REPRODUCTIVE HEALTH matters

FEATURE

Invisible wounds: obstetric violence in the United States

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Abstract: *In recent years, there has been growing public attention to a problem many US health institutions and providers disclaim: bullying and coercion of pregnant women during birth by health care personnel, known as obstetric violence. Through a series of real case studies, this article provides a legal practitioner's perspective on a systemic problem of institutionalized gender-based violence with only individual tort litigation as an avenue for redress, and even that largely out of reach for women. It provides an overview of the limitations of the civil justice system in addressing obstetric violence, and compares alternatives from Latin American jurisdictions. Finally, the article posits policy solutions for the legal system and health care systems.*

Keywords: obstetric violence, disrespect and abuse in childbirth, mistreatment in childbirth, respectful maternity care, United States

Introduction

In June 2014, a Florida obstetrician, Dr. Sarah Digiorgi, declared to a television news interviewer that there is no such thing as a forced caesarean surgery.[1] Asked to comment on an incident unfolding at a nearby hospital, she told media, "If that woman says, 'No way, I refuse to have a C-section,' then you cannot take that person to the operating room."

Despite Digiorgi's insistence that no such thing was possible, this was the exact threat being levelled against Jennifer Goodall, a mother of three who hoped to deliver her fourth child vaginally after three caesareans. In her thirty-seventh week of pregnancy, Goodall had received a letter from her obstetrician's office. The letter, signed by the hospital's chief financial officer, advised her that the hospital planned to take the following actions:

"1. We will contact the Department of Children and Family Services about your refusal to undergo a Cesarean section and other care and treatment recommended by your physicians and the high risks your refusals have on your life and health, as well as the life and health of your unborn child.
2. We will begin a process for an Expedited Judicial Intervention Concerning Medical Treatment Procedures. This is a proceeding for expedited judicial intervention concerning medical treatment procedures relating to the delivery of your child.
3. If you present to our hospital in labor, and your physician deems it clinically necessary, a Cesarean section will be performed with or without your consent."

The letter claimed that the hospital's ethics committee had authorized these threats and included a curious assessment of Goodall's rights:

"While we recognize that you have the right to consent to a Cesarean section, you have elected to refuse this procedure despite the advice of your treating physicians. This decision places both you and your unborn child at risk for death or serious injury. We will act in the best interests of you, your family, and your unborn child."

Seemingly, Goodall had a right to consent to the surgery, but not a right to refuse it. And for its part, the institution asserted a right to act in Goodall's best interest (as defined by the hospital) as well as that of her foetus and her family, even over her objection. Finally, having threatened her custody of her children by invoking child protective authorities, her right to due process of law, and her bodily integrity, the hospital urged her to "trust your physicians and our staff to do the right thing for you, your unborn child, and family."

What, then, of Digiorgi's assurance that there is no such thing as a forced caesarean? How is it reconciled with the hospital's claim – that it was justified in performing surgery "with or without" Goodall's consent? In fact, each is only half-right, and the truth is multi-layered: there *is* such a thing

as a forced caesarean, it is illegal, and it is seldom redressed by courts. Most importantly, forced surgery is only the most egregious indicator in a larger underlying pattern of disrespect and abuse toward pregnant and birthing women by health care providers and medical institutions.

Any forced surgery is a violent act. But forced *caesarean* surgery, that takes place in a setting where women hold less power than doctors, in a society where women's capacity for pregnancy has been historically used to sanction their exclusion from full citizenship, is more than a simple battery. It is a form of gender-based violence, increasingly recognized around the world as *obstetric violence*. Most importantly, as the case studies in this article bear out, this obstetric violence is an infringement of women's human rights to non-discrimination, liberty and security of the person, reproductive health and autonomy, and freedom from cruel, inhuman, and degrading treatment. Such an attack on women's human dignity requires a more robust state response than access to civil courts – a remedy that itself remains elusive.

This article takes the important step of acknowledging that the problem of obstetric violence exists in the United States – a proposition that, as Digiorgi's statement demonstrates, is not yet fully recognized. It begins with a discussion of several case studies from recent years (which are a key form of data to a precedent-based, or "common law", legal system such as that of the United States), which illustrate the nature of the problem. It then provides an overview of legal recognition in US courts, exposing the limitations of tort litigation as an avenue for addressing a systemic problem and providing a comparison to avenues of legal redress from other jurisdictions. Finally, it recommends some potential solutions to more fully address the root causes of obstetric violence.

Recent case studies

What follows is only a small sample of the numerous cases of obstetric violence, representing various levels of threat and actual violence, that have been documented or pursued by National Advocates for Pregnant Women and other maternity care advocacy organizations within the past several years.[*] It is difficult to get a sense of how prevalent the problem is from case reports alone; however, the existing US research suggests that women experience significant pressure and loss of autonomy in maternity care. Roth et al[2] surveyed birth workers (including doulas, childbirth educators, and labour and delivery nurses) and found that more than half had witnessed a physician engage in a procedure explicitly against a woman's will, and nearly two-thirds had witnessed providers "occasionally" or "often" engage in procedures without giving a woman a choice or time to consider the procedure. The *Listening to Mothers III* survey by Declercq et al[3] found that as many as a quarter of new mothers who had induced labours or caesarean deliveries felt pressure to do so, and 63% of women who had a primary caesarean identified their doctor as the "decision maker".[†] During the #BreaktheSilence social media campaign led by consumer advocate group *Improving Birth*, hundreds of women shared their experiences of bullying, coercion, and even unconsented procedures such as episiotomies and vaginal examinations during birth.[4]

While the incidents captured in legal and media reports are few in number compared to the approximately 4,000,000 births that take place in the US each year, their significance to the individuals who experienced the violation, and to the health systems in which they occur, is profound. And in a common law jurisdiction like the US, even a single story has the power to shape the law.

Unconsented surgery

Rinat Dray is an Orthodox Jewish woman from the Crown Heights area of Brooklyn, New York.[5,6] In her religion, children are a blessing, and families welcome as many as possible. She delivered her first two children by caesarean surgery. The surgeries had been emotionally difficult for her and she had postoperative pain for many months; she also knew that having more surgeries would lead to greater risk to her health and fertility.[7] Dray was therefore highly motivated to have a vaginal birth after caesarean (VBAC) for her third delivery.

When she became pregnant in 2010, she researched medical recommendations, including the American College of Obstetricians and Gynecologists' (ACOG) 2010 Practice Bulletin on VBAC,[8] which says that VBAC after two surgeries can be a safe option for some women. Dray made use of

[*]Individual cases have been shared with permission.

[†]That said, 83% of women in the same survey reported positive regard (either "good" or "excellent") for the US maternity care system.