bullied, threatened, and operated on against her will, but that she - unlike so many other women - will have her day in court.

The significance of this case and its consequence for Ms. Dray are best elucidated by the case's placement into the larger context of current maternity care practices. Ms. Dray's story shares themes with many other accounts of forced medical interventions and violated bodily integrity in childbirth. In this brief, Amici include 42 personal narratives of women who have given birth in the United States and who have experienced violations of consent. These women, as well as many others whose stories are not told here, call on the Court to affirm women's right to authority over their body during the vulnerable process of childbirth. The Amici call on the court to affirm that informed consent is not just a signature on a form or a lofty ethical principle -- it is an enforceable legal right.

ARGUMENT

Women should not be subject to being treated as if their voices don't matter. – A. M. (TX)

I am not a mannequin, dummy, or teaching instrument. I am a patient too. – Anonymous 1 (TN)

I. Introduction

Informed consent is a core principle of law and medical ethics. As the American Medical Association has explained, "Informed 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."[1] Patients have the right to be informed about the purpose of a proposed treatment, its risks and benefits, and the risks and benefits of alternatives, including the risks and benefits of declining care; to receive recommendations about a course of care; and to be supported in decisions about care, including the decision to decline

[1] American Medical Association, *Opinion 8.08 – Informed Consent* (June 2006), http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.page?.

recommended treatment.[2] The principle recognizes that "an individual's physical, emotional, and psychological integrity should be respected and upheld. This principle also recognizes the human capacity to self-govern and choose a course of action from among different alternative options."[3] This doctrine, grounded in both common and constitutional law, is recognized not only by courts in this country[4] including the United States Supreme Court,[5] but also around the world.[6]

Amici, as organizations that advocate for the rights of women in pregnancy and childbirth, urge this Court to recognize that the right to informed consent is not diminished during pregnancy, and that the law does not tolerate violations of that right. This brief also examines the mechanisms by which such violations occur in maternity care and the harms that result. It explains that the lack of legal redress for such violations and resulting harms is associated with economic and liability factors that allow forced interventions to continue. Throughout this brief, personal narratives about forced maternity interventions illustrate the scope and impact of violations of informed consent. It is the hope of Amici that this brief will encourage judicial action to correct misunderstandings about the rights of pregnant women and thus incentivize maternity care providers to respect those rights.

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

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

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

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

[6] *See, e.g., Konovalova v. Russia*, no. 37873/04, at 5-8 (Eur. Ct. H.R. 2014) (holding that under the Right to Privacy and informed consent, women can refuse the presence of medical students when they give birth) (noting the importance of informed consent in international authority, including The Convention for the Protection of Human Rights and Dignity of the Human Being, The Committee on the Elimination of Discrimination Against Women, and A Declaration on the Promotion of Patients' Rights in Europe).

II. Legal Recognition That Informed Consent Is Required During Maternity Care Would Have Widespread Positive Effects.

In law and bioethics, an individual's right to bodily integrity and self-determination is absolute, even when the death of another is at stake.[7] As the *McFall v. Shimp* court explained, in a case where one cousin sued another for potentially life-saving bone marrow:

> *For our law to compel defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.*

The court refused to order forcible extraction of the bone marrow, even though it might have been life-saving, and it warned of the "revulsion to the judicial mind" that such forced procedure would cause, stating that it would "raise the spectre of the swastika and the Inquisition, reminiscent of the horrors this portends."[8]

Regrettably, the prospect of forced treatment, and its individual and societal repercussions, has failed to constrain the behavior of some hospitals and providers. Accounts received by Amici suggest that some obstetric providers believe they may ignore or override a woman's explicit non-consent. Judicial action in this case would educate providers that informed consent and refusal rights apply with equal force throughout a woman's life, including during labor and delivery.

The World Health Organization recently identified coercive and unconsented medical procedures in childbirth, like those illustrated in this brief and

[7] *See, e g. McFall v. Shimp*, 10 Pa. D. & C. 3d 90 (Allegheny County Ct. 1978).
[8] *Id.* at 92.

in Ms. Dray's case, as breaches of women's fundamental human rights.[9] Consumer advocacy organizations, like Amici, have formed in response to such violations -- violations that are not uncommon in this country. For example, a 2013 survey reported that 25% of women who had experienced an induction of labor or a cesarean section felt pressured to accept those interventions.[10] A 2014 study found that women who perceived pressure to have a Cesarean section were more than five times more likely to have a one, more than six times more likely to have one with no medical basis, and nearly seven times more likely to have an unplanned cesarean.[11] Moreover, 59% of women who received episiotomies did not give consent at all.[12] Finally, 20-38% of women reported that the provider made the "final decision" about whether they would receive a planned cesarean surgery.[13]

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

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[9] World Health Org., *WHO Statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*, 1 (2014) [hereinafter *WHO Prevention*], http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf?ua=1&ua=1.
[10] Eugene R. Declercq, et al., *Listening to Mothers III: Report of the Third National U.S. Survey of Women's Childbearing Experiences*, Childbirth Connection, 35 (May 2013) [hereinafter *LtM III*], http://transform.childbirthconnection.org/wp-content/uploads/2013/06/LTM-III_Pregnancy-and-Birth.pdf.
[11] 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).
[12] *LtM III*, *supra* note 10, at 36.
[13] *Id*. at 38.

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

Ms. Dray's case and the personal narratives excerpted in this brief suggest that some maternity care providers and patients are unclear about the scope of rights to informed consent and informed refusal. For example:

> *During labor I had been pushing for about an hour when the Dr. told me he was going to give me an episiotomy, which I said "NO!" to. He did it anyway. This made the healing process much longer and more difficult, and it was totally unnecessary. I had said NO. He cut a part of my body AGAINST MY EXPLICIT INSTRUCTIONS. – C. S. (MO)*
>
> *I was told if I hit the 40-week mark, I would be induced, no matter what. I did not know I could refuse any of her orders. – Anonymous 1 (TN)*
>
> *... the doctor arrived, rushing into the ER and walked right up, w/out saying a word to me, sticking his arm in me (very painful!). After, he declared i was 12+cm dilated. He then looked at my husband, (who was being pushed to a corner, where i couldn't even touch him, during all this) and i and said that he was "either going to take me in the next room and cut me open or he was going to use the vacuum extractor. Which is it?" I told him neither i nor our baby was in distress so there was no need for either one and that i wanted to proceed pushing naturally. He then repeated his threat, in which we both refused again. He then had four to five nurses hold me down while he forcibly used the vacuum! I tried to back away from it as i told him "no!" But he proceeded very brutally, lacerating my vaginal wall in the process. – K. G. (OH)*
>
> *At some point while the midwife was checking me, she said that it might be time to break my water. I, in the vulnerable position of having someone's hand already up my vagina, said, "Well wait, can we think about that first?" She said "I'm the one who will think about it" and then broke my water . . . " – K. K. (NY)*
>
> *I had expressly told my OB and the nursing staff that I did not, under any circumstances, want an episiotomy. During our pre-natal visits, I was assured by my OB that she would not perform the episiotomy . . . . My daughter's head was crowning and at that moment, my OB said "I'm going to have to cut you." and in that instant, she gave me an episiotomy. Later, after the birth, when she was stitching me up without any numbing medicine, I asked why she did it. Her reply was that it's routine for every delivery! – D. M. (CO)*

Women who attempt to exercise their right to informed consent in childbirth are too often told that they are "not allowed" to make decisions about their care due to hospital policy or "doctor's orders." When the standards of institutionalized

maternity care leave no room for the legal right of a patient to decline interventions, the judiciary must declare that hospital policies do not trump the fundamental right to informed consent and refusal.

> *As soon as I entered my hospital room the nurse started putting an IV into my arm and I politely explained to her that I want a natural birth and I will not be using any forms of IVs, monitors, or anything confining me to my room so that I could walk the halls. She rudely replied "this is not an option, it's hospital policy" and she went ahead and inserted the IV into my arm. Pitocin was given to me shortly after and I tried arguing that I did not want it because my contractions had already started but again they reminded me that I MUST have it because I was 2 weeks overdue. – B. S. C. (TX)*

> *Only when my labor became quite fast and painful did I ask my husband to check the bag on the IV pole. He discovered that it was a bag of Pitocin, to which I had not consented. When we asked the nursing staff to remove the drug, we were told it was impossible to do so because the OB ordered it. – D. M. (CO)*

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

Although the national C-section rate has risen from 4.5% in 1965 to 32.8% in 2012,[14] increased surgeries have not improved outcomes.[15] To the contrary, the United States is one of only eight nations with a rising maternal mortality rate.[16] The CDC has urged that the C-section rate be reduced, and it has concluded that the state-to-state variations in rates of non-medically indicated cesarean surgery demonstrates that there is no systematic pattern of decision-making about its use.[17]

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

[15] The Joint Commission, *Specifications Manual for Joint Commission National Quality Measures (v2013A1), Perinatal Care/Cesarean Section*, (2013) [hereinafter Joint Commission], https://manual.jointcommission.org/releases/TJC2013A/MIF0167.html.

[16] Anna Almendrala, *The U.S. Is The Only Developed Nation With A Rising Maternal Mortality Rate*, The Huffington Post (May 19, 2014, 8:12 AM), http://www.huffingtonpost.com/2014/05/19/us-maternal-mortality-rate_n_5340648.html.

[17] Wanda D. Barfield, *CDC Expert Commentary, Reducing the C-section Rate* (Aug. 25, 2014), http://www.medscape.com/viewarticle/830154.

In other words, the variability of the c-section rate between states and providers appears to be random.[18] Additionally, there is a little science and much personal provider preference behind the decision to perform a surgical birth.[19] Indeed, "[m]any authors have shown that physician factors, rather than patient characteristics or obstetric diagnoses are the major driver for the difference in [C-section] rates within a hospital."[20]

The widespread violation of the patient's right to refuse interventions, in a maternity care system with a massive overutilization of expensive interventions and some of the worst perinatal outcomes in the developed world, is nothing short of alarming. No one should face being taken captive by the medical system. No one should be operated on without their consent. We do not allow such infringements on men, non-pregnant women, parents, or the dead – even the procurement of life-saving organs requires proxy consent. It cannot follow, then, that society imposes a special duty on pregnant women to relinquish their civil rights to bodily integrity, autonomy, and informed consent whenever a physician demands.The American College of Obstetricians and Gynecologists agrees:

[18] *See* Steven L. Clark et al., *Variation in the Rates of Operative Delivery in the United States*, 196 Am. J. Obstetrics & Gynecolology 526e1 (2007) (noting the variations within geographical locations of c-section rates were random and attributable to lack of standardized decision-making and appropriate tools for making these decisions at patient's bedside).
[19] Joint Commission, *supra* note 15.
[20] *Id*.

> *Pregnant women's autonomous decisions should be respected. Concerns 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. In the absence of extraordinary circumstances, circumstances that, in fact, the Committee on Ethics cannot currently imagine, judicial authority should not be used to implement treatment regimens aimed at protecting the fetus, for such actions violate the pregnant woman's autonomy.*[21]

The prospect of violations of informed consent being permitted to continue with impunity – as a finding of no liability in the Dray case would essentially validate – should alarm us all, whether pregnant or not. These violations, far from affecting only pregnant or laboring women, speak to the universal right to control our own bodies and to maintain agency and dignity, even in vulnerable moments. They call into question whether courts will adhere to the basic principle of physical autonomy in American law, and enforce that principle with a finding of liability and damages. The core principle behind the fundamental duty of care that runs from doctor to patient is "that every human being of adult years and sound mind shall have the right to determine what shall be done with his own body."[22] Every human being. Including pregnant women.

> *I must stop and say I am stressed writing about this because I feel betrayed. I feel betrayed by my women doctors. I feel most betrayed by the Black woman resident who I thought would be my ally but she was my enemy. Later the Black woman doctor came back to check on me and recommended they use a buzzer on my stomach to awaken the baby. I was like, NO! She turned to my husband and said you need to talk to your wife. (You want my husband to go against my wishes? This is my body! I never said this while she was in the room. I am shy) The baby is not responding, she said. I asked AGAIN, Is she in danger? No but she needs to wake up. You are not putting that on my belly. That is not natural. If she is asleep there must be a reason. She asked my how old I was. I told her 23. Later I realized the doctor may have thought I was younger than I was (she had my chart, she could have looked it up) and that I didn't know what I was talking about. I think she assumed I was uneducated about birth. My sister! Why? – C. D. F. (MI)*

[21] American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 321: Maternal Decision Making, Ethics, and the Law* (2005).
[22] *Schloendorff v. Soc'y of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.).

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

Ms. Dray's case describes events similar to many other instances of unconsented interventions in maternity care. What is unusual here is not that a pregnant woman was operated on against her explicit non-consent, but that the case has come before a court. Few of the women who relate instances of forced interventions to Amici have been able to obtain redress or accountability for their harms, a fact that plays into the perverse liability incentives discussed in Section IV, below. Access to justice is curbed for many would-be litigants; those who have been threatened with force in childbirth or who have suffered such violations face additional barriers, whether from family, friends, doctors, or lawyers.

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

While access to the civil justice system is far from secure for the general population, women who have suffered violations of informed consent and refusal during childbirth are particularly challenged, all the more so if they are economically or racially disadvantaged. Access requires availability of a public attorney, funds to retain a private attorney, or reliance on the contingency fee structure. Public attorney availability tends to be piecemeal;[23] private attorneys, while abundant in number, charge fees that few new parents can afford.

The contingency fee structure has long been defended as the solution to access problems: attorneys take on cases for the promise of a share of a potential damage award, thereby assisting clients of limited means. However, the

[23] In 2011, the American Bar Association's Civil Justice Mapping Project found the overall picture to be "one of a great diversity of programs and provision models, with very little coordination at either the state or the national level." American Bar Association, *Access Across America: First Report of the Civil Justice Mapping Project* (Oct. 7, 2011), http://www.americanbarfoundation.org/research/A2J.html.

contingency fee structure's efficacy is predicated on a case's promise to return sufficient damages to cover the costs of bringing the case, the attorney's usual fee, and the client award. With average case costs alone estimated at $30,000-$50,000, the potential award must be large indeed. Attorneys' ability to take on cases like the one described in this brief can therefore be expected to turn on the anticipation of courts' willingness to award significant damages for violations of informed consent in maternity care.

Just as women of color and other marginalized communities face inequitable access to health care, they also suffer from inequitable access to redress and accountability for violations like forced surgery. Although privilege and socio-economic status may not protect women from experiencing force and abuse in childbirth, it does help them later to find lawyers willing to advocate on their behalf. The Brennan Center for Justice reports that 80% of low-income people experience problems obtaining access to civil justice system.[24]

Whatever the reasons, studies show that the instances of medical negligence vastly outnumber claims that are brought, much less any successful awards: "...just about 2% of the overall population that experiences negligent injury appears to make a claim, about half of those receive any compensation for damages, and most of the payouts appear to go to legal expenses rather than plaintiffs."[25] It is fair to say that patients are generally not being compensated for their injuries, with victims of obstetric violence facing more hurdles than most.

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[24] Brennan Center for Justice at New York University School of Law, *Closing the Justice Gap*, http://www.brennancenter.org/issues/closing-justice-gap.

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

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

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

Courts tend to privilege claims for damages to fetuses or babies over those of mothers:

> *In the few cases where birthing women have prevailed in maternal harms cases, it is generally through a fetal injury derivative claim where-even in these cases-courts still have to press heavily to maintain the viability of a stand-alone maternal harms claim and defense counsel remains incredulous.*[26]

In fact, mothers themselves tend to downplay their own physical injuries:

> *I have not sought any legal action because I don't have serious medical complications from the birth, unless you count a scarred, torn urethra….. – Anonymous 1 (TN)*

A mother who seeks representation for her own physical injury will have difficulty finding counsel, whereas birth injury attorneys - those who address fetal harm - abound. The lasting damage many women incur from forced treatment is emotional trauma,[27] but tort remedies for infliction of emotional distress are still evolving.[28]

The postpartum period is generally a busy and exhausting time for mothers. Physical recovery from birth is taxing enough, as is newborn care. When there is

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

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

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

additional emotional trauma, that experience is likely to render women less able to undertake resolution of the issue afterwards.

> *I did not take any legal action. I was busy healing and nursing round the clock and I was so so so angry and sad about the whole thing that I could barely even talk about it without crying. ... I still don't think anyone at the hospital would care how I was treated. I was a home birth transfer, some ignorant hippy or whatever, so clearly the Dr was just doing what needed to be done and I was hindering his care for myself and my baby, who I had placed in grave danger by not coming straight to the hospital when I began labor. – P. B. (NV)*

Like many patients who have suffered injuries, most women who have been coerced or harmed in childbirth look to litigation only as a last resort. They turn first to discussions with their providers, then to formal complaints, and finally, in desperation, to litigation in order to uncover the facts of their experience and to make sure that what happened to them does not happen to others.[29] The women who speak through this brief do so not because they can thus secure redress for themselves, but in order to help ensure that other women may be protected from similar abusive treatment in the future.

> *I've tried to write my story to my state's medical board. Every time I try though, I hear [the doctor's] voice jeering at me telling me I'm just a baby crying for not getting her way. If writing my story helps just one woman avoid the abuse I've experienced, it was worth the pain of remembering. – Anonymous 3 (TX)*

> *I hope change is made in how doctors treat women during childbirth. It is an absolute disgrace what is happening now. – M. H. (IL)*

One Florida mother took her concerns all the way from the Labor and Delivery nurses up to her state's hospital regulatory agency - with no success:

> *...[I] was belittled, laughed at, ignored and told I had "issues" by L&D nurses, the hospitals' risk manager, the hospitals' CEO, and AHCA , the board that is supposed to regulate hospitals. These people DID NOTHING. – V. M. (FL)*

A New York woman was forcibly twisted from her position on her hands and knees onto her back for no medical reason, just as her baby's head was emerging.

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

She pursued accountability directly with her providers, but her treatment was condoned as hospital policy:

> *Several months afterward, I asked to meet with the doctor and nurse(s) who attended my birth, but the hospital denied my request. The hospital did allow me to meet with the head of OB/GYN and head of L&D nursing. … Both of the hospital officials expressed sympathy for my trauma and said they were sorry I was unhappy with my care. However, they firmly stated that all women deliver on their backs in that hospital, and if a woman is not on her back when the doctor wants her to be, she will be forcibly moved into that position. They said they were sorry there had not been time for the doctor to explain that this was the way their hospital worked. They promised to implement new training to help nurses be more gentle when they forced women on to their backs. I did follow up to see what sort of new training they had implemented, but they did not give me any information. – J. R. (NY)*

Forced medical treatment is a clear-cut violations of informed consent, actionable under a tort negligence theory. One would expect the fundamental autonomy rule expressed in *Schloendorff* to have the medical malpractice plaintiffs' bar leaping to represent victims of unconsented obstetrical surgeries.[30] But few attorneys are willing to bring cases for violation of informed consent and refusal, their reluctance reflecting a cultural assumption that injury during childbirth is inevitable, and that a mother should be grateful to have a healthy baby.[31]

> *I talked to my husband about it, and while he was so supportive and kind, he ultimately told me I got my healthy baby and that we were all ok, and that was what I needed to focus on. Everyone told me that. – M.H. (IL)*

Both medical and legal actors maintain a curious reluctance to acknowledge that unwanted cesarean surgery, even when perfectly and expertly performed, constitutes an injury. If no meaningful "damage" is perceived, juries will not be instructed with formula to translate significant harms to bodily integrity into dollar values, beyond the professional and facility fees for the surgery itself. While these

[30] 105 N.E. at 93.

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

costs are significant for many families, they are insufficient to cover the costs expended by an attorney to win a compensatory award, let alone the real value of the wrongdoing. Attorneys cannot be expected to mount cases without both clear precedent and the prospect of adequate reimbursement. Ms. Dray herself faced these hurdles. As she recalled, "I was turned down by several attorneys before Silverstein & Bast agreed to take my case."[32]

Broader systemic restraints also act against birth violence plaintiffs. Tort reform is a favorite political undertaking of states to reign in perceived excesses of the civil justice system. Of the measures under that umbrella, caps on non-economic damages are the favored approach.[33] Strictures vary among states, but some are so extreme that recovery is considerably hampered.

> *Health professionals have often actively lobbied for caps on non-economic damages, whereas consumer advocates have generally held that such limits … are unfair to injured parties and especially create burdens for those with more serious injury. Further, caps may provide a disincentive for lawyers to take clients with meritorious cases and reduce incentives for deterring harm.*[34]

> *I called over one hundred attorneys and only one took my case. He said the same thing the others did. That Florida is an impossible state to recover damages from medical malpractice, that he would have to try it as a battery… He went ahead, and my case was dismissed on "summary judgment" that my medical malpractice claim was couched as a battery! – V. M. (FL)*

In the end, it matters very little whether attorneys turn away clients because they predict insufficient damages, or because courts have actually refused to recognize certain injuries as damages. Attorneys play the same role of assuming

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[32] Pl.'s Aff., *Dray v. Staten Island Univ. Hosp.*, No. 500510/2014 (Sup. Ct. Kings County 2014).
[33] National Conference of State Legislatures, *Medical Liability/Medical Malpractice Laws* (Aug. 15, 2011), http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx.
[34] Carol Sakala et al., *Maternity Care and Liability: Least Promising Policy Strategies for Improvement*, 23 Women's Health Issues e15, e17-18 (Jan. 2013) [hereinafter *Sakala*, *Least Promising*].

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

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

Obstetric providers recommend intervention on the basis of numerous non-clinical factors, including financial incentives; intervention rates therefore vary widely by provider. When patients' clinical needs are not driving providers' recommendations, patients need a clear legal right to refuse, which can be assured only if courts impose meaningful damage awards for violations of informed consent and refusal.

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

It is widely acknowledged that provider behavior is affected by economic incentives, including perception of liability risk. Economic incentives and liability incentives can lead to good or bad practices and outcomes.[35] The public relies on courts to make rules that deter harm and incentivize the careful assessment of risks and benefits in decision-making. Courts must attune themselves to the economic

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

factors and liability incentive effects of cases before them that are relevant to obstetric practice.

Empirical studies show - and doctors confess - that hospitals perform c-sections for non-medical reasons including financial gain, time convenience, and perceptions of liability pressure.[36]

> *My doctor came in to the room at 11:45pm. I specifically remember what time she came in, because she said that I would probably want to have my baby within the next 15 minutes because it was going to be Friday the 13th at midnight. She yelled at me to push, repeatedly, as I had contractions. I remember looking down and seeing her grab scissors from the tray beside her. I asked her what she was doing (mid contraction) and she didn't respond. I said "no episiotomy" and continued to push through my contraction. She then looked up at me and said "it's okay, you didn't even feel it. Now you can have your baby quickly." Then my son was born at 11:53pm, 7 minutes before Friday the 13th. ... I truly believe that she was just tired and wanted to go home, and I was taking too long to push, even though I had been pushing for less than an hour which is extremely common for first time mothers. – K. K. (TX)*

> *I had an endoscopy this summer and I had flashbacks pretty bad, and the anesthesiologist asked me what was wrong. When I explained, he was angry, and told me they were all a bunch of greedy buggers over at that hospital. – P. B. (NV)*

The fact that doctors perform unnecessary surgery for financial gain or time convenience does not prove their collective or individual moral turpitude, only

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[36] *See, e.g.*, Emmett B. Keeler & Mollyann Brodie, *Economic Incentives in the Choice between Vaginal Delivery and Cesarean Section*, 71 The Milbank Quarterly 365 (1993) (finding that pregnant women with private, fee-for-service insurance have higher C-section rates than those who are covered by staff-model HMOs, uninsured, or publicly insured); Jonathan Gruber & Maria Owings, *Physician Financial Incentives and Cesarean Section Delivery*, 27 RAND J. Econ. 99 (1996) (analyzing the correlation between a fall in fertility over the 1970-1982 period and the rise of cesarean delivery as an offset to lost profit); H. Shelton Brown, 3rd, *Physician Demand for Leisure: Implications for Cesarean Section Rates*, 15 J. Health Econ. 233 (Apr. 1996); Joanne Spetz et. al, *Physician incentives and the timing of cesarean sections: evidence from California*, 39 Med. Care 535 (June 2001); David Dranove & Yasutora Watanabe, *Influence and Deterrence: How Obstetricians Respond to Litigation against Themselves and their Colleagues*, 12 Am. L. & Econ. Rev. 69 (2010) [hereinafter Dranove] (finding a short-lived increase in cesareans following the initiation of a lawsuit against obstetrician or colleauges); Lisa Dubay et al., *The impact of malpractice fears on cesarean section rates*, 18 J. Health Econ. 491 (Aug. 1999) [hereinafter Dubay] (finding that physicians practice defensive medicine in obstetrics, resulting increased cesarean sections).

their very human response to economic incentives. When a provider decides whether to recommend an intervention for a given patient, financial considerations and time-convenience factors likely operate on a subconscious level. While higher costs and longer inpatient stays for surgical deliveries benefit hospitals more directly than individual doctors, these institutional economic forces can translate into imperatives that constrain doctors from providing individualized care, or into a medico-cultural argument that "this is the way we do it around here." On a macro level, these forces play out in significantly higher c-section rates in for-profit medical settings around the world.[37]

From the perspective of individual doctor-patient encounters, the proven role of non-clinical factors in recommendations for surgery is ethically problematic, as is the lack of transparency about these factors in discussions with patients about their care. While economic pressures and incentives faced by physicians may drive them to recommend surgery that patients do not need, doctor and patient alike must understand unequivocally that the patient can decline.

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

Doctors' recommendations for intervention, including c-section, are colored also by their own perspective and values. Studies show that obstetricians choose cesarean section deliveries for themselves in higher numbers than the general population,[38] and are more likely to undervalue physiological birth while considering cesarean delivery a good solution to "perceived labor and birth problems."[39] If providers believe that cesarean delivery is a good choice and vaginal birth is unnecessary and undesirable, they may pressure patients on the belief that refusal of surgery is an unnecessary choice for vaginal birth.

> *In 2007 I gave birth to healthy twin boys. I opted for a vaginal birth…. My birth moved quickly and without any complications. I was forced to birth in a surgical suite, just in case. Baby A was born vaginally, after two pushes. I was allowed to hold him for about 30 seconds before I told to focus on birthing baby B. After confirming that baby B was head down and descending, the OB reached for a vacuum to speed up the delivery. I protested, stated that if there was no danger or concern about baby, I didn't want have a vacuum assisted birth of baby B. The OB stated that she didn't have all day to wait for the baby to move down and I was taking up an OR with my twin birth. She also stated I could've saved myself the trouble and had a C-section. She proceeded to use the vacuum, without consent, causing tearing in my vaginal wall." – M. A. (TX)*

The multiplicity of factors that influence each obstetric provider's decision-making process are reflected in the significant variability of protocols and intervention rates across states, hospitals, and individual doctors. Studies show c-section rates ranging from 7.1 – 69.9% across U.S. hospitals.[40]These variations are not reflected in differences in maternal diagnoses or pregnancy complexity of individual patients.[41] From the consumer perspective, this means that a woman

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[38] *See* Raghad Al-Mufti et al., *Obstetricians' personal choice and mode of delivery*, 347 Lancet 544 (Feb. 24, 1996).

[39] Michael C. Klein et al., *Attitudes of the new generation of Canadian obstetricians: how do they differ from their predecessors?*, 38 Birth 129-39 (June 2011).

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

[41] Katy B. Kozhimannil et al., *Maternal Clinical Diagnoses and Hospital Variation in the Risk of Cesarean Delivery: Analysis of a National US Hospital Discharge Database*, PLOS Medicine

could bring her pregnancy to five different doctors or hospitals and receive five different recommendations for induction, cesarean, or episiotomy.

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

> *Because a stranger with credentials assumed that he knew what was best for my body, I had to pay for a medical procedure that I did not want, I was put at an increased risk for infection, and I was denied the privilege of feeling my baby being birthed. – R. M. (NE)*

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

Obstetric providers experience liability risk as a heavy pressure in their practice.[42] Perceptions of risk turn into hospital policies that tie doctors' hands from providing individualized care. Sometimes doctors turn to hospital lawyers and administrators for advice or assurance. It is not apparent that the hospital attorney who approved Ms. Dray's forced surgery perceived the violation of her right of informed consent and refusal as a liability risk. Whatever liability analysis directed Ms. Dray's care seemed to assume that the doctor's risk assessment

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(Oct. 21, 2014), http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001745.

[42] *See, e.g.*, Sakala, *Least Promising*, *supra* note 39, at e16.

trumped the patient's, and that a competent woman's explicit non-consent could be overridden without a court order.

Doctors commonly report a strong perception that liability mandates the overuse of interventions in maternity care, citing these liability concerns as a significant driver of the rising c-section rate.[43] A series of studies show that the role of liability pressure is in reality far more modest. Doctors are not necessarily rationally responsive to litigation, nor do c-section rates fall with tort reform.[44] Nevertheless, doctors report a strong *belief* in liability pressure, and perceptions about liability risk shape discourse about problems and solutions in maternity care.[45]

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

Liability incentives in obstetrics currently do not incentivize good care. For this reason, judicial action is urgently needed. Reports on the role of liability pressure in obstetrics rest on an assumption that providers can protect themselves from liability risk if they impose interventions, including cesarean surgery.[46] A

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[43] *See, e.g.*, Dubay, *supra* note 42.

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

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

[46] *See, e.g.*, Sakala, *Least Promising*, *supra* note 39, at e15.

liability rule that inclined doctors toward cesarean delivery might make sense if cesarean surgery carried no risks or costs, and vaginal birth were risky and dangerous. But that is not what the evidence shows. When cesarean surgery is medically needed, it can save lives. But when it is not needed, it carries a long list of risks and costs, including a significantly elevated risk of maternal death.[47] Courts must recognize that women are giving birth in environments where doctors claim that "liability" compels them to push for a surgical birth that happens to profit and convenience the hospital, but imposes risks on mother[48] and baby,[49] up to and including the risk of death. Obstetric providers currently perceive a "liability" mandate that urges intervention and ignores informed consent and refusal, while failing to incentivize judicious decision-making or health care that optimizes maternal and infant health. Instead, the perceived rule accrues profit to the provider while externalizing to the mother and baby the interventions' short- and long-term costs, as well as the risks.

C. Providers Should Not be Held Legally Responsible for Patients' Informed Decisions.

When the day comes that courts hold providers liable for violations of women's right to informed consent and refusal in maternity care and, moreover, impose damage awards that recognize the individual and social significance of the

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

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

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

harm, doctor-patient dynamics in obstetrics will be liberated from perverse incentives and reorient toward woman-centered care. Along with the right to informed consent comes responsibility for the decisions of care. Providers deserve assurance that their responsibility ends where their patients' rights begin. Legal reinforcement of informed consent and refusal must cut both ways: just as courts must find liability for violations of women's right to consent on the basis of information and advice, courts must also protect doctors from liability in cases where they are blamed for a woman's informed choice. Decisions that hold doctors or midwives legally responsible for a woman's informed decisions undermine the right to consent for all patients, and leave doctors vulnerable for providing respectful support.[50] When doctors honestly share their knowledge of risks and benefits, and support women in the decision at stake, they must not later be found liable for that decision on the theory that the patient lacked the expertise to assess and understand the risk. Informed consent and refusal rests upon the assumption that, despite the esoteric nature of medical knowledge, ordinary people can assess their medical alternatives and make decisions about them—including decisions to go against doctors' advice.

How much would change in childbirth, if it were clear to everybody in the room that the birthing woman has the right to be supported and respected in all decisions about her care? As the stories of these women and many others have suggested, the effect could be transformative in reducing intervention rates as well as disrespect and abuse, and in improving maternal health in the fullest sense of the term.

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

[50] Steve Lash, *Hospitals: $20.6M Award Could Spur C-Sections*, The Daily Record (Dec. 7, 2014), http://thedailyrecord.com/2014/12/07/hospitals-20-6m-award-could-spur-c-sections/.

making becomes a legally enforceable right.[51] We call on the Court to protect that right in a maternity care system in which it is in critical need of reinforcement.

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

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

Despite the many factors that drive providers' recommendations of cesarean section,[52] only one tends to be discussed with their patients: clinical need, expressed in terms of risk. Doctors usually fail to disclose to their patients when "liability pressure" is causing them to recommend surgery. Instead, they warn the patient that her baby might be at risk of injury or death, as is always going to be true to some extent, because risk exists throughout the birth process, no matter how a baby is delivered. People give birth at the hospital for the express purpose of minimizing the risks of childbirth, so when their doctor suggests that their baby is in danger, they are likely to do whatever their doctor says is necessary to save the baby.

> *It was only many months later, when I requested my medical records, that I learned that my baby's heart rate had stabilized before we ever went to the OR. My baby was fine. I was already pushing when they took me up. If anyone had told me the baby was ok I never would have agreed to the c-section. I only consented because I was told my baby was in danger. Which he wasn't. – K. M. (FL)*
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> *[My midwife] did not relay to us that over a one-hour time period after the balloon catheter was removed, during my surgical prep, and up until the monitors were off in the OR, my baby's heart rate had stabilized. She brought this to our attention at a follow-up visit that was scheduled to discuss what happened and how similar circumstances could be prevented in the future. Although she admitted that his heart rate was strong and*

[51] 105 N.E. at 93.
[52] *See* section IV, *supra*.

stable with maintained strong contractions during this time frame, her reasoning for proceeding with the surgery was 'that train had already left the station.' – S. L. (KY)

Some women, like Rinat Dray, disagree with their attending doctor's assertion that the circumstances mandate intervention, and decline treatment. The disagreement can therefore turn on a discussion of risk to the baby. Without legal clarity that birthing women retain a right of informed consent and refusal, some providers assert the authority to make the decision on behalf of women's unborn babies. When women are pressured, bullied, and forced into submitting to unconsented care in childbirth, it happens in the name of their babies.

Rinat Dray reports that the doctor who bullied and forced her into surgery threatened at one point to have authorities take her baby away if she didn't submit. Unfortunately, the use of that particular threat is a theme in the coercion of laboring women:

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

The physician's assistant told me she'd call the OB and see if he could see us the next day. When she came back she told us that he was very upset with me and that I wasn't to leave until I saw him or they'd have to call CPS [Child Protective Services]. The physician's assistant was incredibly sympathetic, and told me she'd let us go, but he would definitely follow up on his threat. . . . When he finally did arrive, he called us into his office, and told me that I had to be induced today for the safety of my baby. He said this without so much as even listening to her heartbeat. I told him that I knew she was ok, and I wanted to wait until I went into labor on my own. This seemed to infuriate him. He verbally abused me, and my husband - yelling at the top of his lungs about what a horribly selfish and dangerous parent I was. He said if I didn't go through with the induction today that he would do everything in his power to make sure CPS would take my children. – Anonymous 3 (TX)

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

Under the U.S. legal system, individuals bear no legal obligations to save others or to allow use of their own bodies to do so. While it is sometimes suggested that parents' special duties to their children override this tenet, the law does not in fact impose such obligations. No court has compelled a father to submit to an operation to remove a kidney – something that he could survive without – to save a child dying from renal failure. If parents are not held to a heightened obligation to undergo surgery to save their ailing children, why must a pregnant woman submit to any bodily intrusion that a physician deems necessary? Indeed, the U.S. Court of Appeals for the District of Columbia has explicitly opposed this stance in *In re A.C.*, stating, "Surely, however, a fetus cannot have rights in this respect superior to those of a person who has already been born."[53]

[53] 573 A.2d 1235, 1244 (D.C. 1990).

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

> *What if A.C. had refused to comply with a court order that she submit to a caesarean? . . . Enforcement could be accomplished only through physical force or its equivalent. A.C. would have to be fastened with restraints to the operating table, or perhaps involuntarily rendered unconscious by forcibly injecting her with an anesthetic, and then subjected to unwanted major surgery. Such actions would surely give one pause in a civilized society, especially when A.C. had done no wrong.*[54]

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

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

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

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

[54] *Id*. at n8.

baby. In an obstetric system with perverse economic incentives and a 32% c-section rate, this assumption is both preposterous and dangerous. Yet it is in play every time the right to informed consent and refusal in childbirth is debated with the question, "What if a woman puts her baby at risk?" No decisions in childbirth are risk free; bad outcomes sometimes occur whether or not the doctor's advice is followed. Women must be upheld in the process of assessing the risks and making the best decisions they can for themselves and their babies.

> *When I met [Dr. B. to discuss birth options], she was surrounded with two interns. I was by myself. Instead of explaining the risks and consequences of the interventions (ECV, vaginal breech birth, c-section...) she aggressively told me: "There are 5% risks of complications for vaginal breech birth. Do you want to take them?" "Imagine your son crossing the street. A car is coming. Do you grab his hand or do you wait?" "We are going to schedule a c-section one week prior your due date." ... It's only after the c-section that I discovered that grabbing my son's hand had nothing to do with being sliced open. That it had risks, high risks that were never explained to me ahead of time, even though I did all I could to gather information at that meeting. ... It's only after meeting with the medical staff afterwards that I learned that Dr B. was trying to clear litigation records due to past complications with a breech birth. " – A. P. (IL)*

The information provided in the informed consent process can be manipulated and presented in a way that is coercive and misleading to the patient. Putting aside the inaccurate representation of perinatal risk in the account above,[55] cesarean delivery for breech babies can result in the mother's death.[56] When the choice for surgery carries a risk of death to the woman, only the woman should have the authority to decide whether she will take on that risk.

If heard, birthing women exercising informed consent and refusal reveal that they are trying to make good decisions for themselves *and* their babies, and should

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[55] Society of Obstetricians and Gynecologists of Canada, *Clinical Practice Guidelines: Vaginal Delivery of Breech Presentation* (2009), http://sogc.org/guidelines/vaginal-delivery-of-breech-presentation/.

[56] Joke M. Schutte et al., *Maternal deaths after elective cesarean section for breech presentation in the Netherlands*, 86 Acta Obstetricia et Gynecologica Scandinavica 240-43 (2007).

be supported in that process. The person giving birth is the person best positioned to weigh her needs and options in combination with the needs of the child *in utero*, in whom she is investing her womb, her labor, and her life force. The first decisions that women make for their babies are meaningful to them as parents and important for their babies' short- as well as longer-term health and well-being.

> *Both babies were taken from me immediately after delivery. I don't know that I can say this was without consent, except that I was totally unaware I had the choice to consent or not. I wish I had asked. Or that they had actually used the words "do we have your consent" - in the first case, where NICU was warranted, I would have given consent. In the second, just to the nursery, I likely would have at least asked for a little more time first. This can have an impact on breastfeeding success, etc. – K. K. (CA)*

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

The enforcement of meaningful informed consent and refusal in maternity care would verify to providers and women alike that the woman, and nobody else, holds the final authority to make the decisions for herself and the baby she carries, on the basis of information, advice, and support from her health care providers. The resulting reorientation of responsibility and support would promote the respectful exchange of medical information and opinions to best equip women to

make the complex personal decisions that arise throughout pregnancy and childbirth.

VI. The Violation of Informed Consent in Childbirth Causes Damages that Must be Assigned Meaningful Monetary Value.

Women subjected to violations of informed consent in childbirth may experience a range of injuries as a result, including physical, psychological,emotional, and social harms. Because physician discussion of risk often focuses on dangers to the baby should the patient refuse interventions, Amici feel called upon to catalog real, individualized harms that result from interventions carried out against birthing women without their consent.

A. Forced Interventions in Childbirth Impose Physical Injuries.

Although maternity care providers often minimize the risks of interventions, and by definition fail to disclose the additional risks of *non-consented* interventions, these risks nevertheless exist and have real, individualized consequences for mothers and babies.

> *After nearly 2 weeks and I was still in the same shape I was in following delivery. I couldn't take care of my baby or myself. We failed at breastfeeding because I was in too much pain to sit and feed him every 2 hours. My milk never fully came in due to the trauma of the delivery. … My husband is scheduled to return to work next week and [my doctor] advised she didn't think it was a good idea for me to care for our son alone. We are now faced with the decision of him going back to work and hoping that I can manage to care for the baby and myself without further injury or my husband has to take additional time off work at no pay, causing us to fall behind on our bills. I am now 9 weeks post-partum and still having daily pain. I am still on full doses of laxatives, still not walking correctly, and still not able to wipe upon using the restroom. I cannot have sex with my husband, nor do I see being able to in the near future. – K. W. (OH)*

They forgot to restart my epidural before using the forceps. The horrible pain I endured at their hands still causes issues for me today. With no anesthesia the doctor pulled and pulled on my baby's head until she gave a last ditch effort by placing her foot up on the table between my legs for more leverage and ripped my baby boy from my body. I suffered third degree tears as well as severe emotional trauma, knowing my screams didn't mean anything to any of them. – M. C. (LA)

The right to informed consent and refusal exists to protect the fundamental human right to physical autonomy and integrity. *Schloendorf* and *McFall* both demonstrate the expression of this right in the context of tort law. Informed consent and refusal applies the right to physical autonomy in the healthcare setting, as traditional jurisprudence on informed consent has acknowledged.[57]

Women who have suffered violations like Rinat Dray should receive judicial acknowledgment that the encroachment upon their right to physical integrity is an injury in itself. When a woman's baby is removed from her body through unconsented abdominal surgery, she is physically injured by the surgery itself, regardless of whether she suffers an infection, embolism, or other additional damage. Similarly, physical injury occurs when a woman's vagina is cut or penetrated without her consent, or when she is forcibly twisted onto her back and held down on a gurney over her protests. For the right to informed consent to have any meaning, the law must recognize the violation of physical autonomy and integrity as an actionable injury in itself.

To acknowledge the basic physical injury caused by a forced intervention in childbirth is to grasp the transformative significance of consent for medical treatment, as for other forms of contact. This concept is understood with sexual violence. When a man penetrates a woman's vagina without her consent, the law recognizes that he has violated her right to physical integrity, whether or not she sustains any identifiable pelvic injuries. When a man penetrates a woman *with* her

[57] *See* Sections I & II, *supra*.

consent, the same action isn't an injury; it's intercourse. When a cesarean section is performed with consent, it isn't an injury; it's health care. When that same surgery is performed *without* consent, it is a traumatizing violation of physical integrity at one of the most vulnerable moments of a woman's life. That violation is *in itself* an injury, no matter what peripheral or additional harms result.

> *I've never been raped in my life, but soon after the surgery I felt like something sacred had just been stolen from me. I actually felt violated!! I was angry and I felt like these people were butchers. I felt like they pushed me into the surgery and I knew in my heart that I did NOT need surgery! I still cringe when I think about it. – S. I. (AZ)*
>
> *I read recently an article that likened a traumatic birth experience to rape. I don't want to compare it to that but there is something about people doing things in your nether regions, something that you did not give them permission to do that is traumatic. – C. D. F. (MI)*
>
> *Even though my treatment resulted only in PTSD and minor, if permanent, injuries, it is on the same spectrum as that of women who emerge with severe complications from unconsented procedures. Even if no permanent damage results, I still believe it is wrong for women giving birth to have no say over who touches them where, and what procedures are done to them. – J. R. (NY)*

B. Unconsented Interventions Cause Emotional Damages that Affect the Health of Both Mother and Baby in the Short and Long Term.

When medical intervention is forced upon a patient who has refused it, the physician, in usurping the patient's power to make decisions about a deeply personal matter, undermines her autonomy and personhood.[58] Women frequently suffer from the betrayal of trust and resulting sense of powerlessness caused by providers' actions at a particularly vulnerable time. Their symptoms may range from mild distress all the way to Post Traumatic Stress Disorder (PTSD). These new mothers are left with depression and trauma, struggling to reconcile their emotional suffering with their love for their new babies. Well-meaning loved ones often encourage mothers to move on, reciting the common refrain, "all that matters

[58] Studies show that satisfaction in childbirth is felt primarily through a sense of personal control. *See, e.g.*, Petra Goodman et al., *Factors related to childbirth satisfaction*, 46 J. Advanced Nursing 212, 216 (2004).

is a healthy baby." As important as healthy babies are, they are not *all* that matters. The physical and emotional health of mothers also matter. The demanding care needed and deserved by every newborn is sufficiently challenging without the addition of flashbacks and sorrow from treatment in childbirth.

> *I had nightmares and could not sleep more than 10 minutes because I would be jolted awake by a nightmare and then was afraid to fall asleep again. I was nursing my daughter at the time, so the added lack of sleep was unbearable. – M. H. (IL)*
>
> *When I got home, the flashbacks and nightmares started. For weeks I woke my new baby and her father each night, screaming. It was the same dream, over and over. I was having a baby. I could feel her coming out of me, first the head, then the shoulders. There were a lot of people in the room, but no one could hear me shout for help, no matter how loudly I screamed. I was diagnosed with post-traumatic stress disorder about six weeks after my baby's birth. I was still having the nightmares, and my normally low blood pressure was sky high. Typical sounds, like the quick honk of a car locking on the street, made me jump. For the first time in my life I had no appetite, and I lost 40 pounds – all the baby weight and more – in less than two months. To top it all off, my episiotomy was taking its time to heal. Imagine, with every single step you took for six weeks, being reminded that someone violated you without your consent. And that you were supposed to be happy about it because you had a healthy baby. – E. S. (MO)*
>
> *I can't stop thinking about it all the time, reliving every detail. I am experiencing nightmare flashbacks and anger about the entire event. What should have been the happiest day of my life is mired in humiliation, degradation, and suffering. I am mad at the hospital staff for their treatment of me. I am mad at my husband and mom for failing to protect me and allowing those people to treat me that way. I am mostly mad at myself for letting this all happen and giving other people the power over my experience. I was so mistrusting of myself and my abilities, that I just went along with whatever "experts" recommended, to be a "good patient," and for that, I am ashamed. My husband does not fully understand my emotions regarding this event, and any time I try to talk to my mom about it, she just points out that "we got a healthy baby." It almost makes the entire thing worse because it makes me question myself and my experience, like I imagined all the mistreatment. In my heart, I know I will never fully heal from this experience, but I hope over time, it won't hurt so much that the birth of my first born child was so dehumanizing. – M. D. (IL)*

Understandably, women who suffer such emotional harm are even less likely than the average new parent to be able to attempt any kind of redress for her injuries.

I did not attempt to discuss the birth with my providers due to PTSD symptoms that I did not want triggered in their medical office. – C. D. (NY)

I did not try to take legal action. Interventions without consent seem to be the standard in childbirth and I don't think anyone would understand what I lost that day. How do I prove what was damaged when my perineum was cut open without my consent? The lasting physical damage pales in comparison to the emotional damage. I did not file a complaint because I didn't think anyone would listen. - H.E. (GA)

Violation of bodily integrity may cause not only direct emotional harm in the form of PTSD, but also an additional layer of injury that accrues as a result of violation of dignity that comes with the dehumanization of unconsented care. Rinat Dray is not alone in experiencing forced care as "frightening and degrading:"

I was hardly addressed at all. I felt like I was an animal they were working on.--K. W. (OH)

It took me almost 5 years til I was pregnant with my next child that I finally healed from all the emotional pain I went through, having my birth experience taken from me, being treated by the entire staff like a piece of dirt and not taking my feelings into consideration. – B. S. C. (TX)

Had he taken 15 seconds to say, "Baby's heart is telling us she needs to come out quickly, I'm going to use this vacuum and I might have to make an incision, OK? Alright, now 1, 2, 3, push…," I probably would have spent the first weeks of my daughter's life writing thank-you notes to the hospital instead of complaint letters. Instead, I was treated like I didn't exist, like I didn't matter. But it did matter, certainly to my health. … During labor I pushed for a very short 13 minutes. All those hours crying on the bathroom floor, all those dollars spent on a counselor, all the stress on my husband from caring for an ill wife, all the stigma of having a mental condition that I now battle every day – it all could have been avoided if I'd been treated like a human being for 13 minutes. Every mother deserves that, no matter what kind of birth she has. – E. S. (MO)

The Dr. was very rude to me and treated me like a non-person. Often asked questions directed at the nurse about me like "when is the last time she voided?" and made me feel afraid. Above all, I was severely traumatized by the experience and suffered PTSD afterwards. – C. G. (CT)

C. Additional Social and Emotional Ills Result from Forced Treatment in Childbirth.

Forced interventions can harm mothers and babies by creating difficulty with bonding and breastfeeding. These processes are heavily dependent on hormonal balances, which in turn are easily disrupted by fear and stress.

My birth experience left me feeling violated and disconnected with my daughter. Every time I looked at her, I had a flashback of the condescending tone used on me and experienced the shameful, helpless emotions that I felt in labor all over again. My heart would race and I had a few night terrors continuing to remind me of how I had been disrespected. – A. W. (MO)

They told me they would be putting me to sleep and deliver my baby. I panicked. I couldnt breathe. I tried to sit up but they restrained me to the table. And the next thing I remember was waking up in recovery. I didn't get to hold my daughter until she was 10 hours old. Being under medication and coming out of surgery, I dont even have the memories of holding my daughter for the first time. They had fed her formula while I was asleep, something I requested NOT to be done. We never had the successful breastfeeding relationship I so had dreamed about. I pumped for 6 weeks but never responded well to the pump. I couldn't even get an ounce from both sides. – Anonymous 10 (IN)

Following the surgery, the prolonged time waiting to hold my baby was torture. My doula was with me and the incessant beeping of the monitors. The question settled with me again: how is this happening? Once our family was united in the triage bay, I held him. I looked into his eyes; he latched. We didn't have much time before the nursing staff persistently and repeatedly asked to return him to the nursery and take us separately to the mother-baby unit. At least three separate times, they insisted that as part of their policy, we would need to be transferred separately. Each time I refused, but I could feel the panic rising in my chest. I'm so thankful for my doula in that moment. "You're right," she reassured us, "they have no reason to take him." Sure enough, when the nurse in charge realized that we would have stayed in triage all night if needed, she allowed us to be wheeled down together. – S. B. L. (IN)

Finally, violation of informed consent can easily cause a loss of trust in the medical community. The World Health Organization recognizes 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."[59] After experiencing abusive care from medical providers in hospitals that appear to condone the abuse, women hesitate to turn to such systems of care in the future, for themselves or their families. In addition to their wariness surrounding provider motives and actions, they also fear that the medical process will trigger their earlier trauma.

Mentally and emotionally I have a deep distrust of all OBs now. I am afraid that doctors will pretend to be kind and then flip out and turn into a monster like that OB. We had to

[59] *WHO Prevention*, *supra* note 9, at 1.

*move away from that town because just going *near* that hospital would send me into a panic attack. – Anonymous 3 (TX)*

I had a lot of negative feelings surrounding my daughter's birth which I feel contributed to my post partum depression. I also absolutely do not trust Drs anymore. I am due with another baby in december, and he will be birthed at home with a midwife in attendance. It is a travesty that the medical establishment is able to get away with what are, beyond a doubt, human rights violations under the guise of something being "medically necessary". – C. S. (MO)

I do not plan to give birth in a hospital the next time around. In case my next pregnancy requires hospital care, I would like to have an attorney on retainer, and I plan to pre-print "Against Medical Advice" forms to bring with me. I am even considering having a male friend serve as my "bodyguard." I am also giving some thought to the possibility of giving birth unassisted in case I cannot find a trustworthy medical provider. – Anonymous 4 (NY)

I kept blaming myself for my experience. I should have spoken up more. I should have chosen with the mean midwife. I should have stayed at home longer. I should have said no to the fetal monitor. I should have pushed on my own. I still get weepy and angry and though I have had gentle births since, I am now always terrified of hospitals. I pray I never have twins. I pray I don't have a breech baby. I pray my baby is 100 % healthy because I am scared of doctors and hospitals. It is very hard for me to trust them. – C. D. F. (MI)

CONCLUSION

Pregnant American women are currently giving birth in the world's most expensive maternity care system, with some of the world's worst outcome rates. Medical interventions that were developed to save lives are used to actively manage healthy births, at great cost to consumers and insurers. Direct accounts like the ones appendixed to this brief indicate that the use of interventions has been institutionalized to the point that hospital staff impose them as "policy." These reports suggest a need for legal clarification that hospital policies do not trump human rights. Pregnancy and childbirth are challenging enough without mothers being disrespected, abused and traumatized by the health care professionals they hired to support them. When institutional mandates and economic incentives drive providers to impose surgeries that patients do not need, every patient must be

legally armed with the right to say "No." That shield against dysfunctional or abusive care is the right to informed consent and refusal.

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

Respectfully submitted,

Human Rights in Childbirth

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