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THE ILLUSION OF AUTONOMY IN WOMEN'S MEDICAL DECISION-MAKING

JAMIE R. ABRAMS*

ABSTRACT

This Article considers why there is not more conflict between women and their doctors in obstetric decision-making. While patients in every other medical context have complete autonomy to refuse treatment against medical advice, elect high-risk courses of action, and prioritize their own interests above any other decision-making metric, childbirth is viewed anomalously because of the duty to the fetus that the state and the doctor owe at birth. Many feminist scholars have analyzed the complex resolution of these conflicts when they arise, particularly when the state threatens to intervene to override the birthing woman's autonomy. This Article instead considers the far more common scenario when women and their doctors align in the face of great decision-making complexity and uncertainty. What decision-making framework normalizes this doctor-patient alignment, and how does this decision-making framework complicate the actualization of autonomy for the women who do not elect this framework? This Article concludes that many, if not most, of the four million women who birth in hospital settings attended by physicians align with their doctors by applying a shared decision-making framework that presumptively elects the outcome that minimizes any, even minor, risks to the fetus. While individual patients can certainly elect this approach autonomously, when understood in the context of tort law—in which the actions of “most women” and “most doctors” can become the standard of care itself—this framework is deeply concerning.

This fetal-focused decision-making framework perpetuates an illusion of autonomy because doctors can apply the framework independently and universally. This decision-making model problematically resurrects the ghost of Roe v. Wade's medical model in which doctors effectuate decision-making autonomy for women. Understood through a tort law lens, while this illusion of autonomy might not seem problematic to the individual women who elect this framework, it risks imputing a distorted standard of care to all obstetric cases by creating a primacy that always prioritizes fetal risks over maternal risks, a primacy that explicitly contravenes existing tort standards. Tort law ordinarily governs “unreasonable risks,” whereas this framework elevates any fetal risk to an unreasonable risk and reduces any maternal risk short of death to reasonable. It risks imputing to all women a standard requiring the complete acceptance of medical guidance.

This Article concludes that tort law standards should explicitly govern not just the “what” of childbirth outcomes, but the “how” of childbirth decision-making by using decision-making aids to ensure that women's autonomy is actual and not illusory. Incorporating decision-making aids in the standard of care would remedy the illusion of autonomy by

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ensuring that “most women’s” decision-making frameworks are not presumptively applied to all women so as to distort tort law and undermine patient autonomy.

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I. INTRODUCTION

This Article occupies an uncomfortable, but necessary, place for women’s rights—it considers how “most women” navigate medical decision-making in childbirth. It considers why there is not *more* conflict between women and their doctors over medical decision-making in childbirth. It does so to reveal the critical importance of the tort law lens to actualizing women’s birthing autonomy.

While patients in every other medical context have complete autonomy to refuse treatment against medical advice, elect high-risk courses of action, and prioritize their own interests above any other decision-making metric, childbirth is viewed anomalously because of the duty to the fetus that the state and the doctor owe at birth.¹ These duties have led to excessive medical interventions,² forced medical procedures, and criminal prosecutions against pregnant and birthing

1. See Lidia Hoffman & Monica K. Miller, *Inconsistent State Court Rulings Concerning Pregnancy-Related Behaviors*, 22 J.L. & HEALTH 279, 280 (2009) (explaining how the state has a “compelling interest” in protecting human life after viability).

2. See *generally* THE BUSINESS OF BEING BORN (New Line Home Video 2008) (depicting the interventionist cycle of American childbirth, including labor-inducing drugs, forceps, cesarean sections, and pain medications); MARSDEN WAGNER, BORN IN THE USA: HOW A BROKEN MATERNITY SYSTEM MUST BE FIXED TO PUT MOTHERS AND INFANTS FIRST 5 (2006) (explaining how obstetricians “find medical solutions to normal situations” in childbirth).

women.³ Reproductive rights scholarship has defended women's autonomy in medical decision-making when conflicts arise between women and their doctors,⁴ women and the state,⁵ and women and their fetuses.⁶ This scholarship lens examining conflict is vital to women's autonomy.⁷

This Article instead considers the far more common scenario when women and their doctors align in the face of great decision-making complexity and uncertainty. Despite historical advocacy for choice, most women regularly enter the most expensive and interventionist childbirth health care system in the world with great normalcy.⁸ Most medicalized hospital births still lack adequate informed con-

3. See, e.g., Nina Martin, *A Terrifying Precedent: Woman to Be Tried for Murder for Giving Birth to Stillborn*, SALON (Mar. 22, 2014), http://www.salon.com/2014/03/22/a_terrifying_precedent_woman_to_be_tried_for_murder_for_giving_birth_to_stillborn/ (reporting on a woman's prosecution for depraved heart murder after her baby was stillborn with its cord wrapped around its neck with trace amounts of cocaine byproduct detected). See generally Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y & L. 299, 331 (2013) (chronicling the arrests and forced interventions of hundreds of pregnant women nationwide and concluding that these forced interventions are pervasive and "raise numerous concerns about the health and dignity afforded to pregnant women in the United States").

4. See generally Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 451 (2000) (explaining how conflicts between women and doctors can arise at any time from conception to birth on issues ranging from testing to delivery methods).

5. See Hoffman & Miller, *supra* note 1, at 283 (explaining how the state cannot generally require one to subordinate her rights to others, even to save a life, but pregnant women can be compelled by the state to "undergo a particular medical treatment [that] conflicts with her right to self-determination and bodily integrity"); Margo Kaplan, *"A Special Class of Persons": Pregnant Women's Right to Refuse Medical Treatment After Gonzales v. Carhart*, 13 U. PA. J. CONST. L. 145, 187-89 (2010) (explaining how forced medical interventions infringe on women's constitutional rights in "abhorrent" ways because they allow the "state to determine for a woman what risks she must assume for the benefit of the fetus and physically appropriate[] her body to serve the state's interest in the fetus," when the state orders no "similar sacrifices in the context of saving the lives of third parties"); Suzanne K. Ketler, Note, *The Rebirth of Informed Consent: A Cultural Analysis of the Informed Consent Doctrine After Schreiber v. Physicians Insurance Co. of Wisconsin*, 95 NW. U. L. REV. 1029, 1039 (2001) (explaining how a birthing woman's right to informed consent is "balanced against state and public concerns").

6. See Oberman, *supra* note 4, at 472 (explaining how the fetus is seen as a "second patient who faces greater risks of serious morbidity and mortality than does the mother").

7. CARSON STRONG, *ETHICS IN REPRODUCTIVE AND PERINATAL MEDICINE* 2 (1997).

8. See WAGNER, *supra* note 2, at 9 (concluding that Americans pay "more per capita for maternity services than any other country in the world"); RICHARD W. WERTZ & DOROTHY C. WERTZ, *LYING-IN: A HISTORY OF CHILDBIRTH IN AMERICA* 63, 141 (1977) (explaining the historically interventionist role that doctors have played in childbirth); Elisabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. TIMES (June 30, 2013), http://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html?pagewanted=all&_r=0 (explaining the "sticker shock" American women experience where charges for childbirth have tripled since 1996).

sent⁹ and are largely uncontested by the four million women who give birth in this manner each year.¹⁰ From a tort law lens, the birthing experience of “most women” greatly influences the governing standard of care applied to all women and is therefore a critical unexamined site for study.

What decision-making framework normalizes the frequency of doctor-patient alignment in obstetric care, and how does this decision-making framework complicate the actualization of autonomy for the women who do not elect this framework? This Article concludes that many women align with their doctors by applying a decision-making framework that always seeks to reduce all risks to the fetus regardless of maternal risks or materiality.¹¹

This decision-making framework might actualize the autonomy of the women who elect this approach, but it perpetuates an illusion of autonomy that is problematic to the women who do not elect this framework.¹² This illusion of autonomy resurrects the ghost of *Roe v. Wade*’s medical model, in which doctors effectuate decision-making autonomy for women.¹³ Understood in a tort lens, this illusion of autonomy risks imputing a distorted standard of care to all obstetric cases by creating a primacy that always prioritizes fetal risks over maternal risks regardless of likelihood or severity, a primacy that is explicitly inconsistent with existing tort standards.¹⁴ Tort law ordinarily governs “unreasonable risks,” whereas this framework elevates any fetal risk to an unreasonable risk and reduces any maternal risk short of death to reasonable.¹⁵ It risks imputing to all women a standard that their autonomy is presumptively exercised by the complete acceptance of medical guidance.¹⁶

This Article concludes that tort law standards should explicitly govern not just the “what” of childbirth outcomes, but the “how” of childbirth decision-making by using decision-making aids to ensure

9. Numerous feminist scholars and historians have chronicled and analyzed the absence of meaningful informed consent in childbirth interventions. Proper informed consent requires presenting the birthing woman with alternatives and medically accurate and complete information, including risks to the birthing woman, not just those to the fetus. See, e.g., Ketler, *supra* note 5, at 1031 (explaining that “the doctrine of informed consent was founded upon the notion that adult persons have a fundamental right to bodily self-determination”).

10. See, e.g., PHYLLIS L. BRODSKY, *THE CONTROL OF CHILDBIRTH: WOMEN VERSUS MEDICINE THROUGH THE AGES 7-9* (2008) (explaining how a “doctor knows best” attitude prevails in childbirth).

11. See *infra* Part III.B.

12. See *infra* Parts IV–V.

13. See *infra* Part VI.C.

14. See *infra* Parts VI.A–B.

15. See *infra* Part VI.A.

16. See *infra* Part VI.B.

that women's autonomy is actual and not illusory.¹⁷ Incorporating decision-making aids in the standard of care would remedy the illusion of autonomy by ensuring that "most women's" decision-making frameworks are not presumptively applied to all women so as to distort tort law and undermine patient autonomy.

II. NORMALCY AND CONFORMITY DOMINATE CHILDBIRTH

Despite the propensity for conflict and difference that childbirth seems to present,¹⁸ childbirth today is pervasively medicalized, hospitalized, and intervention-oriented.¹⁹

A. *The Normalized Medical Interventionist Model*

Despite choice in birth methods,²⁰ modern childbirth remains heavily normalized around a medicalized and intervention-oriented model. A survey on *Listening to Mothers II* considered women's experiences with hospital births and concluded that "labor is literally *pushed* by routine or common measures" upon healthy populations through labor induction, augmentation, and direction, and it is also "*pulled* by interventions such as vacuum extraction/forceps, cesarean section, pulling on the cord to hasten birth of the placenta, and separation of babies from mothers after birth."²¹

Modern childbirth is "almost always" in a hospital.²² It is the leading cause of hospitalization today.²³ Only 33,043 babies are born at home for every four million births in hospitals,²⁴ while 98.7% of all

17. See *infra* Part VI.

18. Adele E. Laslie, *Ethical Issues in Childbirth*, 7 J. MED. & PHIL. 179, 181 (1982) (noting that this normalcy has been criticized for "imposing one model of treatment and care on individuals in widely differing circumstances," yet conformity persists).

19. Advocates have sought to de-medicalize childbirth, but this view has not prevailed pervasively. DEBORAH LUPTON, *MEDICINE AS CULTURE: ILLNESS, DISEASE AND THE BODY* 154 (3d ed. 2012).

20. See generally Sylvia A. Law, *Childbirth: An Opportunity for Choice That Should Be Supported*, 32 N.Y.U. REV. L. & SOC. CHANGE 345 (2008) (highlighting birthing choices).

21. Carol Sakala & Maureen P. Corry, *Evidence-Based Maternity Care: What It Is and What It Can Achieve*, MILBANK MEM'L FUND 28 (2008), available at <http://www.childbirthconnection.org/pdfs/evidence-based-maternity-care.pdf>.

22. Laslie, *supra* note 18, at 185.

23. Sakala & Corry, *supra* note 21, at 11 (stating that six of the fifteen most common hospital procedures are related to childbirth).

24. Joyce A. Martin et al., *Births: Final Data for 2011*, 62 NAT'L VITAL STAT. REP. 1, 51 (2013), available at http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf. However, some data positively suggest that the number of home births is increasing. *Id.* at 10 (indicating that "[t]he number of births occurring at home (33,043) [in 2011] was the highest since reporting began for this item in 1989" and that the number of out-of-hospital births attended by Certified Nurse Midwives also rose by 6% from 28.6% in 2005 to 30.2% in 2011); see also BRODSKY, *supra* note 10, at 177 (noting that the incidents of fetal death are identical in hospital and home deliveries).

babies are born in hospitals.²⁵ This is a marked historical shift within the last century.²⁶

Modern childbirth is routinely overseen by physicians. Obstetricians hold a virtual “monopoly . . . over the maternity care system.”²⁷ Of modern hospital births, 86.1% are performed by doctors of medicine, 7.6% by nurse midwives, and 5.8% by doctors of osteopathy.²⁸ The medicalization of childbirth has dramatically exaggerated the role of doctors in birthing care and entrenched it.²⁹ This is a modern continuation of “heroic” medicine traditions whereby physicians supplanted midwives and treated pregnancy with increasingly interventionist measures.³⁰

The rate of cesarean section births in the United States is particularly normalized. The rate of cesarean sections rose every year from 1996 to 2009, including a single year increase of seven percent.³¹ Although the use of cesarean deliveries seems to have remained steady in recent years, the procedure accounted for 32.8% of all registered births in the United States during 2011.³² About one in three babies is delivered by cesarean section today compared to one in five babies in 1996.³³ With the increased cesarean rate comes the increased risks

25. Martin et al., *supra* note 24, at 10.

26. In 1900, “less than 5% of women delivered in the hospital.” WERTZ & WERTZ, *supra* note 8, at 133. In 1940, fifty-five percent of births were in hospital settings, and by 1960, eighty-eight percent were in hospital settings. JUDITH WALZER LEAVITT, BROUGHT TO BED: CHILDBEARING IN AMERICA 1750 TO 1950, at 171 (1986). Generally, the non-hospital births were in rural areas. *Id.*

27. See, e.g., WAGNER, *supra* note 2, at 5 (stating that obstetricians oversee ninety percent of American births and maintain a “monopoly . . . over the maternity care system,” while comparatively midwives oversee seventy-five percent of births in industrialized Western countries like Australia, Netherlands, and Great Britain). “[H]aving an obstetrical surgeon manage a normal birth is like having a pediatric surgeon babysit a normal two-year-old.” *Id.* at 5.

28. Martin et al., *supra* note 24, at 10. Notably, the number of hospital births attended by certified nurse midwives in 2011 reflects a six percent increase since 2005. *Id.* This increase also applies to the number of births attended by certified nurse midwives outside of the hospital. *Id.*

29. WERTZ & WERTZ, *supra* note 8, at 141 (“By 1920 doctors believed that ‘normal’ deliveries . . . were so rare as to be virtually nonexistent.”).

30. BARBARA EHRENREICH & DEIRDRE ENGLISH, WITCHES, MIDWIVES, AND NURSES: A HISTORY OF WOMEN HEALERS 23-24, 28-30 (1973) (documenting the class distinctions of this transition whereby upper-class women first used physicians as medical attendants). Today there are approximately 5700 working nurse midwives in the United States. U.S. DEP’T OF LABOR, BUR. OF STAT., OCCUPATIONAL EMP’T & WAGES, MAY 2012: 29-1161 NURSE MIDWIVES, available at <http://www.bls.gov/oes/2012/may/oes291161.htm>.

31. Martin et al., *supra* note 24, at 10. In 2011, vaginal deliveries constituted 2,651,428 of the 3,953,590 registered births in the United States. *Id.* at 52.

32. *Id.* at 10.

33. Shankar Vedantam, *Money May Be Motivating Doctors to Do More C-Sections*, NPR (Aug. 30, 2013), <http://www.npr.org/blogs/health/2013/08/30/216479305/money-may-be-motivating-doctors-to-do-more-c-sections>; see also Erin M. Johnson & M. Marit Rehavi, *Physicians Treating Physicians: Information and Incentives in Childbirth* 2-3 (NBER

of health complications to women. As major abdominal surgery, cesarean births increase risks of infection and recovery complications to women.³⁴

Modern childbirth is almost universally reliant on medical interventions.³⁵ Childbirth was historically a “natural” event.³⁶ Doctors transformed childbirth over time into a series of “more precise and effective manipulations and interventions, both to prevent and to cure disease” which ensured that doctors were “on the lookout for trouble in birth.”³⁷ Modern birth is viewed as “something that cannot be left alone, that must be interfered with, monitored and ‘helped along.’”³⁸

Modern birth is heavily managed in its timing and pacing. It is characterized by the frequent artificial rupturing of the water, inducement and augmentation of labor, and managed pain treatment.³⁹ Labor induction is the “use of drugs and/or techniques to cause labor to start, as opposed to waiting for labor to begin on its own through a complex interplay of maternal and fetal factors.”⁴⁰ The percentage of medically induced labors rose by 135% from 9.5% to 22.3% between 1990 and 2005.⁴¹ This has in turn contributed to earlier gestational

Working Paper Series, Working Paper No. 19242, 2013), *available at* <http://www.nber.org/papers/w19242> (noting variability in cesarean rates across states from 22.6% in Alaska to 39.7% in Louisiana).

34. Johnson & Rehavi, *supra* note 33, at 8. *See generally* Sakala & Corry, *supra* note 21, at 44 (describing the numerous adverse health complications of cesarean delivery).

35. *See, e.g.*, Peter B. Angood et al., *Blueprint for Action: Steps Toward a High-Quality, High-Value Maternity Care System*, 20 WOMEN'S HEALTH ISSUES S18, S24 (2010). Women's accounts of childbirth in the hospital revealed the use of Oxytocin to speed labor fifty-seven percent of the time, the rupturing of the membrane sixty-five percent of the time, the use of epidurals in seventy-six percent of births, the administration of IVs in eighty-three percent of births, the catheterization of the bladder in fifty-six percent of births, the use of forceps in seven percent of births, and cesarean deliveries in thirty-two percent of births (sixteen percent for first-time births and sixteen percent for repeat births). Sakala & Corry, *supra* note 21, at 27.

36. BRODSKY, *supra* note 10, at 11 (explaining how in ancient times women's bodies were more physically fit and prepared for the task of childbirth, and they birthed smaller babies); WERTZ & WERTZ, *supra* note 8, at 141 (noting that one Boston doctor in 1923 urged women to redefine birth “not as ‘something natural and normal, and not worth the time of obstetricians and specialists’ charges,” but as “a complicated and delicately adjusted process, subject to variations from the normal which may be disastrous to the mother or baby, or both”); Ellen S. Lazarus, *What Do Women Want? Issues of Choice, Control, and Class in Pregnancy and Childbirth*, 8 MED. ANTHROPOLOGY Q. 25, 27 (1994).

37. WERTZ & WERTZ, *supra* note 8, at 136.

38. LUPTON, *supra* note 19, at 153.

39. BRODSKY, *supra* note 10, at 142-43 (noting that epidurals were used in at least ninety percent of all medical deliveries in the 1980s).

40. Sakala & Corry, *supra* note 23, at 35-37 (including breaking the membrane and using drugs).

41. *Id.* at 16 (noting that these validation studies suggest that these rates only identify 45-61% of the induced labor).

births for singleton babies from an average of forty gestational weeks to thirty-nine gestational weeks.⁴²

Some women are requesting cesareans and inductions from their doctors independently.⁴³ Many others are undergoing these interventions without adequate informed consent at their doctor's direction.⁴⁴ In the *Listening to Mothers II* survey of childbirth in U.S. hospitals, forty-one percent of women said that a health professional suggested inducing labor in eighty-four percent of the cases, and a total of thirty-four percent of the respondents actually had a medically induced labor.⁴⁵ Eleven percent of the respondents "felt pressure" to induce.⁴⁶

Fetal monitoring technology has become standardized too. It is the most common obstetrical procedure performed in the United States.⁴⁷ While fetal monitoring technology emerged and garnered acceptance in the 1960s,⁴⁸ it was originally used only for high-risk pregnancies.⁴⁹ Today, electronic fetal monitoring technology "is the standard of care in virtually every community,"⁵⁰ despite persistent questions regarding its reliability and concerns regarding its basis for medicalized interventions.⁵¹ Approximately eighty-five percent of all annual births in the United States use electronic fetal monitoring.⁵²

42. *Id.*

43. See Chris McCourt et al., *Elective Cesarean Section and Decision Making: A Critical Review of the Literature*, 34 BIRTH 65, 65 (2007) (identifying convenience, patient choice, and psychological factors, especially concerning negative experiences in prior childbirths and fear relating to childbirth, the perceived safety of a cesarean, and social and cultural factors).

44. "It is dubious that women have been sufficiently informed about the possible risks associated with artificial stimulation of labor, including over-stimulating the uterus, fetal distress, more painful contractions, and the cascade of procedures that may follow." BRODSKY, *supra* note 10, at 143.

45. Sakala & Corry, *supra* note 23, at 36.

46. *Id.* at 37, 44 (listing consequences and side effects associated with inducing labor).

47. Thomas P. Sartwelle, *Electronic Fetal Monitoring: A Bridge Too Far*, 33 J. LEGAL MED. 313, 313 (2012).

48. *Id.*

49. ANGELA DAVIS, MODERN MOTHERHOOD: WOMEN AND FAMILY IN ENGLAND, c. 1945-2000, at 85 (Lynn Abrams et al. eds., 2012).

50. Sartwelle, *supra* note 47, at 313.

51. SHEILA KITZINGER, THE POLITICS OF BIRTH 46, 91 (2005); Sartwelle, *supra* note 47, at 313-14 ("[I]ts scientific foundation is feeble; inter-observer/intra-observer reliability is poor; the false-positive prediction of fetal distress rate is greater than ninety-nine percent; it has substantially increased the cesarean section rate with attendant mortality and morbidity; and it failed completely in its initial stated promise—reducing by half the incidence of cerebral palsy (CP), mental retardation (MR), and perinatal mortality.").

52. Sartwelle, *supra* note 47, at 313; see also Sakala & Corry, *supra* note 21, at 27 (noting that women's own accounts reveal a seventy-one percent usage of "continuous" fetal monitoring and another sixteen percent usage "most" of the time).

And most of these interventions occur without proper informed consent.⁵³ Doctors readily acknowledge informed consent models governing childbirth and pregnancy are different because of the treatment of the woman and the fetus.⁵⁴ “Most of the time, medical interventions are employed without considering the woman’s choice or obtaining informed consent”; women merely sign a general permission of care form upon admission.⁵⁵ Many women assume that the frequency and regularity of these interventions means that they are always in their best interest, unaware that “they may be exposed to avoidable and potentially harmful interventions . . . because of a lack of transparent comparative performance data to guide decisions and limited access to some effective high-value alternatives.”⁵⁶ Women report wishing they knew more about the risks and side effects of these procedures.⁵⁷ The pace of labor can complicate informed consent. Women report feeling dependent in labor on health professionals to make effective decisions “about which tests or procedures were in fact intrusive.”⁵⁸

And these interventions are heavily interconnected. “As one intervention justifies or increases the likelihood of using others, the cumulative effect is to create a distorted understanding of childbirth as a time when things are likely to go wrong and intensive medical management is required.”⁵⁹ These interventions disrupt the natural process of birth and “incur a cascade of secondary interventions used to monitor, prevent, and treat the side effects of the initial interventions.”⁶⁰

These interventions are normalized and costly even though they may not conform to the standard of care. The medical costs of child-

53. See, e.g., BRODSKY, *supra* note 10, at 142-43 (contesting the “informed consent model” governing the doctor-patient relationship in childbirth); Ketler, *supra* note 5, at 1033 (explaining how underlying presumptions in historic cases position birthing women as “incompetent, irrational, ruled by nature, and therefore unable to make informed decisions” and noting that even modern cases position women as vulnerable and weak); Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 221 (1985).

54. Oberman, *supra* note 4, at 472. See generally Pamela Harris, *Compelled Medical Treatment of Pregnant Women: The Balancing of Maternal and Fetal Rights*, 49 CLEV. ST. L. REV. 133, 134 (2001) (noting how informed consent is believed to be more complicated in childbirth because of the fetus).

55. BRODSKY, *supra* note 10, at 166; see also KITZINGER, *supra* note 51, at 46, 91; Andrew Iverson Almand, Note, *A Mother’s Worst Nightmare, What’s Left Unsaid: The Lack of Informed Consent in Obstetrical Practices*, 18 WM. & MARY J. WOMEN & L. 565, 593 (2012) (“Why are such seemingly material risks of drugs and procedures unconscionably being withheld from expectant mothers by obstetricians? Without a doubt, every mother would expect to be told the preceding information, yet so few actually receive it.”).

56. Angood et al., *supra* note 35, at S25.

57. Sakala & Corry, *supra* note 21, at 66.

58. Lazarus, *supra* note 36, at 37.

59. Sakala & Corry, *supra* note 21, at 28.

60. *Id.*

birth have risen by \$3 billion annually from 1996 to 2009.⁶¹ Costs are particularly high for interventionist childbirths in hospital settings.⁶² Yet, critically, these interventions are not achieving better outcomes. The United States spends far more on medicalized childbirth, yet lags behind many countries in key indicators.⁶³ The U.S. Department of Health and Human Services' *Healthy People 2010* report found that the United States is moving away from healthy birth weight targets and experiencing a rise in maternal mortality rates.⁶⁴ This is particularly so for women of color and lower-income women.⁶⁵ And women are having more physical and mental problems immediately after birth.⁶⁶

"Most women" experience a medicalized birth in a hospital setting with sub-standard informed consent. To the extent that maternal-doctor alignments are normalized within certain patterns, this raises the question of which cultural norms are being endorsed and sustained.⁶⁷ Lisa Ikemoto explained this powerfully as the "Code of Perfect Pregnancy," where essentialism prevails and acts to

direct the power of the state at women along race, class, and culture lines in the name of "protecting fetal interests." The resulting narrow standard . . . has an effect beyond that of taking from women the authority to construct pregnancy and motherhood for themselves; it also eliminates the possibility of difference.⁶⁸

61. Vedantam, *supra* note 33 (noting how obstetricians may be paid more for cesarean sections).

62. Sakala & Corry, *supra* note 21, at 15, 47 (explaining that the average charge in 2005 ranged from \$7000 for uncomplicated vaginal deliveries to \$16,000 for complicated cesarean deliveries and that non-hospital births averaged \$1624).

63. Angood et al., *supra* note 35, at S24 ("The United States spends far more than all other countries on health care, yet lags behind many on currently available global maternal and newborn indicators."). Maternal and newborn hospital charges totaled \$86 billion in 2006, far exceeding those of any other hospital condition. *Id.*

64. Sakala & Corry, *supra* note 21, at 3. The World Health Organization reports that twenty-nine nations have better rates for maternal mortality in childbirth, thirty-five nations have better rates for neonatal mortality, and twenty-three nations have lower rates of low birth weight births than the United States. *Id.* at 17 (reporting 2005 data for mortality rates and 2003 data for low birth weights).

65. See, e.g., Angood et al., *supra* note 35, at S27 (noting particularly that black, non-Hispanic women were increasing in negative health statistics for neonatal deaths, low birth weight infants, and other negative birthing outcomes).

66. Sakala & Corry, *supra* note 21, at 16 (indicating that women birthing in hospitals in 2005 reported high rates of new-onset physical and mental problems in the first two months after birth, with many problems persisting to six months or more postpartum).

67. See EHRENREICH & ENGLISH, *supra* note 30, at 28-30 (documenting the class distinctions of pregnancy).

68. Lisa C. Ikemoto, *The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law*, 53 OHIO ST. L.J. 1205, 1208 (1992).

The relative normalcy of a dominant birthing experience therefore bears further examination.

B. The Propensity for Frequent Conflict

The uniqueness of obstetric care would seem to present the opportunity for *more* conflict.⁶⁹ It is one of the only medical contexts in which a doctor considers possible liability to two potential litigants—the fetus and the birthing woman—and in which the state has expressed a clear interest and willingness to intervene.⁷⁰

Typical obstetric care involves a series of decisions made with imperfect information surrounding the simultaneous health risks facing both the fetus and the birthing woman.⁷¹ Obstetric decisions frequently involve medical considerations that threaten or invoke both the health of the pregnant woman and the fetus.⁷² These decisions include cesarean delivery or vaginal labor, electronic fetal monitoring, responses to breech positions, vaginal births after cesarean sections, and choice of pain management.⁷³

Obstetric medicine is an imperfect, judgment-based practice that responds to uncertainty.⁷⁴ It relies heavily on science and skill, but at bottom, doctors are acting with informed judgment in resolving conflicts involving some degree of uncertainty.⁷⁵ There is little consensus within the medical community regarding which services are essential to maternal care and which interventions actually improve health outcomes, which should cause more variation in medical decision-making.⁷⁶ Even where there is medical consensus, that consensus does not necessarily match the realities of the medical care that is

69. See MANUAL OF OBSTETRICS 404 (Arthur T. Evans & Kenneth R. Niswander eds., 6th ed. 2000) (explaining that the “[m]anagement of labor should achieve delivery in a reasonable period of time while providing maternal support and avoiding any significant compromise to the mother or fetus”).

70. See generally Harris, *supra* note 54, at 158 (explaining that “[a]s this idea of maternal tort liability grows, a pregnant woman’s choices diminish and the state begins to play a role in her pregnancy”).

71. See Oberman, *supra* note 4, at 451 (explaining how conflicts between women and doctors can arise at any time from conception to birth on issues ranging from testing to delivery methods).

72. CYNTHIA R. DANIELS, AT WOMEN’S EXPENSE: STATE POWER AND THE POLITICS OF FETAL RIGHTS 3, 42 (1993).

73. Law, *supra* note 20, at 366.

74. See KATHRYN MONTGOMERY, HOW DOCTORS THINK 3 (2006) (explaining how doctors draw on skill as well as judgment in making decisions).

75. *Id.* (noting how medical education teaches what is “known” in medicine and then the clinical apprenticeship prepares doctors to act in response to the uncertainty).

76. Angood et al., *supra* note 35, at S34 (documenting a “lack of consensus on a comprehensive package of essential maternity services that have been shown to improve health outcomes, and should be covered by public and private insurance,” which leads to “unwarranted variation in maternity care”).

provided. Some “[p]ractices that are disproved or appropriate for mothers and babies in limited circumstances are in wide use, and beneficial practices are underused.”⁷⁷

This variation in best practices should lead to more variety of patient choice. There are choices available, women are competent to make the choices, and “reasonable professionals, and hence reasonable patients, disagree” about which options are best.⁷⁸ Literature available to birthing women describing the range of childbirth and child rearing perspectives also offer competing, even contradictory, theories that would suggest more disagreement or conflict to be resolved in doctor-patient relationships.⁷⁹ Given the individuality of birth, the range of options and choices presented, and the lack of medical consensus in standards of care, why then is there not *more* conflict or disagreement between doctors and birthing women?

C. *The Relative Normalcy of Alignment and Absence of Conflict*

Yet, but for a few iconic cases,⁸⁰ very few women actually sue or explicitly challenge this medicalized, interventionist model of childbirth.⁸¹ “Most women” do not explicitly object to these interventions contemporaneously or retroactively. Rather, women’s accounts of hospitalized childbirth and medicalized childbirth “indicate[] that they had a rather ambivalent response to” the hospitalization and medicalization itself.⁸² While “ ‘some women are alienated by their experience of medicali[z]ed birth,’ ” many women across social classes

77. Sakala & Corry, *supra* note 21, at 1. “Many maternity practices that were originally developed to address specific problems have come to be used liberally and even routinely in healthy women”; these practices include labor induction, epidural analgesia, and cesarean sections. *Id.* at 4. “Available systematic reviews also do not support the routine use of other common maternity practices, including numerous prenatal tests and treatments, continuous electronic fetal monitoring, rupturing membranes during labor, and episiotomy.” *Id.*

78. Law, *supra* note 20, at 366.

79. See DAVIS, *supra* note 49, at 114 (noting the “tensions, ambiguities, and indeed the contradictions that are present in the women’s accounts” of caring for children).

80. See, e.g., *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247, 1249 (N.D. Fla. 1999); *Gilbert v. Miodovnik*, 990 A.2d 983, 991 (D.C. 2010) (“Of course, [the doctor] could not ‘order’ surgery without the patient’s consent.”); Ketler, *supra* note 5 (examining patient control and autonomy in labor and birth).

81. See Jamie R. Abrams, *Distorted and Diminished Tort Claims for Women*, 34 CARDOZO L. REV. 1955 (2013) (concluding that women rarely sue for birthing harms); see also David M. Engel, *Perception and Decision at the Threshold of Tort Law: Explaining the Infrequency of Claims*, 62 DEPAUL L. REV. 293, 293-94 (concluding that fewer than one in fourteen personal injury victims consults a lawyer, only one in fifty sues, and nine out of ten never contact injurer or insurance company of injurer). Sparse tort literature considers why this is so, although speculation considers money, time, and aggravation as possible explanations. *Id.* at 294.

82. DAVIS, *supra* note 49, at 107.

welcome medical intervention, if not management, and are quite satisfied with hospital deliveries.⁸³ Women's interviews describing epidural anesthesia and caesarean sections, for example, are not described as "turning points" in labor, but rather "just another procedure undergone."⁸⁴

In the relatively rare cases when doctors and birthing women conflict in decision-making, the results of judicial intervention have been notably mixed and inconsistent.⁸⁵ Where conflicts do arise, occasionally courts resolve the dispute between the birthing woman's selected course of action and the doctor's recommended course of action.⁸⁶ Some courts have held that women's decision-making autonomy is absolute, while others have said that the rights of the fetus or the state override her rights.⁸⁷ This uncertainty—particularly when it derives from high-profile cases—emphasizes a divide, which leaves women with little clarity regarding their birthing rights.⁸⁸ The law certainly recognizes a strong presumption in favor of maternal autonomy, but that autonomy is far from absolute.⁸⁹ The inconsistency

83. TINA MILLER, MAKING SENSE OF MOTHERHOOD, A NARRATIVE APPROACH 31, 73 (2005) (quoting Bonny Fox & Diana Worts, *Revisiting the Critique of Medicalized Childbirth: A Contribution to the Sociology of Birth*, 13 GENDER & SOC'Y 326, 328 (1999)).

[W]omen "regardless of social class or ethnicity . . . spoke about childbirth as a natural process, but at least to some degree, they accepted the medical view of birth; that any number of things could go wrong and that ultimately they had to rely on authoritative knowledge and concomitant technological expertise of their physician to ensure that they had done everything possible to have a healthy baby."

Id. at 73 (quoting Ellen Lazarus, *What Do Women Want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth*, in *CHILDBIRTH AND AUTHORITATIVE KNOWLEDGE: CROSS-CULTURAL PERSPECTIVES* 132, 133 (Robbie E. Davis-Floyd & Carolyn F. Sargent eds., 1997)). That is certainly not to say that women are universally *happy* with their birthing experiences. Women do state that they want more information and they are not always happy with the relationships underlying the *care* they are given, a point that might ordinarily *increase* the likelihood for suit. Angela Davis's account in *Modern Motherhood* explains that women surveyed about their birthing experiences *did* "often report[] their unhappiness with obstetric interventions," but she concludes that this was "as much a criticism of the lack of information they received, the lack of choice they felt that they had in their care, and their dissatisfaction with their medical attendants (doctors, midwives, and nurses), as their dislike of the procedures themselves." DAVIS, *supra* note 49, at 107. Women might report that they received "excellent medical care" overall but still criticize the interpersonal treatment they received from hospital staff. *Id.*

84. DAVIS, *supra* note 49, at 98.

85. See Hoffman & Miller, *supra* note 1, at 280 (concluding that "[d]ifferent state courts have issued many competing decisions, which emphasizes a lack of unification in this area of law").

86. Oberman, *supra* note 4, at 451.

87. Hoffman & Miller, *supra* note 1, at 288.

88. *Id.* at 289.

89. See, e.g., STRONG, *supra* note 7, at 183. The author concludes as follows:

The bodily integrity of mentally competent individuals who are persons in the descriptive sense is an extremely important ethical value. Control over one's

itself creates “confusion for women concerning the scope of their legal protections.”⁹⁰

Constitutional approaches addressing women’s decision-making autonomy and state interventions do not translate effectively into the private clinical setting of obstetric medical care.⁹¹ Nor have constitutional frameworks yielded consistent outcomes. Even cases that are deeply enshrined as beacons of patient autonomy, such as *Schreiber v. Physicians Insurance Co. of Wisconsin*,⁹² do not provide workable guidelines explaining when doctors should follow maternal decision-making and when they can override it.⁹³

This inconsistency and lack of clarity, however, has not necessitated or yielded any explicit tort standard or medical standard to address the anomalous nature of childbirth. At the moment of birth, doctors owe a duty of care to both the birthing woman and the fetus, and the doctor can be sued by either.⁹⁴ Nowhere in tort literature or precedent is the complexity of childbirth decision-making fleshed out in a primacy lens clarifying how doctors should respond if these duties conflict.⁹⁵ Nowhere in tort literature or precedent is a workable methodology presented for resolving disputes that might arise from decision-making conflict between the woman’s autonomy and her doctor’s duty to the fetus in birth, revealing the relative normalcy of alignments and rarity of conflict.

Likewise obstetric training texts generally make no mention whatsoever of the possibility of conflict or resolution of it, further supporting the normalcy of alignment and rarity of conflict. For example, Williams’ *Obstetrics* text, a leading text in obstetric practice,

body is a crucial aspect of self-determination. Only the most compelling of reasons would justify a significant violation of the physical integrity of a person’s body.

Id. at 180.

90. Hoffman & Miller, *supra* note 1, at 280.

91. See STRONG, *supra* note 7, at 4-6 (describing a disconnect between clinical approaches and policy frameworks); WENDY SIMONDS ET AL., LABORING ON: BIRTH IN TRANSITION IN THE UNITED STATES (2007) (explaining how doctors in a practice group setting often do not know the birthing preferences of patients at delivery).

92. 588 N.W.2d 26 (Wis. 1999).

93. Ketler, *supra* note 5, at 1054 (“Furthermore, *Schreiber* fails to give physicians any guideline whatsoever about where their duty to renegotiate informed consent ends.”).

94. See, e.g., *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994) (concluding that doctors owe a duty of care to the fetus). Precisely when that duty begins and how it might change throughout the course of the pregnancy is not clearly defined in tort law.

95. For example, the *Restatement of Torts* likewise is silent on these issues. There is no positioning of obstetric care in any way as anything different than general medical malpractice claims. There is no description of the dual duties owed or the tort complexities raised. See RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 37.

makes no mention of conflicting duties or potential ethical conflicts that may arise between women and their doctors.⁹⁶ *Foundations of Maternal & Pediatric Nursing*, a foundational text used to train students in maternal and pediatric nursing, says nothing whatsoever about the distinction or complexities of managing two duties at birth and the conflicts this might present.⁹⁷ In Charles R.B. Beckmann et al.'s *Obstetrics and Gynecology*, there is a general statement that the rights of the woman and the fetus create ethical considerations that a doctor must resolve, but no guidance about how to resolve issues.⁹⁸ And this is not occurring regularly in clinical instruction either. Rather, "little time is spent in resident programs in medical specialties on bioethics, informed consent, professional responsibility, and communicating with patients."⁹⁹

Modern birth is extremely normalized toward the alignment of women and their doctors. The question then becomes, what decision-making framework are women and doctors applying to yield this alignment?

III. HOW "MOST WOMEN" MAKE DECISIONS IN CHILDBIRTH

This section considers possible explanations for the normalcy of maternal-doctor alignments in obstetric decision-making. It first highlights briefly the existing accounts of women's decision-making in childbirth. It then concludes that a shared framework in which women and doctors align to focus on the minimization of all fetal risks accounts for much of women's alignment with their doctors. The remainder of this Article will consider the implications of this fetal-focus.

A. Existing Accounts of Decision-Making in Childbirth

One explanation for the normalcy of women-doctor alignments is that it reflects the ongoing subordination of women. Theories reflecting the subordination of women in reproduction are well documented in feminist scholarship and women's history. This explanation defines women's subordination by their reproductive function.¹⁰⁰ Innumerable historical examples exist of childbirth as subordination, par-

96. F. GARY CUNNINGHAM ET AL., WILLIAMS OBSTETRICS (23d ed. 2010).

97. LOIS WHITE, GENA DUNCAN & WENDY BAUMLE, FOUNDATIONS OF MATERNAL & PEDIATRIC NURSING (3d ed. 2011).

98. CHARLES R. B. BECKMANN ET AL., OBSTETRICS AND GYNECOLOGY 25 (6th ed. 2010).

99. Lazarus, *supra* note 36, at 41.

100. See generally ADRIENNE RICH, OF WOMAN BORN 175 (1986) (explaining how "Eve's curse" creates a "social victimization of women-as-mothers").

ticularly as birth moved into hospitals and during the “Twilight Sleep” movement.¹⁰¹

The reproductive subordination of women has particularly targeted women of color and poor women.¹⁰² Powerful historical accounts exist of doctors forcing and coercing sterilizations on poor women.¹⁰³ Lynn Paltrow’s modern pioneering work documents the race and class distinctions of forced interventions today. She concludes that “low-income women and women of color, especially African American women, are overrepresented among those who have been arrested or subjected to equivalent deprivations of liberty.”¹⁰⁴ Fifty-nine percent of the forced interventions were on women of color and seventy-one percent were on economically disadvantaged women.¹⁰⁵

Modern reproduction subordination is less about women’s subordination to doctors and more about women’s subordination to their fetuses.¹⁰⁶ The fetus is “the newest ‘social actor’ in the American conservative imagination.”¹⁰⁷ Some modern political framings have posi-

101. Hospital births and professionalized medicine distinctly shifted the balance of power, pushing out women’s domestic support systems. See LEAVITT, *supra* note 26, at 181, 190. In the mid-nineteenth century obstetric care model, women were “willingly submitting their bodies to their physicians without questioning,” and “[i]nstead of women birthing their babies, their babies were ‘delivered’ from them.” BRODSKY, *supra* note 10, at 7-8. In the “Twilight Sleep” movement characterized by the heavy use of sedatives, women were “knocked out while their babies were ‘dragged out’ ” by obstetricians, and their babies were born “floppy,” “sedated,” and difficult to be stimulated. *Id.*

102. See generally SIMONE M. CARON, WHO CHOOSES? (2008) (chronicling the troubling history of racialized interventions in the reproductive choices of the poor and of African-American women); DANIELS, *supra* note 72, at 53 (concluding that women of color or in lower economic status are “more likely to be subject to forced medical treatments”); DOROTHY ROBERTS, FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY 102 (2011) (chronicling how medical stereotyping leads to unequal access to high quality medical care and concluding that “[b]lack women are less likely to get desirable medical interventions and more likely to get undesirable interventions that good medical care would avoid”); Robin Fretwell Wilson, *Autonomy Suspended: Using Female Patients to Teach Intimate Exams Without Their Knowledge or Consent*, 8 J. HEALTH CARE L. & POL’Y, 240, 263 (2005) (describing the performance of intimate exams on patients absent full consent as a phenomenon that has “short-circuited the ethical sensitivity of many medical educators, who clutch to a variety of rationales for dispensing with the simple step of disclosing forthrightly the educational nature of practice procedures and asking permission”).

103. CARON, *supra* note 102, at 213-14 (describing a high-profile account of Carol Brown, a woman in South Carolina who was pregnant with her fifth child and could not find a doctor in her town to deliver her baby unless she agreed to forced sterilization).

104. Paltrow & Flavin, *supra* note 3, at 300-01 (examining more than four hundred cases of arrests, detentions and forced interventions in forty-four states from 1973 to 2005).

105. *Id.* at 311.

106. See DANIELS, *supra* note 72, at 49 (explaining how physicians and hospital administrators have become “much more inclined to compromise the patient’s right to autonomy in the interests of fetal health,” and they “lean heavily in favor of forced medical treatment” under the guise of “‘sav[ing]’ fetal life”).

107. *Id.* at 3, 9 (explaining that this political framing emerged in the 1980s from a convergence of “cultural, political, legal, and technological developments,” which collectively brought “the fetus into the public consciousness as an independent and autonomous being”).

tioned the fetus as “‘housed’ inside the pregnant woman’s body” in which it can become “victimized by the woman’s neglect, ignorance, or abuse.”¹⁰⁸ This fetal characterization “‘reduces women to incubators’ who are seen not as ‘full-fledged human beings, but merely better or worse vessels for fetuses.’”¹⁰⁹ Certainly subordination still exists, yet this account cannot fully explain the normalcy of alignment in decision-making because it fails to account for increased women’s autonomy, and it needs to contemplate changing political and social conceptions of the fetus.

On the other extreme, is some measure of the normalcy of women-doctor alignments explained by the success of the women’s movement and consumer health movement securing women’s decision-making autonomy? Doctor-patient relationships were historically more paternalistic, particularly in childbirth.¹¹⁰ Activists successfully challenged this model of care in the 1970s and strengthened women’s active decision-making through informed consent.¹¹¹ The “authoritarian physicians” of times past are being replaced by “doctors who enthusiastically support, or at least accept, the self-motivated patients who seek out information for themselves.”¹¹² Indeed, “[r]espect for auton-

108. *Id.* at 28 (explaining how conservative politics have depicted the fetus as the “victim” of women’s “excesses and freedoms”); LUPTON, *supra* note 19, at 166 (“The pregnant woman is increasingly portrayed as separate to and the adversary of her own pregnancy/fetus, by presenting a ‘hostile’ maternal environment or refusing proposed medical intervention.”).

109. Linda Greenhouse, *Should a Fetus’s Well-Being Override a Mother’s Rights?*, N.Y. TIMES (Sept. 9, 2000), <http://www.nytimes.com/2000/09/09/arts/should-a-fetus-s-well-being-override-a-mother-s-rights.html?pagewanted=print>.

110. See MARTIN L. PERNOLL, BENSON AND PERNOLL’S HANDBOOK OF OBSTETRICS & GYNECOLOGY 1 (10th ed. 2001) (noting that “the paternalistic care model,” which gave the physician the right to determine how much information a patient received about her condition and possible treatments, is “waning”); Law, *supra* note 20, at 363-64 (describing how “[t]raditions of paternalism and disrespect for patient choice” permeated the childbirth experience as women’s care became routine in hospitalized settings by the 1950s, historically including sedation, removal by forceps, episiotomies to facilitate the forceps, and restraints).

111. See generally Holly Goldberg, *Informed Decision Making in Maternity Care*, 18 J. PERINATAL EDUC. 32, 34 (2009).

112. RIMA D. APPLE, *PERFECT MOTHERHOOD: SCIENCE AND CHILDREARING IN AMERICA* 161 (2006). Apple cautions, however, that “we must be careful not to romanticize this modern partnership of mother and physician.” *Id.* at 168. It has “created a new clinical world for both patient and doctor, a world in which there are no simple rules or procedures. Cooperation between mothers and experts should be our goal. But it will not be easy to attain.” *Id.* This success story explanation might be further supported by the increased role of women in obstetric care and the role of choice in health services as women “shop around” for the “right doctor.” MILLER, *supra* note 83, at 74, 77-78 (describing how women’s narrative accounts position the selection of hospitals, doctors, and pain relief protocols as means of gaining or retaining control). But see ANN BOULIS & JERRY A. JACOBS, *THE CHANGING FACE OF MEDICINE: WOMEN DOCTORS AND THE EVOLUTION OF HEALTH CARE IN AMERICA* 152 (2008) (concluding that “although differences in practice styles between male and female physicians exist . . . [s]ocial and structural factors will ultimately restrict such gender-linked differences”). Women are actively seeking out hospitals and doctors in ways that

omy has become the dominant and controlling principle in both informed consent law and medical ethics.”¹¹³ Modern women’s relationships with their medical experts are normatively framed more as a partnership, “albeit an unequal partnership,” whereby women work *with* their medical caregivers and, in turn, practitioners seek to understand their patients’ needs and encourage patients to bring questions and be informed.¹¹⁴ The American Medical Association acknowledges that “[t]he patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice’ and that ‘the patient should make his or her own determination about treatment.’”¹¹⁵

Women still value and retain a strong appreciation of science and medical expertise, but they also inform themselves and supplement medical guidance.¹¹⁶ Women have more access than ever to information about childbirth. They rely on books, the Internet, and relationships to supplement the expertise of their doctor, providing a diverse array of perspectives.¹¹⁷

Yet importantly, not *all* women are attaining such idealized partnerships. Rather, many women are not “afforded the ability of shopping for a doctor that will honor their beliefs.”¹¹⁸ Class, immigration status, insurance coverage, and geography reveal that this explanation cannot entirely account for the absence of conflict in medical decision-making. “Poor women are constrained by the conditions under which they have babies and the kind of care open to them . . . and this affects their ability to acquire knowledge about birth and their ability

assert their control over childbirth. Today, nearly half of the students enrolling in medical school are women. *See id.* at 2. (comparing this statistic to the eleven percent of women medical students in 1970). The authors caution that “complete integration remains elusive.” *Id.* at 190. Women are particularly strongly represented in pediatrics and obstetric/gynecology practice areas. *See id.* at 66 (noting that women represent 53% of pediatricians and 34.3% of OB/GYNs).

113. Benjamin Moulton & Jaime S. King, *Aligning Ethics with Medical Decision-Making: The Quest for Informed Patient Choice*, 38 J. L. MED. & ETHICS 85, 87 (2010). “[A]bsent the pregnant woman’s consent, her doctor has no more right to adopt the fetus as his ‘second’ patient than he does to make any of her other living children, or even her husband, his patient.” Oberman, *supra* note 4, at 473.

114. APPLE, *supra* note 112, at 125, 139 (2006) (explaining how these shifting hierarchies were brought about by the Women’s Health Movement and reformers such as Grantley Dick-Reid’s work on *Childbirth Without Fear* and Fernand Lamaze’s focus on childbirth preparedness, as well as the transformative publication of *Our Bodies, Ourselves*).

115. Moulton & King, *supra* 113, at 87.

116. APPLE, *supra* note 112, at 153 (noting that they do not rely much on innate expertise).

117. *Id.* at 144. *See generally* MAY FRIEDMAN, MOMMYBLOGS AND THE CHANGING FACE OF MOTHERHOOD (2013) (documenting the diverse range of maternal experiences reflected in the “mamasphere” and the vast numbers of women who engaged in Internet “dialogue and interactivity” to share experiences).

118. Hoffman & Miller, *supra* note 1, at 289.

to act on such knowledge.”¹¹⁹ Poor women more often give birth in public hospitals where they face long waits and interact with innumerable “nurses,” “aides,” “clerks,” “nutritionists,” “social workers,” and doctors.¹²⁰ These institutional and inter-personal obstacles impede the flow of information, lead to contradictory advice, and complicate autonomy.¹²¹ Poor women birthing in public hospitals “rarely reach[] a point at which they ha[ve] sufficient knowledge to manipulate the system to obtain more influence over their childbirth.”¹²² As the *2010 Blueprint on Maternity Care Report* concluded, in the current model of hospital-based maternity care “[t]he vision of engaged and empowered childbearing women and families at the ‘center’ of well-coordinated maternity care is largely unrealized at present.”¹²³

And even the exercise of autonomy requires careful study of the doctor-patient relationship because informed consent requires unbiased thorough counseling.¹²⁴ This is particularly important given the anomalous distinction of childbirth where the doctor needs to present information regarding maternal risks and fetal risks. We generally endorse the principle of individual autonomy but it is harder to position in the doctor-patient relationship.¹²⁵ Women do not hold total agency in childbirth,¹²⁶ nor is that necessarily the goal.¹²⁷ Thus, while the actualization of women’s autonomy might partly explain the absence of conflict, it is far from a complete or universal explanation.¹²⁸

Alternatively, do birthing women and doctors align with such normalcy because women acquiesce to medical expertise? This explanation aligns with a longstanding historical shift to the primacy of

119. Lazarus, *supra* note 36, at 26 (internal citation omitted).

120. *Id.* at 32.

121. *Id.* at 32-33, 39 (further noting that women are, in turn, frustrated by these information gaps, and they struggle to even communicate that dissatisfaction to caregivers).

122. *Id.* at 39.

123. Angood et al., *supra* note 35, at S35 (concluding that the modern system “does not engage consumers as partners and empower them to take an active role in coordinating their own care”).

124. Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 436-37 (2006).

125. Shultz, *supra* note 53, at 221.

126. See, e.g., LUPTON, *supra* note 19, at 154 (noting that, despite these movements, “recent commentators have pointed out that such a shift in discourse and practice has not necessarily liberated women to enjoy freedom and agency while in childbirth”).

127. MILLER, *supra* note 83, at 31 (revealing “ways in which . . . expert knowledge is not rejected or even particularly resisted, but rather engaged with and thereby reinforced”).

128. See Rebecca A. Spence, *Abandoning Women to Their Rights: What Happens When Feminist Jurisprudence Ignores Birthing Rights*, 19 CARDOZO J.L. & GENDER 75, 97 (arguing that all women do not enjoy “meaningful birthing rights” and that “feminist lawyers can and must play a part in developing a robust conception of reproductive justice that includes birthing women, centering and prioritizing the needs of those with the least access to reproductive freedom”).

doctors in reproductive decision-making.¹²⁹ Women endure tremendous pressure to be “perfect mothers.”¹³⁰ This involves a deep pressure to make decisions that do not negatively impact their children.¹³¹ It is child-centered and it relies on the role of experts.¹³² If women do not “do everything (which means availing herself of technological birth), the process is her individual responsibility, and ultimately she must be blamed if she does not have the perfect birth.”¹³³

In this context, even for women, it is harder to position autonomy in the doctor-patient relationship when we hire doctors because of their expertise.¹³⁴ Women’s own accounts of childbirth confirm that they “seek out and prioritise what they see as expert knowledge.”¹³⁵ In fact, women have “increased engagement with expert bodies of knowledge and practices” and report that such practices are “reassuring” and help them “allay fears around perceived risks.”¹³⁶ This reliance on experts is part of a transitional process *into* motherhood whereby uncertainty is mitigated by risk avoidance: “[S]ecurity is maintained throughout this period of transition based on a relationship of trust in experts and the knowledge that appropriate and responsible preparation, which implicitly diminishes risk, is being undertaken.”¹³⁷ *After* birth, many women subsequently “question their ‘expert’ preparation” and question experts, demoting the positioning of experts.¹³⁸

129. See EHRENREICH & ENGLISH, *supra* note 30, at 28-30; LEAVITT, *supra* note 26, at 191.

130. Erika Horwitz, *Resistance as a Site of Empowerment: The Journey Away from Maternal Sacrifice*, in MOTHER OUTLAWS: THEORIES AND PRACTICES OF EMPOWERED MOTHERING 43, 44 (Andrea O’Reilly ed., 2004); see, e.g., JULIE BORT, AVIVA PFLOCK & DEVRA RENNER, MOMMY GUILT (2005) (proposing principles of a “guilt-free” philosophy of mothering); PHILIP G. PETERS, JR., HOW SAFE IS SAFE ENOUGH? OBLIGATIONS TO THE CHILDREN OF REPRODUCTIVE TECHNOLOGY 256 (2004) (describing the risks to “future children” in modern reproductive technologies and proposing greater regulation that would “minimize the risks that they impose on future children by proceeding cautiously and carefully”).

131. Horwitz, *supra* note 130, at 47.

132. Charlotte Faircloth, *‘Intensive Motherhood’ in Comparative Perspective: Feminism, Full-Term Breastfeeding and Attachment Parenting in London and Paris*, in PARENTING IN GLOBAL PERSPECTIVE: NEGOTIATING IDEOLOGIES OF KINSHIP, SELF AND POLITICS 119, 122 (Charlotte Faircloth, Diane M. Hoffman & Linda L. Layne eds., 2013) [hereinafter PARENTING IN GLOBAL PERSPECTIVE] (explaining how critics of intensive motherhood say that it reduces the agency of children, and the effect of “peers and social climate on child development is eclipsed through this focus on parents”).

133. Lazarus, *supra* note 36, at 25, 27 (internal citations omitted).

134. Shultz, *supra* note 53, at 221.

135. MILLER, *supra* note 83, at 48.

136. *Id.* at 74.

137. *Id.* at 61; see also *id.* at 72 (“Through engagement with the medical profession and the regular monitoring of their pregnancies the women could be seen to be preparing to become mothers, in appropriate ways, reducing risk and acting responsibly.”).

138. *Id.* at 61-62 (describing this subsequent questioning as part of becoming a mother and “regaining a sense of . . . self”).

Acquiescence to medical expertise in childbirth also often involves acquiescence to technology. Modern women rely less on social support and inter-generational guidance, and defer more to *technological* understandings of pregnancy and childbirth.¹³⁹ This changes the calculus of deference to medical expertise by leaving women to ironically perceive “greater uncertainty and risk” when expert knowledge is ordinarily called upon to achieve *more* certainty and predictability.¹⁴⁰

Acquiescence to medical expertise invokes historical skepticism, however. As Lupton concludes, “[w]omen’s deference to the ‘doctor knows best’ ideology may be related to the asymmetry of information between doctors and patients, socialized respect for professionals with specialized training and for men in general.”¹⁴¹ It puts doctors in a position to “preempt patient authority.”¹⁴² Women’s own accounts of childbirth question the autonomy of acquiescence. They express frustration that their doctors acted like “*they*, rather than their ‘patients,’ knew best.”¹⁴³ Women who knew and trusted their attendants believed their attendants “acted in their best interests” and “remembered their care far more positively,” while those with poor interpersonal relationships reported less positive experiences.¹⁴⁴

The acquiescence to medical expertise explanation is further complicated by the complexities of modern medical decisions. Physicians work within a complex web of forces that shape their own decision-making, including private insurers, federal programs, and hospitals administrations.¹⁴⁵ While women’s subordination, autonomy, and acquiescence to medical expertise might explain some degree of women’s alignment with their doctors, these accounts are polarized and even demonizing at times. The next section explores a more complex and nuanced explanation.

B. *The Shared Fetal-Focus Framework*

Some women and their doctors align in decision-making by adopting a framework that always selects the outcome that minimizes any risks to the fetus, presumptively and universally subordinating risks

139. *Id.* at 49-51 (noting how this phenomenon has been described as “technobirth”).

140. *Id.* at 48 (noting that this has moral underpinnings grounded in “‘responsible’ motherhood”).

141. LUPTON, *supra* note 19, at 158.

142. Shultz, *supra* note 53, at 221.

143. Angela Davis, *Choice, Policy and Practice in Maternity Care Since 1948*, HIST. & POL’Y (May 30, 2013), <http://www.historyandpolicy.org/policy-papers/papers/choice-policy-and-practice-in-maternity-care-since-1948> (emphasis added).

144. See DAVIS, *supra* note 49, at 107.

145. Lazarus, *supra* note 36, at 40 (noting that medical services are provided by many genuinely caring medical providers, but within the confines of a profit-based system).

to the birthing woman.¹⁴⁶ This explanation raises complex and pervasive issues regarding how we understand obstetric care, decision-making methodologies, birthing autonomy, and reproductive rights. As the next section explores, while this decision-making methodology might actualize the autonomy of the women who elect it, it normalizes a problematic standard of care that creates an illusion of autonomy for all women.

While shared medical decision-making is not unique to childbirth, it is particularly distinct when the decision-making lens is focused on a putative third party—the fetus. This is not *exclusively* a problem involving doctors or the state giving primacy to fetal interests. Rather, doctors and women patients *both* purport to function in a fetal-focused frame.

Doctors do acknowledge that they often act primarily to minimize fetal risks. Many care providers admit that they feel “legally (or morally) responsible for the fetus and as such may override the needs of the women in order to assist the fetus.”¹⁴⁷ The focus on minimizing all fetal risks has been offered to explain the absence of adequate informed consent in childbirth as well.¹⁴⁸ The unique presence of the fetus in birth might

account for the seemingly lax manner in which the informed consent doctrine has been applied in such cases. In the circumstances of labor and birth, the mother’s individual right to informed consent must be weighed against a heavier counterbalance—the newborn infant—which carries with it a heavy load of emotional and cultural force.¹⁴⁹

146. Despite its joyous and celebratory framing, pregnancy and childbirth is still dangerous for women. Indeed the maternal mortality rate in the United States has nearly doubled in the last two decades, hovering between twelve and fifteen deaths per 100,000 live births between 2003 and 2007. Jiaquan Xu et al., *Deaths: Final Data for 2007*, 58 NAT’L VITAL STAT. REP. 13 (2010), available at http://cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf. In addition, considerable racial disparities exist in maternal mortality rates. The maternal mortality rate for African American women was 26.5, roughly 2.7 times the rate for white women (10 deaths per 100,000 live births). *Id.* Although maternal mortality declined dramatically over the last century, the ratio has increased over the last several decades. U.S. DEP’T OF HEALTH & HUMAN SERVS., CHILD HEALTH USA 2008–2009, at 24 (2009), available at <http://mchb.hrsa.gov/publications/pdfs/childhealth200809.pdf>.

147. Sue Kruske et al., *Maternity Care Providers’ Perceptions of Women’s Autonomy and the Law*, 13:84 BMC PREGNANCY & CHILDBIRTH 4 (2013); see also Jamie Abrams, *Distorted and Diminished Tort Claims for Women*, 34 CARDOZO L. REV. 1955 (2013) (concluding that women are subordinated to fetuses in the dual patient model).

148. Pamela Laufer-Ukeles, *Reproductive Choices and Informed Consent: Fetal Interests, Women’s Identity, and Relational Autonomy*, 37 AM. J.L. & MED. 567, 600-03 (2011).

149. Ketler, *supra* note 5, at 1039-40.

Fear of costly litigation for fetal harms might also drive doctors to prioritize minimizing all fetal risks.¹⁵⁰ Scholars have previously acknowledged how this fetal focus is problematic for women.¹⁵¹

Notably, however, many women are also electing the decision-making framework that minimizes any risks to the fetus although the rationales and implications are quite different for women than for doctors. Many women's own framings of childbirth have changed too.¹⁵² Childbirth is often understood as a sacrifice distinctly of women's health in the name of perceptively or actually minimizing risks to their fetus. Many identify mother as "synonymous with sacrifice."¹⁵³ "[M]others are now being usurped in the public consciousness by their fetuses,"¹⁵⁴ reflecting a "giant collective wish for perfect mothering."¹⁵⁵ This leaves "the stakes of motherhood . . . so high."¹⁵⁶ One anesthesiologist described her own delivery as follows:

I don't really care about the birth experience like a lot of patients do—into soft lights, soft music garbage. For me it was getting a good baby. I've seen too many times where patients are so concerned about it being a lovely experience for them that this has overridden the desires for having a good baby and they put themselves and their birth experience in front of having a "good" baby come out and having the best care for that baby.¹⁵⁷

These cultural shifts continue into parenting too. Many women today deploy "intensive mothering" frameworks "focus[ing] on chil-

150. OB/GYNs face great medical malpractice liability, in terms of the frequency of lawsuits and the magnitude of the verdicts recovered. See *generally* AM. COLL. OF LEGAL MED., MEDICAL MALPRACTICE SURVIVAL HANDBOOK (2007). The American College of Legal Medicine reports that nearly eight out of ten OB/GYNs have been sued at least once in their career, and almost half have been sued three or more times. *Id.* at 341, 347-48 (noting that these suits are often for shoulder dystocia or failure to perform a timely cesarean delivery). These suits often yield high monetary damages because of the extent of injuries (e.g., cerebral palsy) and the emotionally compelling nature. *Id.* Recovery rates are nearly fifty percent greater in obstetric malpractice claims than overall medical malpractice claims. *Id.* at 347.

151. KITZINGER, *supra* note 51, at 87 ("[G]iving prime consideration to the fetus as a patient and seeing the woman merely as a container for it, she is reduced to a being a non-person.").

152. SHARI L. THURER, THE MYTHS OF MOTHERHOOD: HOW CULTURE REINVENTS THE GOOD MOTHER xv (1994) (noting that these re-inventions are a mythology). Indeed, parenthood itself is "political" and understanding how parents act as decision makers is noteworthy. LAUREL ELDER & STEVEN GREENE, THE POLITICS OF PARENTHOOD: CAUSES AND CONSEQUENCES OF THE POLITICIZATION AND POLARIZATION OF THE AMERICAN FAMILY (2012).

153. Horwitz, *supra* note 130, at 43.

154. THURER, *supra* note 152, at 294.

155. *Id.* at xvi.

156. *Id.* at xxiii.

157. Lazarus, *supra* note 36, at 35.

dren to the exclusion of a focus on one's own concerns as an adult."¹⁵⁸ Modern parenting is uniquely child-centered.¹⁵⁹ While specific choices and strategies for parenting exist, this child-focused frame of modern parenting is "widely shared and often unquestioned."¹⁶⁰ Modern parenting is "virtually synonymous with worry" as parents seek to ensure that their children are "healthy—physically, mentally, and emotionally."¹⁶¹ These modern anxieties distinctly position parents as more engaged in the "formative stage, and believe that children's experiences during the first two or three years of life mold their personality, lay the foundation for future cognitive and psychological development, and leave a lasting imprint on their *emotional life*."¹⁶²

This approach—the shared focus on minimizing all fetal harms—is critical to examine when understood through a tort law lens, to understand how this framework is problematic for the women who do not adopt it. These dominant practices become "ritual[ized]" and then "transmit and reinforce gendered values"¹⁶³ that are, in turn, enshrined in tort standards of care, as explored below.

IV. WHY WHAT "MOST WOMEN" DO IS CRITICAL TO AUTONOMY FOR ALL WOMEN

The question of what "most women" do is deeply antithetical to reproductive rights advocacy. Women's reproductive rights advocacy has worked extensively to defend the childbirth choices and autono-

158. MARGARET K. NELSON, *PARENTING OUT OF CONTROL: ANXIOUS PARENTS IN UNCERTAIN TIMES* 19 (2010) (noting how changes in technology such as baby monitors and GPS systems have changed parenting greatly).

159. Diane M. Hoffman, *Power Struggles: The Paradoxes of Emotion and Control Among Child-Centered Mothers in Privileged America*, in *PARENTING IN GLOBAL PERSPECTIVE*, *supra* note 132, at 229 (describing how modern parents focus on the child's developmental needs and keenly respect the child as an individual).

160. *Id.* at 230.

161. APPLE, *supra* note 112, at 1. Beginning in the 1970s distinctly, "parental anxieties greatly increased both in scope and intensity" as parents first sought to protect children from harms more consciously with inventions such as car seats, bike helmets, and baby-proofing products. *Parenting*, *ENCYCLOPEDIA OF CHILDREN AND CHILDHOOD IN HISTORY AND SOCIETY*, <http://www.faqs.org/childhood/Me-Pa/Parenting.html> (last visited Feb. 10, 2015) [hereinafter *Parenting*]. This stands in stark contrast to earlier framings of American parenting, which have shifted from "adults in training" models to scientific models to the quest for emotional and psychological fulfillment. *Id.* The term "parenting" itself is new—injected with deep "critiques of value, practice and ideals and critiques of power." *PARENTING IN GLOBAL PERSPECTIVE*, *supra* note 132, at 8; *see also id.* at 2 ("['P]arenting' also demands a discussion of reflexivity and individual 'identity work': to parent is to be discursively positioned by and actively contributing to the networks of idea, value, practice and social relations that have come to define a particular form of the politics of parent-child relations within the domain of the contemporary family.").

162. *Parenting*, *supra* note 161.

163. Miller, *supra* note 83, at 59.

my of women, particularly where such rights are positioned in conflict with their doctors, with the state, and with the fetus.¹⁶⁴

But tort law reveals what “count[s]” as an injury in our society and which injuries matter more.¹⁶⁵ Tort law is not an “objective system of adjudication”; rather, value judgments are embedded within this system to distribute suffering.¹⁶⁶ Tort law does not just recognize and compensate injuries; it “does the political and social work of determining what will count as an injury and, ultimately, how it will be distributed.”¹⁶⁷

It is thus critical that tort law standards are grounded in community-based determinations of reasonable behavior that are entirely shaped by what “most women” do. Thus, when a “community shares a value widely” that dominant value can become the standard of care.¹⁶⁸ For example, many states approach informed consent from the perspective of what is significant to the “reasonable patient,” effectively “most patients.”¹⁶⁹ For example, one informed consent birthing form states, “[f]etal monitoring by electronic machine is welcomed by the majority of mothers—any fears or questions?”¹⁷⁰

Communities in tort law are distinctly invoked to make negligence law palatable. Community-based standard setting helps to “soften the hard surface” that the imposition of objective standards on indi-

164. See, e.g., Amy Kay Boatright, *State Control Over the Bodies of Pregnant Women*, 11 J. CONTEMP. LEGAL ISSUES 903 (2001) (examining the state's authority to control a woman's body during her pregnancy); Beth A. Burkstrand-Reid, *The Invisible Woman: Availability and Culpability in Reproductive Health Jurisprudence*, 81 U. COLO. L. REV. 97 (2010) (examining how courts use the theoretical availability of alternative reproductive health services to prove that women's health will not suffer and that courts also blame women for the lack of available services in ways that undervalue women's health); V. Chandis & T. Williams, *The Patient, the Doctor, the Fetus, and the Court-Compelled Cesarean: Why Courts Should Address the Question Through a Bioethical Lens*, 25 MED. & L. 729 (2006) (presenting a bioethical lens to address conflict); Law, *supra* note 20, at 361-62; Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951 (1986); Benjamin Grant Chojnacki, Note, *Pushing Back: Protecting Maternal Autonomy from the Living Room to the Delivery Room*, 23 J.L. & HEALTH 45 (2010) (proposing changes to promote maternal autonomy).

165. SARAH S. LOCHLANN JAIN, INJURY: THE POLITICS OF PRODUCT DESIGN AND SAFETY LAW IN THE UNITED STATES 13 (2006) (“[E]normous amounts of discursive energy frame and consolidate what will count as rational behaviors and whose interests these will privilege.”).

166. *Id.* at 34 (explaining how law functions in “highly specific contexts” and reflects the socially constructed view of “acceptable relations between persons and things”). Tort law “redistribute[s] human wounding . . . with vast implications of whose bodies the costs of progress fall into.” *Id.* at 5.

167. *Id.* at 2 (chronicling differences in legal responses to different types of product injuries).

168. Jay Tidmarsh, *A Process Theory of Torts*, 51 WASH. & LEE L. REV. 1313, 1354-55 (1994).

169. King & Moulton, *supra* note 124, at 430.

170. KITZINGER, *supra* note 51, at 91.

viduals can create.¹⁷¹ Communities can stifle resentment of the more “distant, impersonal commands of negligence doctrine.”¹⁷² It allows the law to “outsource” the liability question to a group and “away from an abstract universal ideal.”¹⁷³

The role of community-based consensus among doctors is distinctly acute in setting standards of obstetric care. Tort law standards “require that physicians provide reasonable care under the circumstances, as judged against the level of knowledge and skill exercised by their professional peers.”¹⁷⁴ Tort law gives a heightened deference to the customs of the medical community.¹⁷⁵ Obstetric medical practitioners themselves set the standards of care that govern obstetrics, thus valuing collective professional medical organizations and consensus heavily. This standard setting and the uniquely community-based approach in which it occurs reveal how critical the tort law lens is to understanding the treatment of birthing women.

What “most women” do is also important because it shapes our very understanding of injuries. We process injuries against a larger social and political backdrop in a process that is “largely nonconscious or preconscious.”¹⁷⁶ “[I]njuries are not objective facts; rather, they are events that humans perceive and interpret within ideational frameworks that reflect a deep interaction between self and culture.”¹⁷⁷ They are processed in the context of the physical environment in which they occur.¹⁷⁸ The processing of an injury is subject to recursive interactional influences of friends, family, and others “that takes place over time and draws third parties into the victim’s processes of cognition and response to injuries.”¹⁷⁹

171. Anita Bernstein, *The Communities That Make Standards of Care Possible*, 77 CHL.-KENT L. REV. 735, 736 (2002).

172. *Id.* at 739.

173. *Id.* at 741.

174. *Id.* at 764.

175. *Id.* (explaining that, whereas for “many other occupations [courts] think of custom as merely relevant or admissible, the law of medical malpractice equates custom or substantially accepted practice with the standard of care”). Historically, this deference was quite problematic because the medical community perpetuated a norm of “cohesion” that prevented physicians from testifying against each other in court. *Id.* at 764-65.

176. Engel, *supra* note 81, at 303-04; *see also id.* at 296, 321; *id.* at 328 (explaining how “[t]he embodied mind would integrate [an injury] instantly and nonconsciously into its life story, and the injury victim would very likely describe the injury to others, including friends, family, and co-workers, as well as professional service providers,” and with each retelling arises an “opportunity for revision”).

177. *Id.* at 319.

178. *Id.* at 314-18.

179. *Id.* at 306; *id.* at 328 (describing how with each retelling of an injury “each listener might offer comments or reactions that alter the original perception and, recursively, help to create a revised narrative the next time around”).

The risk of bias is particularly problematic in the tort system. The tort system involves jurors comparing the conduct of stakeholders to their own “prototypes of how reasonable people behave.”¹⁸⁰ Jurors can employ many biases in this process. Accordingly cognitive bias complicates autonomy in cases where women seek to exercise their autonomy in ways other than that which most reduces risks to the fetus.¹⁸¹

So, while antithetical to conventional framings of women's birthing rights, the lens of what “most women” do is critical to understanding the standard of care that is applied to all women in childbirth.

V. HOW DECISION-MAKING MODELS TO MINIMIZE FETAL HARMS CREATE AN ILLUSION OF AUTONOMY

While women's alignment with their doctors to choose the outcome that minimizes all fetal risks can actualize autonomy in individual cases, that approach—when adopted by communities of women—risks becoming the standard of care that is applied to all women. The framework is problematic because it creates an illusion of autonomy given the ease with which doctors can “preempt patient authority.”¹⁸² Women's autonomy can easily be overridden by the doctor unilaterally selecting the outcome that best minimizes fetal risks and thereby foregoing actual informed consent and consideration of maternal risks. This positions doctors with a “trump card” to play to ensure that maternal-doctor conflicts arise only rarely. For example, “if you say to a woman that there's a 1% chance this may save the baby's life, she'll take it.”¹⁸³ This is particularly so in the context of cesarean sections: “[m]ost women, if told by an obstetrician that a cesarean is best for the baby, go along with professional advice.”¹⁸⁴ Thus, the model looks at first glance like it actualizes women's autonomy, but it is an illusion because her decision is pre-ordained by the doctors' communication of fetal risks and can be easily over-stepped, ignoring maternal risks. It suggests that medical providers' “conscious belief in women's autonomy may not translate to actual practice.”¹⁸⁵ Providing increased information to obstetric patients is not likely to change the outcomes.¹⁸⁶ Thus, “all but the most idiosyncratic patients will agree with the doctor's recommendation.”¹⁸⁷

180. Neil R. Feigenson, *The Rhetoric of Torts: How Advocates Help Jurors Think About Causation, Reasonableness, and Responsibility*, 47 HASTINGS L.J. 61, 73 (1995).

181. *Id.* at 85-87.

182. Shultz, *supra* note 53, at 221.

183. KITZINGER, *supra* note 51, at 77 (internal citations omitted).

184. *Id.* at 80 (explaining how this accordingly becomes a “quick fix” to problems).

185. See Kruske et al., *supra* note 147, at 4.

186. Law, *supra* note 20, at 365.

187. *Id.*

The illusion of autonomy can be seen in one medical text that purports to instruct obstetricians in responding to conflict with birthing women over medical decision-making. *Clinical Obstetrics: The Fetus & Mother* includes a chapter on the medico-social considerations of pregnancy, which discusses the “Ethical and Legal Dimensions of Medicine of the Pregnant Woman and Fetus.”¹⁸⁸ The text explains that any balancing between fetal benefit and maternal risk “must recognize that a pregnant woman is obligated only to take reasonable risks of medical interventions that are reliably expected to benefit the viable fetus or later child.”¹⁸⁹ It states that, unbelievably, “[s]uch conflict is best managed preventatively through the informed consent process as an ongoing dialogue throughout a woman’s pregnancy *augmented as necessary by negotiation and respectful persuasion*.”¹⁹⁰

This illusion of autonomy can also be seen in the results of an Australian study considering health care professionals’ perceptions of women’s accountability and the providers’ own legal accountability.¹⁹¹ Notably, both midwives and doctors had previously agreed that women hold the right to autonomy in birthing.¹⁹² Participants were asked about the extent to which they agreed with this statement: “In collaborative practice, working with primary carers, the final decision should always rest with the woman.”¹⁹³ Midwives agreed with this statement significantly more than doctors. When asked to rate disagreement with the statements, “ ‘For the safety of the baby, the maternity care team sometimes need[s] to override the needs of the woman’ and ‘Encouraging women to have more control over their childbearing compromises safety,’ ” doctors agreed that they sometimes had to override the woman’s interests, but midwives were more neutral with respect to that statement.¹⁹⁴ Midwives disagreed significantly more than doctors with the idea that autonomy created safety concerns.¹⁹⁵ Thus, doctors perceived a tension between autonomy and practice. As one researcher summarized, both midwives and obstetricians “only support women to make the final decision about an aspect of their care when this decision is what the care provider prefers.”¹⁹⁶ American doctors “expresse[d] a dedication to letting patients have

188. Judith L. Chervenak, Frank A. Chervenak & Lawrence B. McCullough, *Ethical and Legal Dimensions of Medicine of the Pregnant Woman and Fetus*, in *CLINICAL OBSTETRICS: THE FETUS & MOTHER* 1039 (E. Albert Reece & John C. Hobbins eds., 3d ed. 2007).

189. *Id.* at 1042.

190. *Id.* (emphasis added).

191. See Kruske et al., *supra* note 147.

192. *Id.* at 3.

193. *Id.*

194. *Id.* (emphasis omitted).

195. *Id.*

196. *Id.* at 4.

decision-making power” but then described the patients’ desires as “frivolous and as potentially conflicting with what [the doctor] decides ‘needs to happen.’”¹⁹⁷ “Obstetricians continually described their primary role as sentries on the lookout for peril; they encountered conflicts as they heroically attempted to persuade misinformed or poorly informed patients to understand that doctors were the best judges of what is safe.”¹⁹⁸ This is the illusion of autonomy.

Medical providers reported “a poor understanding of their own legal accountability, and the rights of the woman and her fetus.”¹⁹⁹ This lack of clarity is problematic both for both women and their doctors. Health care professionals need clear guidance on how to handle requests to refuse medical treatment specifically in a system that values evidence-based decision-making and autonomy.²⁰⁰

Technology can distinctly perpetuate the illusion of autonomy in its perceived objectivity, but its distinct focus is on fetal outcomes. Fetal monitoring technology emerged in the 1960s to project images of the fetus, “seemingly independent” from the woman and “taking on a human form.”²⁰¹ Notably, its scientific reliability and its necessity have been heavily contested.²⁰²

Fetal monitoring technology has “displaced the woman’s testimony from the central position it once held in the understanding of the fetus and the development of her pregnancy.”²⁰³ While a woman’s sensory awareness of her fetus, which long predated technological capabilities, used to be valued, many would say that today it is “completely ignored.”²⁰⁴ Fetal imagery perpetuates the illusion of autonomy because “representation of the fetus in isolation, abstracted from the body of the woman within which it is located, facilitates a perception of the fetus as a being that deserves no fewer rights than the wom-

197. SIMONDS ET AL., *supra* note 91, at 219.

198. *Id.* at 218.

199. Kruske et al., *supra* note 147, at 1.

200. *Id.*

201. Caroline Morris, *Technology and the Legal Discourse of the Fetal Autonomy*, 8 UCLA WOMEN'S L.J. 47, 51 (1997).

202. MANUAL OF OBSTETRICS, *supra* note 69, at 408 (concluding that “[s]ome form of evaluation of fetal well-being during labor is recommended,” but noting that “no randomized controlled study has ever shown continuous electronic fetal monitoring to be associated with better fetal outcomes than other forms of monitoring”). The authors explain that “[t]he main risk of electronic fetal heart rate monitoring is inaccurate pattern interpretation, thereby allowing a nonreassuring fetal status to go unrecognized or, conversely, and more commonly, precipitating unnecessary intervention in a healthy fetus.” *Id.*

203. MALCOLM NICOLSON & JOHN E.E. FLEMING, IMAGING AND IMAGINING THE FETUS: THE DEVELOPMENT OF OBSTETRIC ULTRASOUND 257 (2013) (noting that feminists have critiqued the universal use of the ultrasound).

204. *Id.* at 258, 264 (“It is not surprising, therefore, that the ultrasound image has been accepted as a virtually unchallengeable source of authoritative knowledge about the fetus, by professionals and laypeople alike.”).

an.”²⁰⁵ It produces an “image of the fetus . . . independent of the uterus and sustains it, and by constituting the fetus as a patient in its own right, ultrasound has divided . . . the fetus from the pregnant woman.”²⁰⁶ So, the use of fetal technology pushes the fetus’s status as a patient forward, removes the woman’s voice as a patient (to varying degrees), and yields a primacy in the “objective” nature perceived to derive from fetal monitoring.²⁰⁷ “The animation of fetal life through such imagery did more than just personify the fetus. As the fetus emerged as a person, the pregnant woman began literally to disappear from view.”²⁰⁸ Indeed, fetal monitoring often triggers (many times inaccurately) fetal distress, which is the basis for cesarean delivery.²⁰⁹

Yet, again, it is not exclusively a problem with medical professionals. While women have deferred to the medical expertise of doctors in childbirth for over a century,²¹⁰ modern women distinctly defer to *technological* understandings of pregnancy and childbirth.²¹¹ For example, many women describe fetal imagery as “reassuring.”²¹² The reliance on medical experts reveals the “seduction of formal, medicalized preparation” for childbirth, seduction rooted in women’s “notions of risk, safety,” and desire to be “seen to act responsibly.”²¹³

It is hard—if not impossible—for women to “counterpoise the natural against the artificial, our intuitive, direct knowledge of our own bodies against the alien information derived from a machine.”²¹⁴ This is an example of “demythologizing,” whereby women are not just trying to disprove an outcome, but to break an entrenched stereotype,

205. Morris, *supra* note 201, at 63.

206. NICOLSON & FLEMING, *supra* note 203, at 258, 264, 267 (explaining how fetal imagery “has been used beyond objective diagnostic tools” and explaining that the fetal image holds “affective, ethical, and religious rather than narrowly diagnostic” roles).

207. *Id.* at 262.

208. DANIELS, *supra* note 72, at 21.

209. STRONG, *supra* note 7, at 178.

210. “The concept of scientific motherhood . . . permeated . . . the country,” however, by the turn of the twentieth century, as mothers began to accept a “crucial role of contemporary science and medicine” in child rearing and care and “expect that medical and scientific experts and expertise should intervene in their daily lives.” APPLE, *supra* note 112, at 10, 33. Women actively sought out expert medical and scientific guidance in “all areas of child care, from mundane tasks to critical illness,” and this quest still thrives today. *Id.* at 33; *see also id.* at 157 (stating that popular culture reveals “just how far scientific motherhood [has] been normalized”).

211. MILLER, *supra* note 83, at 49 (noting how this phenomenon has been described as “technobirth”).

212. LUPTON, *supra* note 19, at 157 (explaining how women’s views of fetal imagery are shaped by their “age, past reproductive experiences, ethnicity, sexual preference, health status and desire for a child”).

213. MILLER, *supra* note 83, at 75.

214. NICOLSON & FLEMING, *supra* note 203, at 263 (explaining how we are perceived to “aid and improve our senses with technology”).

which can be futile.²¹⁵ Doctors can easily cut the birthing woman out of the decision-making metric and act directly in the interests of minimizing fetal harms. As the former chairman of the Department of Obstetrics and Gynecology at Columbia-Presbyterian Medical Center in New York and co-chair of the American College of Obstetrics and Gynecologists' committee reviewing obstetric practices once concluded, "we were beginning to forget that instruments such as electronic fetal monitors were tools to be used by the doctor, not decision-making machines to replace medical judgment."²¹⁶

This illusion of autonomy can—and indeed has—distorted the standard of care itself, thus implicating all women, as explored more below.

VI. WHEN THE DECISION-MAKING FRAMEWORK OF MOST WOMEN IS APPLIED TO ALL WOMEN IT PROBLEMATICALLY ALTERS MEDICAL STANDARDS OF CARE

The minimization of all fetal harms decision-making model is problematic because its replication by "most women" in childbirth risks distorting the standard of care governing childbirth for all women. It suggests that the standard of care in childbirth requires complete compliance with medical advice and the minimization of all fetal risks. The actual standards of care, however, would require patient autonomy and only the minimization of unreasonable risks. This reveals the ghost of *Roe v. Wade*'s²¹⁷ medical model.

A. *Minimization of All Fetal Harms Instead of Unreasonable Risks*

Standards of care are ordinarily framed around unacceptable or *unreasonable* risks. Yet the risk-avoidance behaviors discussed above suggest an elevated standard of care that requires the elimination of *any* risk to the fetus. This is socially constructed risk avoidance.

Indeed some doctors do suggest that the "minimization of fetal risks" is the lens that should govern women's decision-making. One explicit example of this thinking can be seen in the specialty text, *Ethics in Reproductive and Perinatal Medicine*. The text acknowledges the bodily integrity of the birthing woman as an "important ethical value" crucial to the right of "self-determination."²¹⁸ It advises only "the most compelling of reasons" would allow for these rights to be

215. DANIELS, *supra* note 72, at 100.

216. Lazarus, *supra* note 36, at 28.

217. 410 U.S. 113 (1973).

218. STRONG, *supra* note 7, at 180 (explaining that these rights are supported by a wealth of literature).

violated.²¹⁹ It concludes that, while prevention of harm to the fetus is a “serious concern,” it cannot override the “normative personhood status” of the woman carrying the child.²²⁰ Yet, notably, the text then acknowledges repeatedly that the argument can be made that the woman has an “*obligation* to promote the interests of her fetus” and that this obligation increases in advanced gestational states.²²¹ It states that mothers owe “an obligation to protect the offspring from harm.”²²² These statements suggest poignantly that some degree of conflict is avoided by a wholesome presumption—the imputation of an unwritten duty even—that women will always act to minimize fetal risks.

*B. Complete Compliance with Medical Advice Has
Never Been a Standard of Care*

It further suggests that complete compliance with expert advice becomes the standard of care by which women are judged to be “acting responsibly and avoiding unnecessary risks.”²²³

During pregnancy, childbirth and motherhood, avoiding risk, and so being seen to be responsible, continues to involve placing trust in experts. To resist such engagement, to avoid screening tests, clinic visits and expert advice would be regarded as irresponsible behaviour. Such actions would be seen to jeopardise the woman’s own health “and more importantly, that of the foetus she is carrying and expected to protect and nourish in a proper maternal manner.”²²⁴

As one woman articulated, “[t]here comes a point where you feel not trusting your doctor is not trusting your own judgment because you put time into selecting him and, should you begin to doubt him, you lose confidence in your own ability to make sound judgments.”²²⁵

The “reasonable patient” matters greatly to tort law from the perspective of juror perception, comparative negligence claims, and informed consent models. Thus, the idea that all women are normalized toward a particular decision-making framework marginalizes those who adopt a different framework. Doctors’ accounts of patient inter-

219. *Id.*

220. *Id.* at 181.

221. *Id.* at 179 (“Moreover, if there is going to be a future child with normative personhood status, the woman has a parental obligation to avoid actions that would be harmful to the child.”).

222. *Id.* at 62.

223. MILLER, *supra* note 83, at 74, 87.

224. *Id.* at 48-49.

225. Lazarus, *supra* note 36, at 38.

actions indeed describe “noncompliant patients as irritating and irrational.”²²⁶ One doctor explains the discomfort of patient autonomy:

[Patient autonomy] makes it much more difficult. So I try to explain, in layman's terms always, the consequences of the decisions and empower the patient to make the choice. Almost always they'll end up choosing my recommendation when they realize that the choice is theirs. It's very rare for someone, when they understand that my training says that [if] we go down this road, we do have the risk of compromising the baby, most folks choose and trust my training. Occasionally, when they don't, it's very difficult, but we can't assault someone, you know!²²⁷

Researchers describe how the obstetrician quoted above “saw her expertise as ultimately trumping patients' contradictory viewpoints. She portrays women's acquiescence as informed and sensible decision making rather than as an act of submission. As she sees it, patients must trust her to be the judge of whether what happens poses a risk to the baby.”²²⁸ Requiring complete compliance with medical guidance would be distinct to childbirth, as any other patient can decline medical treatment.

It is only in the context of pregnancy that doctors assert the right to compel their patients to heed medical advice. Doctors' responses to their pregnant patients therefore emerge as a startling exception to the nearly universal consensus that patients, not doctors, should control determinations about whether and when to undergo medical treatment.²²⁹

This is particularly problematic when understood in conjunction with the preceding point whereby the standard is minimizing *all* fetal risks. Women must cede to medical authority at the expense of their own autonomy, but also often at the expense of their own medical risks. One author describes this as a “gestalt picture” where “[a]s the fetus comes into view, the woman disappears.”²³⁰ Thus, women have lost their autonomy and are being medically compelled to a self-sacrificial view of motherhood. “Good mothers, it is implied, should always wish to do what Doctor considers best for the fetus and unquestioningly take his advice.”²³¹

226. SIMONDS ET AL., *supra* note 91, at 218.

227. *Id.* at 217-18.

228. *Id.* at 218.

229. Oberman, *supra* note 4, at 469.

230. Morris, *supra* note 201, at 50.

231. *Id.* at 64.

C. *The Ghost of Roe v. Wade's Medical Model*

This complete compliance with medical authority further reveals the resurrection of the ghost of *Roe v. Wade's*²³² medical model. The medical model in *Roe* positioned pregnant women as shared decision-makers with doctors, but really entrusted doctors with primacy. *Roe* squarely positioned the decision to terminate a pregnancy as a medical decision, and moreover, one in which the doctor distinctly held primacy over the pregnant woman.²³³ The Court held that, in the first trimester, the abortion decision “must be left to the medical judgment of the pregnant woman’s attending physician.”²³⁴ In the third trimester, the Court limited the state’s regulatory power by mandating an exception to prohibitions on abortion “where it is necessary, *in appropriate medical judgment*, for the preservation of the life or health of the mother.”²³⁵ *Roe* thus described the decision as one that “vindicates the right of the physician to administer medical treatment according to his professional judgment” and characterized the decision as “a medical decision” the “basic responsibility for [which] must rest with the physician.”²³⁶

When read in conjunction with *Doe v. Bolton*,²³⁷ the medical lens was notably a broad one—at least initially and doctrinally—that positioned the physician to make decisions based on women’s health, age, family status, and emotional well-being. In *Bolton*, the companion case to *Roe*, the Court further reinforced and explained the medical frame of the decision to terminate a pregnancy. In *Bolton*, the appellants challenged the criminal abortion statute in Georgia.²³⁸ The statute had an exception de-criminalizing abortions when “continuation of the pregnancy would endanger the life of the pregnant woman or would seriously and permanently injure her health,” but it hinged that exception on the “best clinical judgment” of a physician.²³⁹ The plaintiffs challenged the statute, arguing that the “necessary” language was not objective enough and fearing that doctors would

232. 410 U.S. 113 (1973).

233. This medical approach derived explicitly from historical advocacy leading up to *Roe* in which doctors and the American Medical Association sought to liberalize the criminal abortion laws by bestowing physicians with increased discretion to make the decision for their female patients in limited circumstances. Yvonne Lindgren, *The Rhetoric of Choice: Restoring Healthcare to the Abortion Right*, 64 HASTINGS L.J. 385, 387 (2013).

234. 410 U.S. at 164 (emphasis added).

235. *Id.* at 165 (emphasis added).

236. *Id.* at 165-66. Doctors had already exerted great influence in the early 1900s over birth control regulation, many opposing its legalization and ultimately securing a “monopoly over its delivery.” CARON, *supra* note 102, at 4-6 (articulating the implications of physician control over abortion on working-class women who could not afford the health care fees).

237. 410 U.S. 179 (1973).

238. *Id.* at 181.

239. *Id.* at 183.

“choose to err on the side of caution and will be arbitrary.”²⁴⁰ The Court upheld the district court’s holding that “health” was not vague and was “a judgment that physicians are obviously called upon to make routinely whenever surgery is considered,” explaining that the physicians’ medical judgment

may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman’s age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the pregnant woman.²⁴¹

Roe’s progeny later modified this health exception in critical ways by limiting abortion to only the most extreme of medical harms facing the pregnant woman—functionally to save the life of the pregnant woman only.²⁴² The breadth of the medical framing in *Bolton* is particularly noteworthy in the context of woman-doctor alignments. Notably, the “medical model” of abortion empowered doctors in reproductive decision-making and further empowered doctors to police their own professional membership.²⁴³

Roe’s adoption of the medical model was widely criticized, yet it persists.²⁴⁴ It is widely accepted that abortion jurisprudence has since shifted to the woman’s right to choose, away from a doctor’s right to decide in consultation with her. Yet, while abortion was characterized in *Roe* distinctly in the context of health care, the health care delivery model for pregnancy termination became quickly isolated among specialist doctors in specialized medical facilities. Current framings of reproductive health “sever[] the right to decide to terminate a pregnancy from access to healthcare necessary to exercise that decision.”²⁴⁵ The systematic access issues that this marginalization

240. *Id.* at 191 (arguing that the language is subject to diverse interpretation).

241. *Id.* at 192 (positioning the decision as “routine[]” for physicians).

242. Khiara M. Bridges, *When Pregnancy Is an Injury: Rape, Law, and Culture*, 65 STAN. L. REV. 457, 497 (2013). Bridges compares this narrow framing to a broader range of medical, nonmedical, physical, and psychological reasons that might necessitate an abortion in the *Roe* and *Bolton* framing. *See id.* at 459-60, 497, 516.

243. CARON, *supra* note 102, at 8.

244. *See, e.g.*, Lawrence M. Friedman, *The Conflict over Constitutional Legitimacy, in THE ABORTION DISPUTE AND THE AMERICAN SYSTEM* 13 (Gilbert Y. Steiner ed., 1983) (explaining how *Roe* “sent shock waves through the country, affecting every aspect of political life”); Lindgren, *supra* note 233, at 396 (explaining how the medical model has been “uniformly criticized” for “deferring women’s decisionmaking to the judgment of physicians”).

245. Lindgren, *supra* note 233, at 388 (explaining how “the right of abortion is in danger of becoming a right without a remedy as courts and legislatures restrict access to abortion healthcare services and regulate the consumer-provider relationship while nominally reaffirming the ‘right to choose’”).

creates are well documented and understood.²⁴⁶ Pregnancy termination services have been pushed out of health care models, and the physicians who provide the care have been pushed out of professional and social regard. The doctors who provide termination services have been demonized, marginalized, and ostracized from the medical profession through professional regulations, litigation, harassment, and violence.

The problematic bifurcation of obstetric health care and pregnancy termination health care was poignantly articulated in *Gonzales v. Carhart*.²⁴⁷ The Court concluded that doctors protect fetal interests, “abortion doctors” protect women’s autonomy, women are naturally destined to be mothers, and women who seek to terminate a pregnancy need to be protected.²⁴⁸ Indeed, Justice Kennedy in *Carhart* specifically reflected the magnification of medicalized fetal interests within the medical profession. His opinion reads as “[d]eeply skeptical that the medical profession has used the health exception in good faith,” and he “seems to believe instead that physicians have used the health exception as a proxy for promoting women’s autonomy at the expense of fetal life.”²⁴⁹ *Carhart* reveals this bias most poignantly, not only “sever[ing] abortion from healthcare, but also appear[ing] hostile to abortion providers,” describing them pejoratively as “abortion doctors” and suggesting that women need to be “protected from providers” who might fail to inform or guide them properly in their decision.²⁵⁰ This is a distinctly “woman-protective argument.”²⁵¹ The Court suggested that it was not just that women need to be protected from poor decision-making; it is that women who seek to exercise their decision-making autonomy in any way other than with a fetal focus are in need of protective barriers. It is a false choice for women: either act to protect fetal life or the state needs to protect you from your decision-making.²⁵²

246. *Id.* at 390-91 (“Reclaiming abortion as a right of both healthcare and choice offers the potential for reclaiming the right within the larger framework of reproductive justice by granting all pregnant women, women who carry to term as well as women who choose to terminate their pregnancies, the right to exercise bodily autonomy and access healthcare in every aspect of their reproductive lives.”).

247. 550 U.S. 124 (2007).

248. *See id.* at 159-60.

249. Sonia M. Suter, *The “Repugnance” Lens of Gonzales v. Carhart and Other Theories of Reproductive Rights: Evaluating Advanced Reproductive Technologies*, 76 GEO. WASH. L. REV. 1514, 1572 (2008).

250. Lindgren, *supra* note 233, at 405, 409-10 (explaining how *Carhart* and *Casey* have put “abortion exclusively as a right of choice, uncoupled from healthcare” (citing *Carhart*, 550 U.S. 124, and *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 883 (1991))).

251. *Id.* at 410.

252. *Id.* (arguing that the “woman-protective argument conflates healthcare and choice: [a] woman must be protected from the abortion *decision* because the choice is harmful to her physical and mental *health*”).

While the medical model that bestows doctors with decision-making primacy over women has been largely abandoned in the context of pregnancy termination, this analysis suggests that its legacy persists and pervades obstetric care. Margo Kaplan concluded that *Carhart's* "rationale can be imported into cases involving the medical treatment of women who wish to continue their pregnancies to term."²⁵³ *Carhart's* depiction of the "state interest in fetal life and maternal health" is cast "so broadly that it essentially creates new, dubious state interests that, in the context of compelled treatment cases, expand state justifications for requiring medical treatment of pregnant women, even where such treatment would harm women's health."²⁵⁴ This expanded reach of the state has problematic traction when understood in light of the modern framings of motherhood and parenting on which it feeds, as discussed above.

VII. RE-WRITING AND RE-RIGHTING OBSTETRIC STANDARDS OF CARE

Reproductive rights advocates have fought for decades to achieve women's autonomy in childbirth, yet successes have not been universal or fully incorporated into clinical practices.²⁵⁵

A. *Methodological Standards of Care*

To remedy the illusion of autonomy and the risks it poses to the standard of care, tort liability is needed for the dignitary harms created by the illusion of autonomy—methodological breaches in the standard of care. Incentive systems need to be changed in tort law to ensure that doctors are incentivized to emphasize *how* a decision is made, not just the substantive outcomes.

Doctors admit that methodological process is not prioritized. For example, one obstetrician quoted in a survey revealed the absence of methodological standards of care: "I think there are some patients who get very focused on the process, and all they care about is the process But for me, it is the end result. Do we have a good mom and a good baby? That's what you try to do."²⁵⁶ Researchers studying medical behavior and interviewing doctors explained how clients care about the birthing process, but doctors view their goal as "limiting

253. Kaplan, *supra* note 5, at 148.

254. *Id.* at 145, 158 ("[*Carhart*] expands the 'fetal life' state interest far beyond what *Roe* and its progeny intended, essentially recognizing new state interests in promoting respect for human life and protecting women from medical decisions they might regret.").

255. See, e.g., King & Moulton, *supra* note 124, at 429 ("Much has been written on how to bring the law to bear on medical practice in order to improve patient rights and protect physicians, but far less has been done to bring the practice of medicine to inform our legal standards.").

256. SIMONDS ET AL., *supra* note 91, at 218.

bad things” and “achiev[ing] a good outcome.”²⁵⁷ Doctors deprioritized a “process-related orientation” as less important than a “medicalized orientation” because the former can “jeopardize results, and concentrating on results *justifies* not attending to process.”²⁵⁸ In this medicalized framework, the “most important accomplishment is getting the baby out of the woman.”²⁵⁹

Accordingly, methodological standards are needed to standardize the delivery of care.²⁶⁰ Because tort law has such strong “radiating effects,” it is critical to clearly articulate decision-making norms that can, in turn, directly shape and inform public discourse.²⁶¹ Specifically, obstetric standards of care do not explicitly address how to resolve conflicts deriving from the simultaneous treatment of birthing women and their fetuses. Existing models are either nonexistent or not functional.

Informed consent only creates tort liability based on the actualization of negative outcomes, not the methodology itself. Informed consent examines whether a doctor negligently failed to disclose the nature, alternatives, risks, and consequences of a suggested treatment.²⁶² The physician proposing treatment is required to inform the patient about all “material risks,” which include serious risks, even those with minute chances of actually occurring.²⁶³ The traditional standard focuses on what a reasonable medical professional would tell patients about the nature, alternatives, risks, and consequences of a given treatment.²⁶⁴ Some jurisdictions have adopted a standard in which the test is what “the reasonable patient would want to know.”²⁶⁵

257. *Id.* at 219 (internal quotation marks omitted).

258. *Id.* (“Doctors did not represent birth *as only* pathological or risky, by any means, but they depicted it as *always potentially* pathological or risky. If you never know when disaster can strike, you must always be a sentinel.”).

259. *Id.* at 219, 222 (“[Within this discourse of OBs,] instrumental and operative deliveries are not conceptualized as *risks to* women, because risk is conceptualized as emanating *from* women’s bodies gone wrong or awry, rather than from acts done *to* women’s bodies by medical professionals.”).

260. See, e.g., Lisa Pratt, *Access to Vaginal Birth After Cesarean: Restrictive Policies and the Chilling of Women’s Medical Rights During Childbirth*, 20 WILLIAM & MARY J. WOMEN & L. 105, 121-22 (2013) (concluding that the notion that “all that matters is a healthy mom and healthy baby” does a disservice to women and babies because “women must be full participants in their pregnancies” so as not to “compromise the manner in which we attain the stated goal”). “Everyone agrees that healthy moms and healthy babies are important, but that goal must be carried out in a manner that acknowledges that the process is as important as the end result.” *Id.* at 122.

261. Anne Bloom, *The Radiating Effects of Torts*, 62 DEPAUL L. REV. 229, 233-34 (2013).

262. VICTOR E. SCHWARTZ ET AL., TORTS: CASES AND MATERIALS 195 (12th ed. 2010).

263. *Id.* at 196.

264. *Id.* at 195.

265. *Id.* at 196-97.

Modern reproductive rights arguments are being fought over the “winner take all” autonomy or primacy fight. Reproductive rights advocates have championed absolute women’s autonomy in reproductive decision-making, while opponents have argued for absolute personhood and fetal primacy.²⁶⁶ Analyzing the deeper social and cultural anchoring—as understood through the tort system—suggests reproductive rights advocates might be pursuing an unduly risky strategy by engaging the battle on these terms. It suggests that a *methodological* standard of care might be the most effective way to effectuate autonomy consistent with tort standards of care.

B. Using Decision-Making Aids

Tort standards of care should impose methodological standards of care for how decisions are made to ensure that the patient retains decision-making autonomy and that thoughtful, effective consultation is encouraged beyond traditional informed consent models.²⁶⁷ Decision-making aids should be required within the governing tort standard of care. Interactive decision-making aids facilitate effective decision-making and the processing of information.²⁶⁸

Decision aids are tools that “collect and analyze the latest clinical evidence regarding the risks and benefits of different treatment options and then present the information in a manner patients can understand.”²⁶⁹ The process is to be collaborative with various stakeholders across various disciplines,²⁷⁰ including clinical researchers, practicing physicians, health services researchers, biostatisticians, and others, and they are regularly reviewed “to ensure both the accuracy and integrity of the information conveyed.”²⁷¹ The decision aids provide information on the pros and cons of each option in an unbiased manner. In addition, the aids often offer video interviews and testimonials from patients and physicians regarding positive and negative experiences with each outcome and explanations for limita-

266. “[A]ntichoice activists have used fetal rights and mortality as their primary justification for restricting abortion . . .” CARON, *supra* note 102, at 251.

267. See generally King & Moulton, *supra* note 124, at 480.

268. *Id.* See generally CTR. FOR PERINATAL HEALTH SERVS. RESEARCH, MAKING CHOICES: OPTIONS FOR A PREGNANT WOMAN WITH A BREECH BABY: A DECISION AID FOR WOMEN (2006), available at http://sydney.edu.au/medicine/public-health/shdg/docs/Breech_DA.pdf.

269. King & Moulton, *supra* note 124, at 464. See generally INFORMED MED. DECISIONS FOUND., FOUNDATION-FUNDED RESEARCH HIGHLIGHTS: ADVANCING OUR KNOWLEDGE OF HOW MEDICAL DECISIONS ARE MADE (Jan. 2013), available at http://informedmedicaldecisions.org/wp-content/uploads/2013/01/Research_Highlights.pdf (compiling all of the research the grants of the Informed Medical Decisions Foundation have supported over the last decade as they have worked to measure the problem, assess the quality of medical decision-making, and measure decision quality).

270. Angood et al., *supra* note 35, at S38.

271. King & Moulton, *supra* note 124, at 464.

tions in evidence for one treatment over another.²⁷² Patients are given ample time to then digest and process the information and to make their communications with their physicians more fruitful.²⁷³

Childbirth is distinctly well-positioned for decision-making aids because there is time to plan and prepare.²⁷⁴ It is also cost-effective to create decision aids for childbirth because the decisions are repeated so many times and so consistently. In fact, some decision aids already exist for certain medical procedures.²⁷⁵

Decision aids are currently being integrated into various legislative and clinical settings.²⁷⁶ The Federal Affordable Care Act, for example, makes grants available to health care providers “for the development and implementation of shared decision-making techniques and to assess the use of such techniques.”²⁷⁷ Various medical centers in the United States have started experimenting with decision-making aids.²⁷⁸ A Washington statute also requires competent pa-

272. *Id.*

273. *Id.*

274. See Sakala & Corry, *supra* note 23, at 66 (“[P]regnant women have many months to prepare and would benefit from high-quality information and decision support relating to labor and birth well before labor.”).

275. See, e.g., *Research Summaries for Consumers, Clinicians, and Policymakers: Pregnancy and Childbirth*, AGENCY FOR HEALTHCARE RES. & QUALITY, available at <http://www.effectivehealthcare.ahrq.gov/index.cfm/research-summaries-for-consumers-clinicians-and-policymakers/> (last visited Feb. 10, 2015) (citing existing aids regarding the induction of labor).

276. King & Moulton, *supra* note 124, at 465.

277. Affordable Care Act, 42 U.S.C. § 299b-36(e)(3)(A) (2010). See generally *id.* § 299b-36 (stating that the purpose of this section is to “facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians that engages the patient, caregiver or authorized representative in decision making, provides patients, caregivers or authorized representatives with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan”); Samuel F. Hansen, *The Role of Decision Aids in the Affordable Care Act*, STAN. J. PUB. HEALTH (2013), available at <http://web.stanford.edu/group/sjph/cgi-bin/sjphsite/the-role-of-decision-aids-in-the-affordable-care-act/>. Section 3506 of the Affordable Care Act, “Program to Facilitate Shared Decision-making,” provides standards for the developing, implementation, funding, and certification of decision aids within the national health care system. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3506, 124 Stat. 119, 527 (2010). The section facilitates decision aids by funding a third party entity which will develop standards based on medical consensus and certify patient decision-making aids for use by federal health programs. *Id.* at 527-29. Patient decision aid is defined as “an education tool that helps patients, caregivers or authorized representatives understand and communicate their beliefs and preferences related to their treatment options and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs and preferences.” *Id.* at 527. The aids inform patients and their families of the benefits, risks, costs and effectiveness of tests and treatments. See Emily Oshima Lee & Ezekiel J. Emanuel, *Shared Decision Making to Improve Care and Reduce Costs*, 368 NEW ENG. J. MED. 6, 7 (2013).

278. Moulton & King, *supra* 113, at 91 (highlighting a Dartmouth-Hitchcock Medical Center for Shared Decision-Making); see also *Informed Choice*, DARTMOUTH INST., <http://tdi.dartmouth.edu/research/engaging/informed-choice> (last visited Feb. 10, 2015) (explaining that shared decision-making is needed when there are multiple choices, each

tients to sign written acknowledgement that she engaged in shared decision-making with a certified decision aid.²⁷⁹

The process of developing decision aids would also strengthen evidence-based standards of care. They would reveal the “critical gaps in the evidence needed for decision making on [specific obstetric decisions], then fund and conduct targeted research with time frames that can compare short-term and longer-term outcomes and costs.”²⁸⁰

Embedding a decision-aid framework within the standard of care by which doctors consult with their patients would help remedy the issues described here. This is a tool to facilitate the decision outcome, separate and distinct from informed consent, by which the doctor presents the risks and benefits. One study considered the efficacy in presenting a decision-aid framework to help women decide whether to have a subsequent caesarean birth after a prior cesarean delivery.²⁸¹ The study concluded that such a tool was useful in helping women consider the risks and benefits of delivery options, and it improved the extent to which they felt informed, but it did not improve their relationships with their health care provider.²⁸² High-quality decisions come from “a strategy of ‘vigilance’, where the decision-maker searches for information that is relevant to the decision, assimilates information in an unbiased manner and then appraises the alternatives before making a choice.”²⁸³ A workable decision-making framework would need to acknowledge individual habits that skew toward “unquestioned acceptance, responsibility shifting, rationalisation, bolstering of the least stressful alternative and inattention to additional information that would involve change.”²⁸⁴ Framing a decision-making model would account for the real-world realities of decision-making in the context of time and environmental constraints, such as family or social commitments, relationships, and risk averseness.²⁸⁵

with its own advantages and disadvantages, none of which is a clear “correct” choice, but rather the “correct” choice depends on individual factors and values).

279. Moulton & King, *supra* 113, at 92.

280. Angood et al., *supra* note 35, at S38.

281. Allison Shorten et al., *Preparing Consumers for Shared Decisions: Analyzing the Effectiveness of a Decision-Aid for Women Making Choices About Birth After Cesarean*, in *PSYCHOLOGY OF DECISION MAKING IN HEALTH CARE* 73 (Elizabeth P. Blakely ed., 2007) (studying 227 women). This is a complicated decision because both options are considered “safe” for most women, and both options involve some degree of risk for the mother and the baby. *Id.* at 78. The risk of uterine rupture is relatively small, less than one-half percent, but the consequences of the risk occurring are huge—hysterectomy or fetal death. *Id.*

282. *Id.* at 93-94.

283. *Id.* at 76.

284. *Id.*

285. *Id.* at 77, 79.

Decision aids better perpetuate a model of autonomy. They allow the patient to “make an autonomous choice to participate in a full or limited way or not at all in making the final decision after receiving the relevant information.”²⁸⁶ Thus, patients can elect to defer fully to medical judgment in ways that remain consistent with autonomy, but it is not *per se* the standard of care that they have to do so.²⁸⁷ In that sense, the aids are beneficial to doctors and patients alike. For doctors, decision aids would better address the accountability fears of medical practitioners who perceive conflicts between tort liability for bad fetal outcomes in obstetric care and actualizing women’s autonomy. Including a decision-making framework in the standard of care would better protect doctors when bad fetal outcomes occur and better protect women’s autonomy in the cases where women deviate from normalized mainstream decision-making methodologies.

Decision-making aids can be an effective tool to deter the cognitive bias created by the experiences of *most women* and *most doctors* in tort law. Cognitive bias researchers describe that several mechanisms can reduce or eliminate the problems of cognitive bias. The replacement of human intuition—the origin of cognitive bias—with formal procedures can strengthen decision-making frameworks.²⁸⁸ Many decision-makers lack appropriate “codes” to detect bias. However, this can be remedied by external calibrations.²⁸⁹ Researchers generally believe that it is possible to “debias” a problem; subjects when faced with “falsifying evidence . . . generally did reject their hypotheses . . . and respond accordingly,” “suggest[ing] that subjects may be passive rather than active.”²⁹⁰ In that sense, decision aids can also be a highly effective response to race, class, and ethnic differences in child care decision-making.²⁹¹

Yet the aids themselves need to be managed for risks of bias, which, of course, is extremely sensitive within the history of the state’s problematic regulation of informed consent in abortion.²⁹² To

286. King & Moulton, *supra* note 124, at 436.

287. *Id.*

288. JONATHAN ST. B.T. EVANS, BIAS IN HUMAN REASONING: CAUSES AND CONSEQUENCES 114-15 (1989) (explaining the general belief that critical thinking is a skill that can be taught, yet expressing skepticism regarding this accepted conclusion).

289. Amos Tversky & Daniel Kahneman, *Judgment Under Uncertainty: Heuristics and Biases*, 185 *Science* 1124, 1129-30 (1974).

290. EVANS, *supra* note 288, at 49-50 (noting, however, that the de-biasing mechanisms need to be more interactive than just instructions to decision-makers).

291. Angood et al., *supra* note 35, at S30.

292. Moulton & King, *supra* note 113, at 92 (describing a tension with how states have managed abortion informed consent and proposing resolution through effective certification procedures).

ensure that materials are unbiased, proper certification from neutral bodies is required.²⁹³

Decision aids are also uniquely time and resource intensive to prepare as a tool.²⁹⁴ They are further burdensome on physicians to implement.²⁹⁵ Yet they can achieve critical improvements in “patient comprehension” and “decisional conflict,” and they can also achieve some “improved health outcomes.”²⁹⁶

Successful implementation of decision aids requires compulsion through a tort-based standard of care. Absent a clear standard of care requiring such methodological precision, doctors lack the incentives and tools to implement.²⁹⁷ The standard of care would need to explicitly protect doctors who follow careful methodological decision-making from later litigation. For example, the Washington State bill treats the signed acknowledgment of shared decision-making with the use of a decision aid as *prima facie* evidence of informed consent.²⁹⁸

VIII. CONCLUSION

The complexities of obstetric care where dual duties are owed to both the fetus and the birthing women suggest that there should be *more* conflict in obstetric care. Many women and their doctors resolve this complexity by deploying a decision-making model to minimize all fetal risks. This standard is unworkable and intolerable because it perpetuates a mere illusion of women's autonomy. The deference to medical determinations of fetal risks further resurrects the ghost of *Roe v. Wade*'s medical model. It grossly deviates from baseline standards of care by exaggerating the severity of fetal risks and undervaluing even unreasonable risks to the birthing women. Cognitive bias further entrenches this implicit model and exacerbates it along class, race, and ethnic lines. Tort law should care about the methodology of decision-making, just as it cares about the substance. Furthermore, it should be used to create/install the methodology by which women can regain/establish their actual autonomy over medical decision-making.

293. King & Moulton, *supra* note 124, at 466.

294. *Id.*

295. Moulton & King, *supra* note 113, at 90 (explaining how it has been challenging to integrate decision aids in practice because of administrative challenges and a lack of financial and legal incentives).

296. *Id.*

297. *See id.* at 92.

298. *Id.* Washington State positions shared decision-making as “an alternative means of meeting the informed consent requirement set forth by laws” WASH. REV. CODE § 7.70.060(2)(a) (2012).

