Analyses of problems in U.S. maternity care often focus on medical factors and cost issues, important issues for healthcare policy. But a central factor at play in the use and misuse of medical resources is a foundational concept of healthcare law: the right to informed consent.

Systemic Dysfunction

Across the United States and around the world, people are waking up to the fact that obstetric care could do better for women and babies. The ever-increasing imposition of expensive technological, pharmaceutical and surgical interventions in pregnancy and childbirth does not result in better outcomes. Life-saving technologies are great when they save lives. However, their use in cases when they are unnecessary is not only inefficient, but risky. Few would deny that life-saving technologies are being used on many women who are not in an emergency and could have given birth without those technologies. As the cesarean rate reaches 70 percent in some American hospitals, women observe casually that most of their friends are giving birth with induction drugs that force uterine contractions, having their babies delivered through uterine surgery, or receiving both the induction drugs and the surgery.
Informed Consent in Childbirth: Making Rights into Reality

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The circumstances that give rise to these expensive, interventionist births are shaped by a tangle of factors that interfere with care providers' ability to recommend treatment based solely on what they believe to be best for the individual. Doctors confess that their clinical practices, including their treatment recommendations to pregnant and birthing women, are influenced by many variables beyond immediate clinical need.

“No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. To compel any one, and especially a woman, to lay bare the body, or to submit it to the touch of a stranger, without lawful authority, is an indignity, an assault, and a trespass.” —United States Supreme Court, Union Pacific Railway v. Botsford, 1891

Dysfunctions in modern maternity care are entrenched in complex and convoluted systems of hospital policies, insurance policies, culture, and emotion. Both practitioners and consumers seem to be ensnared in a Gordian knot of “medico-legal factors” that don’t make sense in light of the real risks and benefits of a given intervention. (For example, why do “liability factors” require hospitals to insist that healthy women give birth strapped to a machine that does not increase their chances of going home with a live baby, but greatly increases their risk of cesarean section?)

What can be done to construct systems of care that use medical technology judiciously, to optimize outcomes and promote public health? The clarification of one basic legal principle could serve as a start, and in the meantime would protect women and their babies from the harmful effects of systemic dysfunction. That principle is: All citizens have the right to informed consent in healthcare, and that includes the right to refuse medical interventions.

Genuine informed consent recognizes the patient as an intelligent, autonomous human being capable of making decisions about her body. Unfortunately, the “informed consent” that many women experience during childbirth looks more like, “Here’s what we’re going to do to you; now sign this.” Sometimes—too often—women aren’t told what is going to be done to them at all.

We who hire doctors to advise and assist them with medical care have the right to receive full information from those doctors about our options, and the risks and benefits of those options; we have the right to make the decision about which options we want to pursue. A doctor cannot substitute her judgment for that of a patient by failing to disclose what she is going to do to the patient’s body. The patient’s decision to refuse a doctor’s offer of treatment doesn’t have to seem reasonable or prudent to the doctor, or to anybody else. The right to informed and
autonomous decisions in healthcare is the right to weigh the full spectrum of risks and benefits according to the patient’s personal values and perspective.

A century after Justice Cardozo held in Schloendorff v. Society of New York Hospital (1914) that “a surgeon who performs an operation without his patient’s consent commits an assault,” informed consent is still good law, and should be practiced. The American College of Obstetrician-Gynecologists promotes it, and even advises members that “informed consent should be looked on as a process rather than a signature on a form.” The International Federation of Obstetrician-Gynecologists stands by a rights-based code of ethics that instructs doctors to “support a decisionmaking process, free from bias or coercion, which allows women to make informed choices regarding their sexual and reproductive health. This includes the need to act only on the basis of a fully informed consent or dissent, based on adequate provision of information and education to the patient regarding the nature, management implications, options and outcomes of choices. In this way, healthcare professionals provide women with the opportunity to consider and evaluate treatment options in the context of their own life circumstances and culture.”

These professional organizations for obstetric providers thus understand and promote informed consent. But what are women experiencing, in reality, when they give birth to their babies? The sidebar on the opposite page presents a number of these real-life birth experiences.

Too many women are reporting experiences like those related in the sidebar. There are, doubtless, myriad dynamics at play in individual patient-provider exchanges. Some of these encounters may reflect individual personalities and incidents, and others express systemic issues like hospital and insurance “policy.” But it isn't necessary to understand all the reasons why these events are occurring to talk about the right of the patient to informed consent. The right of informed consent starts with the patient and works outward.

Individual providers, protocols and policies must come into alignment with the fundamental, constitutional right of the consumer of medical services to be recognized and supported as the informed decision-maker about his or her own care. Hospital policies do not trump constitutional rights.

A complication of informed consent in modern maternity care is the question of whether a woman can be said to have “consented” to a procedure when her doctor threatens to “fire her as a patient,” or refuse to care further for her, unless she accepts the intervention. This issue is
urgent in the face of widespread “VBAC bans,” in which doctors or hospitals refuse to support women who choose to give birth vaginally, if they received a cesarean section in a previous birth. This “policy” keeps women from being supported in the decision to take on the very small risk that they might need an emergency cesarean section in a vaginal birth. Instead, every woman must “consent” to planned and scheduled cesarean sections at times manageable to the hospital staff.

In law, coercion generally nullifies consent. Across jurisdictions, it is usually agreed that a person cannot be said to have legally consented to something if that consent was given under threat. Coercion can include the threat of harming the person if they do not consent, or the threat of withholding something that the person would ordinarily expect to receive. The question facing thousands—soon to be millions—of American women is: Can we no longer expect to receive support for vaginal birth? With a current national cesarean rate of one in three births, hundreds of thousands of second-time mothers will grapple with these issues in the next few years.

What Should Informed Consent Look Like?

When I am asked by doctors or midwives what informed consent should mean in birth care, I tell them that it should consist of three parts:

**Inform.** Tell the woman about what you observe to be going on at this moment in her pregnancy or birth. Tell her about all of the healthcare alternatives that are available to her, not just the one you think she should choose. Tell her as much as you know about the risks and benefits of each alternative, and what kind of evidence exists for this information. This part of the discussion should be a transfer of objective facts, and you should leave your opinion out of it.

**Advise.** Tell the woman what you think she should do. Tell her why. This is a good moment to express the limits of your own skills and knowledge. Are you advising a cesarean for breech because you haven’t been trained in breech births? This is a time to mention that. This part of the discussion can be an expression of your subjective opinion about what you would counsel the woman to do.
Support. Support the woman in the exercise of a decision between the alternatives. This includes the decision to not follow your advice. It isn’t informed consent unless the patient has the ability to choose an alternative other than the one that the provider recommends.

Informed consent is the bridge between evidence-based care and human rights in childbirth. The information is evidence—all patients have a right to be informed about the evidence regarding the healthcare alternatives available to them. The consent is the human right, the legal right, the constitutional right. Pregnant women, like all citizens, have the right to informed consent.

Taking Responsibility

Many doctors work to provide the women they serve with genuine informed consent. A clarification of the legal authority of birthing women should serve to protect the ability of practitioners to do this work without fear of “liability” backlash. When a provider supports women in genuine informed consent, that provider recognizes that his own responsibility ends where the patient’s agency begins. You can only be responsible for something you control.

With rights come responsibility. If a patient is provided with reasonable information about the risks and benefits of alternatives, and then supported in her choice among those alternatives, she cannot fairly claim later that the provider should have compelled her to make a different decision or that she couldn’t have understood the risks well enough to make a decision. Informed consent rests upon an assumption that, despite the esoteric nature of medical knowledge, ordinary people can assess their medical alternatives and make a decision about them—including a decision to go against their doctors’ advice.

As everyone concerned with civil rights understands, there is no right without a remedy. In places where birthing women are not treated as if they have the legal right to informed consent, lawyers are needed to ask courts to address this problem.

But in other places, it should be enough to remind the people attempting to support a birthing woman that there is a legal reason to treat her as competent and capable of expressing what
she, personally, needs to give birth to her baby. A reconsideration of the central importance of informed consent to childbirth has the capacity to shake up entrenched dysfunctions in the maternity system. Every woman has an interest in clarifying the fact that women are the ultimate authority in the childbirth decision-making process.

With a national cesarean rate of more than 32 percent, all women have an interest in ensuring that they have the right to make an informed decision about the risks of cesarean for their own births, and that every intervention offered—up to and including surgery—may be freely accepted or freely declined. Many patients freely choose to say, “Doctor, tell me what to do.” But that, too, is an autonomous choice to follow a practitioner’s advice, and must be recognized as such. A “yes” is not meaningful unless you also have the right to say “no.”

Birth matters. Women matter. Women are competent and capable of making good decisions for themselves and the babies they birth, and they have the legal right to be supported in that process.

Problems with Informed Consent

This is a smattering of typical stories received regularly by organizations like ImprovingBirth.org and Human Rights in Childbirth. Names have been withheld for reasons of privacy.

“At 41 weeks, the midwife on call for my appointment told me that I would be induced the next day. I asked what the risks of inducing or not inducing would be, at this point, in my case. (The ultrasound had showed everything fine with the baby, fluid and placenta.) She responded by saying, ‘Look, you are about to become a mother. It's time to stop thinking about yourself, and start thinking about your baby.’ That was the end of the discussion. I was induced the next day.”
“With my first, they hooked me up to Pitocin after delivery without mentioning it. With my third, I arrived fully effaced and 10cm dilated. The nurse was about to give me a shot of Pitocin until my doula told me that she was prepping the shot, and I told her no. She said that the doctor had called it in as an order, and it wasn’t negotiable.”

“The OB stripped my membranes at my 38-week appointment, without warning, explanation, or consent. I was in huge pain during and after. When I asked why that vaginal exam hurt so much, he told me what he had done. I asked him why he hadn’t told me first, or asked if it was OK? He said, ‘Most women want me to do that, and I assumed you would too.’”

“The doctor cut an episiotomy, without notice, after I expressly forbade it. I have not trusted doctors since that day. Traumatizing. I felt assaulted.” “After the birth of my son, my doctor manually removed the placenta without first telling me what he was about to do or asking my permission. It was a brutal and horribly painful procedure and I felt overwhelming shock and horror. He told me that I should just be happy to have a healthy son. I am pregnant again and terrified to give birth again after my experience.”

“I’m a registered nurse, and informed consent was one of the biggest things I was taught during nursing school. And then I graduated and started working in maternity, and all of a sudden informed consent was important to no one. I can say from experience that while patients have to sign an informed consent, their signatures don’t follow a real discussion of both risks and benefits. So they might think they are informed; sadly, they are not.”
“When the ultrasound showed twins, I was referred to a high-risk practice. The only discussion of ‘options’ was the date when my cesarean would be scheduled. When I tried to ask about how the risks of twins birth applied in my personal case, I received frowns but no answers. I explained that I wanted to attempt a physiological birth unless there was evidence that intervention was needed. I was told that this kind of birth would not be allowed at any hospital in the area. When I said that I was looking for a midwife who could support a physiological twins birth, the OB said that she would have no choice but to call Child Protective Services.”

“Most of the OB practices in my area make patients sign an agreement in advance to continuous monitoring and a lot of interventions; they were up front that they would not support natural birth. One new hospital advertised itself as being woman-centered, focusing on women’s ‘choices’; they offered water birth. I chose that hospital for my fourth baby. My OB promised that I would have freedom of movement and that, even if they had to monitor me, I wouldn’t have to lie on my back.

My labor went fast; when I arrived at the hospital, I was just about ready to push. They said water birth wasn’t available. The nurse told me to lie on my back on the bed. I told her that I couldn’t do that, and that my doctor promised me freedom of movement. She said that my doctor wasn’t on call, and it was a rule that I had to lie on my back. I was on my hands and knees on the bed, trying to explain that I wouldn’t lie on my back but that my baby was coming. My water broke. The nurse hit a button that made lots of people run in. She knocked my arms out from under me and started twisting and pulling me onto my back. Somebody was also pushing on my baby’s head to hold him in.

I was using my foot—it was instinct—to try to push her off of me. I can’t describe the position I was in, on my side in mid-air, struggling. He came out then, and I had not only a fourth degree tear, but pudendal nerve damage that put me in bed for 6 months on medication…with four children under the age of 7. I’m still in a lot of pain. When I tried to talk to the hospital about what happened, I was told that ‘risk management declined my request for a meeting.’ The doctor, who was present for 1 minute of that birth, wrote in my notes, ‘Unfortunately, patient was not able to act in a controlled manner. She was all over the bed.’”