'Obstetrical Violence': New Legal Phrase That Hurts More Than Helps

By Chuck Dinerstein, MD, MBA — August 24, 2018

“In the United States, women are routinely forced to undergo cesarean section, episiotomies and the use of forceps, despite their desire to attempt natural vaginal delivery. Yet, the current American legal system does little to provide redress for women coerced to undergo certain medical procedures during childbirth. Courts and physicians alike are prepared to override a woman’s choice of childbirth procedures if they believe this choice poses risks to the fetus, and both give little value to the woman’s right to bodily autonomy.”

That is the opening to an article in a recent issue of the Duke Law Journal – and the language only becomes more emotionally charged from there. [1]The care provided to women in childbirth varies across the globe and in some countries, there is growing use of the term “obstetric violence” to describe care that is coerced, without informed and voluntary consent. Venezuelan law criminalizes cesarian sections and the artificial acceleration of labor without informed and voluntary consent and is presented as an inspirational model. [2] In a world where we recently saw a British pediatrician charged with manslaughter after the death of her patients, the line between civil and criminal penalties is blurring. Before the term obstetric violence enters our lexicon, perhaps we should understand the underlying issues and evidence.

Obstetrics is an outlier when we think of medical care. It is the only specialty that deals with two entwined lives simultaneously, mother and baby. The term baby itself can be controversial whether talking about a fetus or infant. So obstetricians can be confronted with a question of whose rights are pre-eminent, mother or baby. The setting is critical to the discussion because it provides the context for these cases under consideration. So let us carefully mark our boundaries. We are speaking about women who disagree with medical authority (e.g., their doctors) about the balance
between their health and desires and the health of the soon to appear child. More importantly, we are talking about urgent, not emergent care, a setting where there is time to decide how best to proceed. Coercion in these instances are not moments when a woman is tied down by the staff in the labor and delivery room and subjected to medications and procedures against her will – no health professional coerces a patient in this manner. Coercion, in the context of “obstetrical violence” is the State, through the Courts, subjugating the mother’s interests to those of the child. [3]

The reality in the United States
The authors identified a review identify 443 court cases meeting their concern of the mother’s health and risk at odds with those of the baby, during the period 1973 to 2005. 84% involved illicit drug use, primarily cocaine and methamphetamine, and resulted in the detainment of the mothers in a controlled environment limiting their access to these drugs. Only 7% of these 443 court cases involved forced medical interventions, cesarian sections or medications to accelerate labor. So we are talking about 30 documented cases. The authors quickly point out we only see “the tip of the iceberg, because abuse during pregnancy and childbirth is underreported and largely unexplored by medical researchers.”

Our average births hover around 4 million annually, so we are talking about 128 million births over the time course of the 443 court cases. Even if we multiplied their findings a thousand fold, we would be witnessing obstetric violence in less than 1% of women at risk and do you not think, 40,000 cases annually would have attracted attention? [4]

They may be on stronger ground when discussing episiotomy – a procedure in which the obstetrician cut the vagina near the area of the rectum, to enlarge the opening and allow the child easier passage through the birth canal and hopefully to prevent an uncontrolled tear in this region that can result in a persistent connection between the vagina and rectum. These rectovaginal fistulas, the medical term for that connection, create a lot of problems for women and if they can be avoided, an episiotomy, a “surgical” cut that is easily repaired can be very beneficial. Now like many things we learned in medical school the dogma was wrong, all women do not need episiotomies, you can be selective. [5] Here are the words of the Cochrane analysis:

“Overall, the findings show that selective use of episiotomy in women (where a normal delivery without forceps is anticipated) means that fewer women have severe perineal trauma. Thus the rationale for conducting routine episiotomies to prevent severe perineal trauma is not justified by current evidence, and we could not identify any benefits of routine episiotomy for the baby or the mother.”
The incidence of episiotomy in the United States has been diminishing, from 25% of births in 2004 to 14% in 2012. I could find no more current US numbers, but for comparison, the worldwide average is 27.4% and reflects a broad range of values from 9% to almost 100%. When a concerted effort is made to educate obstetricians and establish health-system level guidelines, the episiotomy rate can drop to 3% as they have done in Northern California’s Kaiser-Permanente system. So perhaps, before we criminalize a procedure, we can try to educate the women receiving the care as well as the physicians providing it.

**Legal remedies**

Civil litigation including malpractice, is the usual home for care provided without informed consent, why not in these instances? The authors point to two inter-related reasons; first mothers are “less valued” than the fetus. In the cases where judgments have been made, mother’s are reimbursed for additional medical expenses, not for their psychologic trauma. Second, as a result, the ultimate “dollar value” of these claims is small and “disincentivizes plaintiff’s lawyers to pursue these causes of action. This constitutes a barrier to access.” So much for the concept of pro bono care.

Another approach is to directly discuss the need for both a cesarian section or medications to accelerate labor with the mother long before it is a necessity, long before the mother comes into the birthing center, home or hospital. That discussion would inform the physician and mother of their intended plans, and it can be simply put, who makes the ultimate decision about risk, the mother or the physician. In this way everyone’s autonomy is preserved, the mother is clear on her rights and their boundaries and the physician if they are unwilling to subjugate their judgment to that of the mother can refer her to another, willing physician. And while this may represent a change in the consent process, it would be of value and avoid more litigation and aggravation — because winning a malpractice case does not make the winning party whole or “heal” the wounds, and I am talking about both the plaintiff and the defendant.

**The Elephant in the Room**

Here is the legal quandary writ large: the courts have found that a woman’s right to refuse care is not absolute and that the State has a role in protecting a viable fetus. On balance, the Courts have subordinated the woman’s interests to those of the fetus. In the words of the author,

“…Court is willing to protect a mothers decision to undergo a procedure that would pose more risk to herself, but improve the fetus’s life expectancy, but not the other way round. This creates a distorted incentive for physicians to avoid liability by prioritizing the health of the fetus over the women’s choice- a typical example of defensive medicine.”

Here is the statement by the American College of Obstetrics and Gynecology

“Although your primary loyalty and duty is to the pregnant woman, you must not neglect the risk of death and irreversible injury to the fetus if the recommended cesarean delivery is not performed.”
Resorting to the Courts, is always the last alternative, because, quite frankly, the law is about words and concepts in isolation. Introducing the term obstetrical violence into the law will do far more violence to the relationship of physician and their patients, than the harm that already comes to all parties in the handful of cases discussed.

[1] To give you a sense of the tone and viewpoint, consider the following quotes; “That Women are the primary victims of obstetric violence follows from the fact that pregnancy is – by and large-a uniquely female experience.” And “Physicians and courts are not motivated by intent to cause harm, it is part of a ‘value system that subjugates women and diminishes their status in society.”

[2] I am not sure that a country that is unable to feed 90% of its citizens appropriately and is experiencing both an unstable government and economic system should be a model for our legal system.

[3] Even fetus and infant come with their own cultural baggage. While the issues at childbirth have similarities to issues surrounding abortion, I am not writing about that topic and am trying my best not entangle the two different conversations.

[4] A rough calculation puts a 1% incidence at 40,000 cases out of 4 million


Management of Pregnant Patients Who Refuse Medically Indicated Cesarean Delivery

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