DISTORTED AND DIMINISHED TORT CLAIMS FOR WOMEN

Jamie R. Abrams†

Childbirth is distinctly characterized in tort law by the literal emergence of a potential putative plaintiff. This Article seeks to position the birthing woman—distinct from the pregnant woman or the parent—squarely within the negligence framework and, in doing so, to challenge prevailing assumptions dominating obstetric medical decision-making. The existence of two patients and two putative plaintiffs is unique to childbirth, yet largely unexamined in tort. This Article examines how the dominant focus on fetal harms in modern childbirth overshadows the birthing woman in tort and distorts the normative dualities of childbirth.

While theoretically childbirth falls within a traditional negligence framework, unique dualities dominate the tort framework when applied to birthing malpractice cases. First, absent extenuating circumstances, the doctor and the woman make birthing decisions as dual actors with the woman normatively retaining primacy in medical decision-making. Second, the doctor owes a duty to both the birthing woman and the fetus in utero. Both birthing women and the children who suffer birthing injuries can separately bring tort claims against the physician(s), with some states extending liability through to when an in utero patient reaches the age of majority.

Birthing women rarely sue for their own physical harms resulting form obstetric malpractice, while fetal harms are frequent, emotional, and yield

† Jamie R. Abrams is an Assistant Professor of Law at the University of Louisville Brandeis School of Law (LL.M, Columbia University School of Law, 2011; J.D., American University Washington College of Law, 2002; B.A., Indiana University—Bloomington). This Article is fondly dedicated to Rebecca Griffin (WCL 2002, J.D.), a brave and inspiring mother of three whose untimely death during the birth of her son in December 2006 painfully reminded her family, friends, and colleagues of the fragility of maternal life today.

Thanks to Beth Burkstrand-Reid, Cynthia Godsoe, Bert Huang, Alice Kessler-Harris, Jessica Knause, Carol Sanger, Margo Schlanger, and Rose Villazor for their guidance and support in developing this Article and to participants in the Midwest Family Law Consortium (Michigan State University School of Law), the New York Area Family Law Scholars Workshop (Benjamin N. Cardozo School of Law), the Maurice A. Deane School of Law at Hofstra University's Junior Faculty Workshop, the Law & Society Conference (Honolulu, Hawaii), and the London Women's Leadership Symposium (London, England) for commenting on earlier drafts of this piece. Thanks to Kristin Birkhold, Brittany Hampton, Lindsay McGrath, and Ashley Sauerhof for research and editing assistance.

huge damage verdicts. This Article concludes that because the fetus has become the dominant patient in childbirth and the far riskier putative plaintiff in modern obstetric malpractice cases, this reality diminishes and subordinates the rights and remedies of birthing woman as patients and plaintiffs in problematic ways. This fetal harms focus has a pervasive and multi-layered impact. It distorts the standard of care that doctors distinctly owe to both the woman and the fetus. It tilts the dualities of childbirth toward the fetus. It valorizes medical judgments in response to uncertainty in childbirth and villainizes maternal responses that do not conform to an essentialized, self-sacrificial, and historically myopic view of childbirth.

Obstetric malpractice cases further reveal fetal-focused consequentialist decision-making whereby, when the child is born healthy, the duality of doctors treating both women and in utero fetuses collapses and birthing women's rights to tort remedies are subsumed within the positive birthing outcome. Healthy babies negate maternal harms. This fetal harm focus is entrenched in litigation patterns and judicial precedent. It reveals real problems positioning the dualities of childbirth in the tort framework and preserving the autonomy of birthing women. This Article further foreshadows the pervasive problems "personhood" law reform initiatives present to the obstetric care model.

TABLE OF CONTENTS

INTRODUCTION

Consider the classic tort hypothetical involving the trolley driver barreling down Track A likely to strike five people yet able to switch the train to Track B where it will instead strike one person.[1] Should the driver switch to Track B to save four lives? Generations of tort students have wrestled with this hypothetical in all of its complexities.[2] Yet the hypothetical notably assumes no specific legal *duty* of the driver to any one individual or another, nor does it contemplate that any of the individuals in danger have a relationship to one another or would suffer different categories or severities of harms. Indeed its complexities are implicitly premised on notions of equality of status and similarity of harms among the putative victims.

This Article seeks to position the birthing woman—distinct from the pregnant woman or the parent—squarely within the negligence framework and, in doing so, to contest prevailing assumptions dominating obstetric medical decision-making. To consider this unique moment in tort, consider instead, a trolley driver bearing down on Track A and owing a simultaneous duty to a person on Track A and another on Track B. This hypothetical would inevitably trigger discussions of primacy—which duty prevails, which duty is subordinated? What if the trolley driver knew that the person on Track A would unequivocally want the driver to strike herself over the person on Track B? What if the driver knew that the person on Track B would almost always sue for catastrophic amounts and the person on Track A would almost never sue and, if so, only to recover miniscule amounts? What if the trolley driver does not know for sure that the person on Track A would want to be stricken to save the person on Track B, but the driver knows that most people on Track A facing this dilemma would want that? What if the driver knew that the state had expressed a paramount interest—even a duty—in protecting the person on Track B?

Childbirth is distinctly characterized by the literal emergence of a potential putative plaintiff.[3] These trolley hypotheticals reveal precisely

---

1 *See* Judith Thomson, *The Trolley Problem*, 94 YALE L.J. 1395 (1985).

2 *Id.*

3 In certain instances spouses may also recover for loss of consortium. *See* JOHN SEYMOUR, CHILDBIRTH AND THE LAW 60–61 (2000).

the inherent tensions that the tort system faces in resolving the dualities of childbirth. They preview how the dominance of fetal harms overshadows the modern birthing woman in tort and risks distorting medical decision-making. Notably, this Article concludes, the fetus has become the *dominant* putative plaintiff in modern obstetric malpractice cases, distorting and diminishing the rights and remedies of birthing women as patients and as plaintiffs. Thus, in the current tort framework, this Article concludes that, during childbirth, the doctor is the trolley driver and the doctor will always strike the birthing woman because the system dictates this result. This conclusion is deeply problematic on its own, but even more so in light of the charging fetal "personhood" movements proposed in states across the country.[4] This Article foreshadows how "fetal personhood"—even the movement itself, without legal status per se—creates unexamined problems in the patient obstetric care model.[5]

Childbirth is as old as human kind, yet despite its universality, the process remains vastly unexamined within the law. Constitutional doctrine has explored the right to "bear or beget a child,"[6] yet astonishingly the legal complexities of *birthing* that child remain under-theorized outside of the constitutional reproductive rights context.[7] This

---

4 *See, e.g.*, S.B. 406, 61st Leg. (Mont. 2009) ("[P]erson means a human being at all stages of human development of life, including the state of fertilization or conception . . . ."); Defense of Human Life Act, H.B. 1450 § 1, 62d Leg. (N.D. 2011) (defining "human being" as "an individual member of the species homo sapiens at every stage of development"); H.B. 1109 § 2, 82d Leg., (Tex. 2011) (providing that life begins at fertilization and that unborn children have "the rights, protections, and privileges accorded to any other person in this state"); *see also* Sanctity of Human Life Act, H.R. 23, 113th Cong. (2013) ("[H]uman life shall be deemed to begin with fertilization").

5 *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 (2013). Using the data revealed in the Article, the National Advocates for Pregnant Women concluded that personhood measures would result in the deprivation of liberties for pregnant women and would create a "'Jane Crow' system of law, establishing a second class status for all pregnant women and disproportionately punishing African American and low-income women." *Executive Summary, Paltrow & Flavin JHPPL Article*, NAT'L ADVOCATES FOR PREGNANT WOMEN (Jan. 25, 2013), http://advocatesforpregnantwomen.org/main/publications/articles_and_reports/executive_summary_paltrow_flavin_jhppl_article.php.

6 *See, e.g.*, Roe v. Wade, 410 U.S. 113 (1973) (holding that the right to privacy extends to a woman's decision to terminate a pregnancy, although preserving a role for the state to intervene to protect prenatal life and maternal health); Eisenstadt v. Baird, 405 U.S. 438 (1972) (recognizing a right of unmarried persons to engage in nonprocreative sex); Griswold v. Connecticut, 381 U.S. 479, 497 (1965) (holding that the right to privacy extends to the "right to bear children and raise a family," known otherwise as the right to "bear or beget" a child).

7 Indeed, the robust literature examining childbirth within the larger context of reproductive rights is far too extensive to survey fully here. *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

is simultaneously revealing and problematic. While patients generally retain the right to control their body,[8] modern childbirth presents unique circumstances that complicate this ideal. Medicine has at least three goals: "to prolong life, to remove obstacles to a person's physical and mental functioning, and to relieve suffering."[9] In any medical decision-making context, these goals do not always align.[10] Notably the goal "to relieve suffering" as to the woman can also be sidelined by the reality that childbirth and its suffering is a distinctly natural event. Even when all parties agree on the aims, the parties may not agree on the best course of treatment due to differing assessments of success rates, side effect severity, and side effect likelihood.[11] Accordingly, the birthing process yields many decision-making points on which professionals, patients—and even the state[12]—may reasonably disagree, such as one's birthing method, timing of labor, and use of fetal monitoring.[13]

Theoretically childbirth falls within a traditional negligence framework. Birthing women can sue their doctors for physical harms caused to them (e.g., death, hysterectomy, tearing, infection), and in

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 J. MED. & L. 729 (2006) (introducing a bioethical lens to analyze forced cesarean-section cases); Sylvia A. Law, *Childbirth: An Opportunity for Choice that Should Be Supported*, 32 N.Y.U. REV. L. & SOC. CHANGE 345, 361–62 (2008); Kelly F. Bates, Note, *Cesarean Section Epidemic: Defining the Problem—Approaching Solutions*, 4 B.U. PUB. INT. L.J. 389, 407–13 (1995) (proposing solutions including physician education, patient education, no-fault liability, voluntary arbitration, and changes in reimbursement rates to address the complexities of unnecessary cesarean sections); 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); Amy F. Cohen, Note, *The Midwifery Stalemate and Childbirth Choice: Recognizing Mothers-to-Be as the Best Late Pregnancy Decisionmakers*, 80 IND. L.J. 849 (2005) (considering the privacy interests of decision-making in pregnancy and childbirth); 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 (2001) (examining patient control and autonomy in labor and birth); Sarah D. Murphy, Note, *Labor Pains in Feminist Jurisprudence*: *An Examination of Birthing Rights*, 8 AVE MARIA L. REV. 443, 444 (2010) (concluding that feminist jurisprudence has not adequately considered birthing rights, and that "excluding birthing rights from feminist jurisprudence undermines the legitimacy of the subject whose purpose purportedly embraces the experience of women in order to raise awareness in a legal system that ignores the concerns, interests, fears, and harms experienced by women").

8 Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 129 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."), *abrogated by* Bing v. Thunig, 105 N.E. 92 (N.Y. 1914).

9 Harry Lesser, *The Patient's Right to Information*, *in* PROTECTING THE VULNERABLE: AUTONOMY AND CONSENT IN HEALTH CARE 151, 153 (Margaret Brazier & Mary Lobjoit eds., 1991).

10 *Id.*

11 *Id.*

12 Paltrow & Flavin, *supra* note 5, at 309, 313, 316, 321–26.

13 Law, *supra* note 7, at 365–66.

doing so, they plead the standard elements of negligence: of duty, breach, causation, and damages. They may often use expert testimony to establish the standard of care. Yet unique dualities dominate the modern tort framework when applied to birthing malpractice cases. First, absent extenuating circumstances, the doctor and the woman make birthing decisions as dual actors with the woman normatively retaining primacy. Second, the doctor owes a duty to both the birthing woman and the fetus *in utero*. Both birthing women and the children who suffer birthing injuries can separately bring tort claims against doctors, with some states extending liability until an *in utero* patient reaches the age of majority. Yet birthing women rarely sue for birthing harms, while fetal harms are frequent, emotional, and yield huge damage verdicts.

This Article concludes that the normative dualities of childbirth are distorted and diminished in tort by the modern dominance of fetal harms and the subordination of maternal harms. Obstetric malpractice cases reveal fetal-focused consequentialist decision-making whereby, when the child is born healthy, the duality of doctors treating both women and *in utero* fetuses collapses and birthing women's rights to tort remedies are subsumed within the positive birthing outcome. Healthy babies negate maternal harms. This fetal harm focus is entrenched in litigation patterns and judicial precedent.

This fetal harms focus has a pervasive and multi-layered impact; it distorts the standard of care that doctors distinctly owe to both the woman and the fetus; it tilts the dualities of childbirth squarely toward the fetus; it valorizes medical judgments in response to uncertainty in childbirth; and it villainizes maternal responses that do not conform to an essentialized, self-sacrificial, and historically myopic view of childbirth.

I. THE MODERN ERASURE OF MATERNAL HARMS AS THE HISTORICAL FOCUS OF OBSTETRIC MEDICAL CARE

Childbirth is "heavily influenced by cultural and economic conditions, the particular time and place in which women lived, and their socioeconomic class or ethnic group."[14] On one level, childbirth is

14 JUDITH WALZER LEAVITT, BROUGHT TO BED: CHILDBEARING IN AMERICA 1750 TO 1950, at 35 (1986); *see also* RICHARD W. WERTZ & DOROTHY C. WERTZ, LYING-IN: A HISTORY OF CHILDBIRTH IN AMERICA xv, xvii (1989) (stating that "[b]ecause people have understood and shaped birth in changing ways, both the means and the meaning of childbirth have a history, an extraordinary one because childbirth is at once a creative act, a biological happening, and a social event," and that "[b]irth is always the product of interacting cultural, social, and medical preferences. Beliefs about proper roles for men and women, for example, have continually shaped birth rituals").

a timeless woman's experience that transcends cultures, historical periods, and legal developments. Yet childbirth—even in its enduring timeless role—has nonetheless been shaped by stark medical trends and fads throughout history.[15] For example, it has moved from the home to the hospital and from the support of women to the support of doctors. It has included periodic reliance on various interventions, and then experienced a subsequent disfavor of such reliance (e.g., episiotomies, twilight sleep, enemas). This Article examines how our modern focus on the minimization of fetal harms is also a historical moment.[16]

Historically, control of childbirth decision-making has vacillated between birthing women and physicians.[17] However, even as childbirth underwent paradigmatic changes, for two and a half centuries both birthing women and doctors remained focused on maternal harms. The historical analysis in this Part reveals that the modern tort framework presents an erasure of the historical dominance of minimizing maternal harms in childbirth, which positions women's perceived risks and anxieties about childbirth outside the margins of reasonability, ignoring a centuries-long history of death and deformations hallmarking women's birthing experiences. It also shows how doctors were historically more candid and self-reflective about their inherent inadequacies in childbirth, the absence of which today compromises birthing women as putative plaintiffs in the context of our tort system.

A. *Living in the "Shadow of Maternity": The Centrality of Maternal Harms in Home Births*

For two and a half centuries, the dominant narrative of childbirth was one of maternal harms, somber and grave at first, and eventually softened somewhat. It is only in recent decades that childbirth has shifted to its fetal-harms focus and—as this Article argues—maternal

---

15 *See* TINA CASSIDY, BIRTH: THE SURPRISING HISTORY OF HOW WE ARE BORN 61, 66–67, 178–79, 186–87 (2006) (describing historical experiments with enemas, stirrups, water births, birthing centers, and other contrivances). As Judith Leavitt has noted: "For each generation that negotiated their available choices the next generation became victim to those choices." LEAVITT, *supra* note 14, at 207.

16 *See, e.g.*, Beomsoo Kim, *The Impact of Malpractice Risk on the Use of Obstetrics Procedures*, 36 J. LEGAL STUD. S79, S82 (2007) (citing scholars who describe modern physicians as "fetal champions").

17 It began with the exclusive support of friends and family assisting the pregnant woman. In time, midwives began to assist birthing women. It gradually shifted to include doctors, while women retained control and social support. Doctors gradually acquired more control, particularly in the "twilight sleep" movement, when mothers were heavily sedated during labor, yet women sought more active control in the consumer health movement and the women's movements. *See* Law, *supra* note 7, at 363–65. The consumer health movement in the 1970s and the women's rights movement gradually encouraged patients to seize more active control in medical decision-making and to restore the balance of control. *See id.*

harms have transformed into the modern derivative of or subset of fetal harms.

Whereas hospital settings and fetal monitoring technology are hallmark characteristics of modern childbirth, social support, religious overtones, and somberness characterized childbirth in colonial times. Childbirth was a heavily social experience as women reciprocally supported one another, eventually adding the additional support of a midwife.[18] Women historically faced direct and traumatic risks in childbirth, most notably the risk of death. Judith Leavitt describes this phenomenon as the "shadow of maternity" whereby the "anticipation of dying or of being permanently injured" during childbirth characterized the event.[19]

Childbearing also defined colonial women's lives to a much larger and more expansive degree, as they often birthed children sequentially from approximately their early twenties through their early forties.[20] Thus, colonial motherhood represented "the culmination of a woman's purpose in society,"[21] but women faced it with "fear of death and eternal judgment" heavily shaping their lives.[22]

Gradually, the gravity and moral hazards of childbirth harms softened and women came to view it more "matter-of-factly."[23] As the gravity of childbirth waned, doctors and medical interventions began to play an increasing role.[24] This started to create tensions regarding medical interventions during childbirth,[25] yet notably these

---

18 *See* WERTZ & WERTZ, *supra* note 14, at 1, 4, 6 (noting that these traditions prevailed for nearly 150 years).

19 LEAVITT, *supra* note 14, at 14, 28–29 (explaining that "[w]omen knew that if procreation did not kill them, it could maim them for life," and that injuries included postpartum gynecology problems, vaginal tears, and a prolapsed uterus). One woman in 1885 wrote that "[b]etween oceans of pain . . . there stretched continents of fear; fear of death and dread of suffering beyond bearing." *Id.* at 33 (internal quotation marks omitted).

20 WERTZ & WERTZ, *supra* note 14, at 2–3. Even by the early 1800s women still bore an average of seven live children in their lifetimes. LEAVITT, *supra* note 14, at 14.

21 DOROTHY A. MAYS, WOMEN IN EARLY AMERICA: STRUGGLE, SURVIVAL, AND FREEDOM IN A NEW WORLD 276 (2004).

22 WERTZ & WERTZ, *supra* note 14, at 23; *see also* LEAVITT, *supra* note 14, at 28, 35 (explaining how religious principles positioned childbirth as God's punishment to women, and how childbirth "created the boundaries within which most women had to construct their lives").

23 WERTZ & WERTZ, *supra* note 14, at 24. The religious connotations of childbirth softened somewhat to reflect a "more distant and more benevolent" God, lifting some of the moral hazards. *Id.*

24 After 1750, a few elite doctors also began bringing knowledge of childbirth practices and techniques back to the colonies from overseas education. *Id.* at 29 (explaining that disdain for elitism and hostility to foreign elitism limited such importation to just a few doctors formally trained in Europe). This period has been described as "the new midwifery" as trained male physicians brought income and status to midwifery and began to share the role of traditional female midwives. *Id.* at 44.

25 *Id.* at 30.

interventions were distinctly focused on maternal risks and women still retained ultimate decision-making power.

The conception of childbirth as a joyous and celebratory event of new life is timeless. However, compared to modern mothers, the excitement of colonial women regarding the prospects of motherhood was often tempered by high rates of fetal mortality and early childhood fatality.[26] Women managed the fears of fetal death and fetal abnormalities by treating them as signs of "the direct expression of God's will or the Devil's power."[27] Thus, maternal harms were historically grave, direct, and dominant over fetal harms and fetal harms were more normalized and subordinated.

B. The Medicalization of Childbirth Yields Interventionist Responses to Maternal Harms, with Fetal Harms Still Subordinated

This Section first examines the increased medicalization of childbirth. As childbirth moves from the home to the hospital, it also moves to the courtroom, subject to tort liability. This Section examines trends in early obstetric malpractice cases.

1. Medicalized Childbirth

Even as childbirth became less somber and more celebrated, interventions focused squarely on minimizing maternal harms, not predominantly on fetal interests. By the 1800s, motherhood was transforming into a means of women's personal fulfillment, a way to find personal happiness and to stabilize marriage.[28] This marked a critical period of transition from republican motherhood to feminine domesticity.[29] As mothers, women molded the moral vision of the country by rearing children.[30] At home, they made their husbands

---

26 *See* MAYS, *supra* note 21, at 66, 280.

27 *See* WERTZ & WERTZ, *supra* note 14, at 21. "References to feelings of joy and ecstasy in giving birth are absent from women's diaries throughout the colonial period. A woman who bore and reared seven or eight children, several of whom were likely to die, while carrying on the tasks of farm life, perhaps found the word 'joy' inappropriate even for an easy birth." *Id.* at 20.

28 Margaret Marsh, *Motherhood Denied: Women and Infertility in Historical Perspective*, *in* MOTHERS & MOTHERHOOD: READINGS IN AMERICAN HISTORY 216, 221 (Rima D. Apple & Janet Golden eds., 1997).

29 *See, e.g.*, *id.* at 223; Naomi Mezey & Cornelia T.L. Pillard, *Against the New Maternalism*, 18 MICH. J. GENDER & L. 229, 238 (2012) (explaining how American culture in the 1800s celebrated women's domesticity and the "emotional and domestic bonds of women and children" (quoting MARY P. RYAN, THE EMPIRE OF THE MOTHER: AMERICAN WRITING ABOUT DOMESTICITY 1830–1860, at 18 (1995)) (internal quotation marks omitted)).

30 Marsh, *supra* note 28, at 221–22.

happy by giving them children who would then strengthen the marriage.[31] Women, particularly white middle- and upper-class mothers, defined themselves in the "good mother role," a role that was "noble, benign, and self-sacrificing."[32]

Female midwives were pushed out of their traditional role of assisting middle- and upper-class women during childbirth by formally trained physicians.[33] This professionalization movement succeeded in the late 1800s on a platform launched in the name of "science and reform," shifting medicine from an occupation to a profession.[34]

The professionalization of medicine positioned men distinctly in childbirth.[35] It created a dynamic of "heroic" medicine whereby

---

31 *Id.* at 222.

32 *See, e.g.*, 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, 1211 (1992).

33 *See* WERTZ & WERTZ, *supra* note 14, at 46–47. Barbara Ehrenreich chronicles this power shift as not simply a preference for "science versus ignorance and superstition"; rather, it is just as much a story of class and sex. *See* BARBARA EHRENREICH & DEIRDRE ENGLISH, WITCHES, MIDWIVES, AND NURSES: A HISTORY OF WOMEN HEALERS 21–22 (1973) (noting that midwives were thought of as delivering the "people's medicine"). This shift began with upper- and middle-class women who could afford the formally trained physicians for obstetrical care and for whom medical attendants served as a status symbol and added perceived assurances. *Id.* at 23; *see also* WERTZ & WERTZ, *supra* note 14, at 65 ("[W]omen may in fact have been choosing male attendants because they wanted a guaranteed performance, in the sense of both guaranteed safety and guaranteed fashionableness.").

34 In the 1830s and 1840s, the medical profession was not fully mobilized and the Popular Health Movement still valued "traditional people's medicine" over "medical elitism." EHRENREICH & ENGLISH, *supra* note 33, at 24–25 (explaining how the popular health movement in the 1830s and 1840s educated patients about hygiene and preventative care, launching "a radical assault on medical elitism, and an affirmation of the traditional people's medicine"). The "regular" doctors enacted regulations, empowered regulating bodies, and marginalized or squashed non-traditional services. The societal value placed on science, combined with the effective political mobilization of organized medicine, eventually marginalized traditional midwifery and branded midwives as "quacks." *Id.* at 28–30 (explaining how the American Medical Association emerged in 1848, and how conditions were ripe for "regular" doctors to dominate in the late 1800s). In the early 1900s, the "irregular" doctor movement challenged midwives directly as the "last holdouts of the old people's medicine." *Id.* at 33. Physicians characterized midwives as ignorant and incompetent, by revering science over traditional practices, and by exalting the safety of the medical profession. *Id.* at 33–34. *See generally* Katherine Beckett & Bruce Hoffman, *Challenging Medicine: Law, Resistance, and the Cultural Politics of Childbirth*, 39 LAW & SOC'Y REV. 125 (2005) (chronicling the medical profession's challenge to the alternative birth movement and the destabilizing of the cultural and legal hegemony of modern medicine). By the late 1800s this shift to physicians controlling childbirth was catalyzed by the increased societal emphasis on scientific knowledge. EHRENREICH & ENGLISH, *supra* note 33, at 21. Powerful and prominent foundations funded by Rockefeller and Carnegie fueled this momentum by pouring money into the creation of a "respectable, scientific American medical profession." *Id.* at 31. While medical organizations pushed for increased regulation and licensing of "lay" practitioners throughout the 1800s, they would not succeed fully until the late 1800s, when the movement was catalyzed by organized medicine and the rise of scientific reasoning. LEAVITT, *supra* note 14, at 40 (explaining how medical education "took root and expanded" during the first half of the nineteenth century).

35 EHRENREICH & ENGLISH, *supra* note 33, at 35, 37, 40. Nursing emerged after the Civil War as an iconic role for women: "the lady with the lamp." *Id.* at 34–35. Inventors of nursing

physicians treated pregnancy with interventionist measures such as laxatives and opium, while midwives relied on natural herbs, diet, and psychological support.[36] Wertz and Wertz explain this complex dynamic and foreshadow the complexities in tort law of medicalized childbirth:

> If doctors believed that they had to perform in order to appear useful and to win approval, it is very likely that women, on the other hand, began to expect that more might go wrong with birth processes than they had previously believed. . . . The appearance of forceps in one birth established the possibility of their being used in subsequent births. In short, women may have come to anticipate difficult births whether or not doctors urged that possibility as a means of selling themselves. Having seen the 'best,' perhaps each woman wanted the 'best' for her delivery, whether she needed it or not.[37]

The medicalization of childbirth did not necessarily make it safer, but it did lessen its pain. The nineteenth century childbirth experience was marked by the introduction of pain management.[38] Better pain management, however, did nothing for the rising maternal death rate. Puerperal fever caused the death of innumerable women in childbirth, reaching "epidemic proportions" throughout the nineteenth century.[39] Documented maternal deaths in childbirth rose from 16,000 in 1916 to 23,000 in 1918.[40] By the end of World War II, women recognized that "maternity was the second highest killer of women aged fifteen to forty-five, after tuberculosis."[41] This fostered a degree of embarrassment for doctors who investigated these issues carefully.[42] Importantly, doctors struggled candidly with their shortcomings in childbirth in the medical literature of the time;[43] but by the 1950s, stronger antibiotics and

---

saw it as a natural vocation for women, second only to motherhood. *Id.* at 37.

36 *Id.* at 23–24; *see also* WERTZ & WERTZ, *supra* note 14, at 67 ("[B]irth was simply one condition among many that doctors treated, and the therapeutic approach they took to other conditions tended to spill over into their treatment of birth."); *id.* at 65 ("[A] curious inconsistency arose between the principle of noninterference in nature and the exigencies of professional practice.").

37 WERTZ & WERTZ, *supra* note 14, at 64–65. The use of forceps, for example, foreshadowed the modern "unnecesarean" debate as doctors debated the frequency of use and their relative benefits. LEAVITT, *supra* note 14, at 52 (noting how one doctor advised another to leave forceps at home so they would not rush to use them and would only use them as a last resort).

38 WERTZ & WERTZ, *supra* note 14, at 109. For Victorian women it was fashionable and socially necessary to appear "weak, invalided, nervous, or subject to fainting spells" as women were typed as weaker than men. *Id.* at 111.

39 *Id.* at 126 (noting that exact statistics were poorly maintained and often distorted the basis for death).

40 *Id.* at 155 (noting that some element of this is explained by better data on maternal mortality).

41 *Id.* at 155.

42 *Id.* at 164 ("Doctors and hospitals were deeply embarrassed by the exposure of their ignorance, incompetence, lack of routine, and failure to maintain asepsis.").

43 LEAVITT, *supra* note 14, at 149–52.

improved standards of medical care notably decreased the risk of maternal mortality during childbirth.[44]

The mid-1900s marked a dramatic migration of births from homes to hospitals. The shift from home births to hospital births was perhaps the "single most important transition in childbirth history."[45] In 1900, less than five percent of women delivered in the hospital.[46] Hospital births were historically treated as "urban asylums for poor, homeless, or working-class married women" in the 1800s.[47] By 1939, fifty percent of births were in hospital settings; with seventy-five percent of women in urban areas giving birth in hospitals.[48] By 1940, fifty-five percent of births were in hospitals; that number rose to eighty-eight percent by 1950.[49]

This institutional shift reflected the "dual attraction of new medicine and comfort, of safety and conscience."[50] It occurred because of a combination of middle- and upper-class women's desire for pain management,[51] doctors' interest in efficiency and control,[52] improved reputations of hospital settings,[53] and perceived maternal health benefits.[54] Hospital births were cleaner and offered more resources, including pain management. They softened the moral tensions of doctors attending at home,[55] and worked more efficiently.[56] Technological improvements such as antibiotics, pain control, and fetal monitoring also dramatically transformed medical care in childbirth.[57]

Hospitalized childbirth also changed the nature of medical care dramatically.[58] While doctors were predominantly managing childbirth by the end of the 1800s, childbirth was still in the birthing woman's

---

44 *Id.* at 194.

45 *Id.* at 195.

46 WERTZ & WERTZ, *supra* note 14, at 133.

47 *Id.* at 132.

48 *Id.* at 133.

49 LEAVITT, *supra* note 14, at 171 (noting that, generally, non-hospital births were in rural areas).

50 *Id.* at 171. "[I]t was more the image of science's potential, the lure of what science could offer, than any proven accomplishments that attracted women to the hospital." *Id.* at 174.

51 WERTZ & WERTZ, *supra* note 14, at 132.

52 *Id.* at 133, 136.

53 *Id.* at 122.

54 *Id.* at 133, 135 (noting that women thought hospitals were safer).

55 LEAVITT, *supra* note 14, at 40–43 (noting how this was further complicated by questions of the proper role of men in childbirth given the moral implications of male exposure to female genitalia).

56 *Id.* at 177 (noting that hospitals had personnel on hand and made childbirth less time consuming for doctors).

57 Maria Fannin, *Domesticating Birth in the Hospital: "Family-Centered" Birth and the Emergence of "Homelike" Birthing Rooms*, 35 ANTIPODE 513, at 522–23 (2003); *see also* WERTZ & WERTZ, *supra* note 14, at 164.

58 WERTZ & WERTZ, *supra* note 14, at 141 ("By 1920 doctors believed that 'normal' deliveries . . . were so rare as to be virtually nonexistent.").

home and it still engendered a certain degree of social support.[59] Doctors transformed it into a series of "more precise and effective manipulations and interventions, both to prevent and to cure disease" which ensured that "[d]octors were on the lookout for trouble in birth."[60] Wertz and Wertz summarized that doctors "found a lot of trouble—so much, in fact, that they came to think that every birth was a potential disaster and that it was best to prepare each woman for the worst eventualities."[61] "Birth remained, in the view of doctors, an abnormal, pathogenic process which required routine medical assistance to prevent disaster."[62] Hospital births and professionalized medicine shifted the balance of power.[63] Institutional births pushed out women's domestic support system. One mother documented the experience as "being alone among strangers."[64] It risked women feeling overpowered by doctors in an institutional setting.[65] The "twilight sleep" movement in the 1920s exacerbated those risks because women were kept in a semiconscious state during delivery, a childbirth technique that "stubbornly persisted" until the 1970s.[66]

Some women keenly sensed these risks and launched counter movements beginning in the late 1930s and 1940s, challenging the movement of birth to hospitals.[67] The second-wave feminist movement later "sharpened the questions"[68] and responded directly to this imbalance of power.[69] Women challenged hospital deliveries as

---

59 LEAVITT, *supra* note 14, at 173 (stating that doctors at home births were "invited guests in women's homes").

60 WERTZ & WERTZ, *supra* note 14, at 136.

61 *Id.* at 136; *see also id.* 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'").

62 *Id.* at 164.

63 LEAVITT, *supra* note 14, at 190 ("Birth was no longer part of the woman's domain").

64 *Id.* As Leavitt further explains:

> The woman was separated from the people she loved; she was in an unfamiliar environment controlled by others; and she was unconscious during parts of her labor and delivery. She was also without the fears and anxieties that had haunted generations of her foremothers. Women did not view the stay in the hospital as a time when they lost important parts of the traditional birth experience, but rather as a time when they gained protection for life and health, aspects of birth that had been elusive and uncertain in the past. They gave up some kinds of control for others because on balance the new benefits seemed more important.

Id. at 181.

65 *Id.* at 191.

66 CASSIDY, *supra* note 15, at 91–94.

67 WERTZ & WERTZ, *supra* note 14, at 179.

68 *Id.* at 283.

69 EHRENREICH & ENGLISH, *supra* note 33, at 40 ("We are mystified by science, taught to believe that it is hopelessly beyond our grasp. . . . Professionalism in medicine is nothing more than the institutionalization of a male upper class monopoly.").

rendering women powerless in birth and isolated from friends and family.[70]

Yet, despite these dramatic shifts in childbirth medical care, the focus still remained on lessening the risks of maternal harms, including both natural harms (like pain) and external harms (like infections). Notably, interventionist care almost certainly did *not* lead to safer childbirth, to the dismay of many.[71] Fears of death remained "central to women's perceptions of their birth experiences throughout the nineteenth and early twentieth centuries."[72] Although the medicalization and hospitalization of childbirth had not greatly improved its safety, nonetheless "[t]he amount of intervention did not itself decrease—in fact, it probably increased—but the interventions were performed more correctly by more qualified doctors."[73]

2. Lawsuits Arising from Childbirth

Doctors moved into childbirth gradually, but by the time that they arrived and dominated in the mid to late 1800s, they made a sweeping entrance, introducing new interventions. Yet the *improvements* were not clear and their focus was more acutely on reducing maternal mortality rate and mitigating maternal pain than on managing fetal harms. The fetus was not an actor in maternal harms tort claims, which allowed standard tort claims and doctrine to apply with little nuance necessary. Malpractice litigation arising out of childbirth only superficially addressed the complexities of childbirth, with doctors focusing mainly on accountability and causation generally to defeat the claims of birthing women.

Obstetric malpractice cases during this time were accordingly quite rare. Birthing women in obstetric malpractice cases can recover the standard damages available in a negligence case: those that are the direct or proximate result of a breach of the standard of care.[74] She may also recover the standard pain and suffering available to tort plaintiffs.[75] Depending on the facts, she may also qualify for special damages, such as the costs of medical care, lost income, funeral costs, and aggravation

---

70 WERTZ & WERTZ, *supra* note 14, at 194 ("The idea of regaining control over one's own body became popular among educated, middle-class women and ultimately became a major tenet of the women's liberation movement."). Grassroots natural childbirth movements sought to restore autonomy and control over birth. *Id.* at 179.

71 *Id.* at 161 (noting that the report of the White House Conference on Child Health and Protection concluded that maternal death during birth had not decreased "between 1915 and 1930 despite the increase in hospital delivery"). Infant deaths had increased. *See id.*

72 LEAVITT, *supra* note 14, at 21.

73 WERTZ & WERTZ, *supra* note 14, at 164.

74 KEITH S. FINEBERG ET AL., OBSTETRICS/GYNECOLOGY AND THE LAW § 1.60, at 56 (1984).

75 *Id.*

of a medical condition.[76] If the harm was aggravated by fraud, malice, or willful conduct, then punitive damages are also available.[77] Depending on the facts, she may recover for a lost pregnancy[78] or a wrongful birth (where continuing the pregnancy was unintended).[79] The birthing woman, standing alone, thus has typical tort remedies available to her with a few nuances to address damages for lost pregnancies, wrongful births, etc.

Throughout the first three quarters of the 1900s, women generally sued with their husbands for birthing harms claims, pleading a broad range of underlying substantive claims.[80] Birthing women routinely lost malpractice cases because they could not hold specific actors accountable within institutional settings, especially as institutional hospitals, doctors, and nurses intersected in hospital births; complicating malpractice liability determinations.[81] A lack of proof of causation further defeated many maternal harms claims as courts struggled to address complicating testimony of maternal ailments that threatened to (and generally did) break the chain of causation.[82] Indeed

---

76 *Id.*

77 *Id.* § 1.60, at 57.

78 SEYMOUR, *supra* note 3, at 82–83 (noting that mothers can recover for lost pregnancies, such as those incurred by negligent amniocenteses administration).

79 *Id.* at 112.

80 *See, e.g.*, Armstrong v. Wallace, 47 P.2d 740 (Cal. Dist. Ct. App. 1935) (alleging negligence for failure to remove a sponge during a cesarean delivery); Lustig v. Beth Israel Hosp., 195 N.Y.S.2d 441 (N.Y. Sup. Ct. 1959) (deciding a suit for injuries to the wife's front teeth during a cesarean delivery); Hammer v. Klegger, 210 N.W. 667, 668 (S.D. 1926) (deciding a suit for an infection caused by a doctor not wearing sterilized gown and sterilized rubber gloves while he was examining the patient and delivering the child).

81 *See, e.g.*, Morey v. Thybo, 199 F. 760, 762–63 (7th Cir. 1912) (holding that one physician was not liable because another consulting physician used unsterilized forceps and failed to remove the afterbirth, and that the defendant "was not bound to assume, in the absence of observable indicia, that [the consulting physician] was incompetent"); *Armstrong*, 47 P.2d at 745 ("[The doctor] could not relieve himself of liability by any custom or rule requiring the nurses to count the sponges used and removed."); Goheen v. Graber, 309 P.2d 636, 643 (Kan. 1957) (finding sufficient evidence that the hospital's nurses "assumed duties which the nurses were admittedly not qualified to carry out, and the doctor, who had the qualifications to realize and diagnose the condition of his patient, left everything up to the nurses").

82 *See, e.g.*, Comte v. O'Neil, 261 N.E.2d 21, 21 (Ill. App. Ct. 1970) ("The evidence is undisputed that at some time the cecum did become kinked, but is silent as to whether it was before, during or after the Caesarean, and that not one, but two successive operations were required before the ailment was corrected."); Murphy v. Conway, 277 N.E.2d 681, 684 (Mass. 1972) (holding that there was no medical evidence to find a causal connection linking the doctor's conduct to the strep infection that caused her death); Wright v. Clement, 190 N.E. 11, 11 (Mass. 1934) (directing a verdict in favor of the defendant because "[t]he difficulty with the plaintiff's case is that there is nothing to show any probability that she would have recovered or lived longer or suffered less, if due care had been used"); *Hammer*, 210 N.W. at 668 (finding no liability arising from lack of sterilization and failure to properly remove afterbirth because of findings that the birthing woman's "run-down or weakened condition at the time of her confinement and that her infection might have been caused by the latent germs in the genital tract"); Edwards v. W. Tex. Hosp., Inc., 107 S.W.2d 729, 733 (Tex. Civ. App. 1937) (affirming judgment for defendant because "even though there was an incorrect diagnosis of the ailment

the "twilight sleep" movement and other pain management techniques and the absence of a social support system for women in the birthing room actually *defeated* many maternal harms liability claims because the res ipsa loquitur doctrine often proved inadequate to permit even inferences of negligence.[83]

These early medical malpractice cases reflect no meaningful effort whatsoever to uniquely position childbirth in the tort system; rather they cite standard tort principles and boilerplate language. Notably, the early tort system was not at all a powerful mitigating presence at this time.[84] Tort law in the United States began as an ad hoc, catchall common law framework.[85]

Critically, maternal harms tort claims—whether successful or not—almost never mentioned in any substantial way the fetus, fetal health, or birthing outcomes, despite that it was often of clear factual relevance to the cause of action.[86] These early cases generally do not name the baby, identify its sex, comment on its current age, health, or in any way personalize it.[87] The landscape of obstetric malpractice lawsuits is dramatically different today.

---

of the deceased, the treatment she received in the hospital was the proper treatment that should have been given had the doctors known her true ailment"). In *Goheen*, for example, the court noted that physicians are not "guarantor[s] of good results, and civil liability does not arise merely from bad results, nor if bad results are due to some cause other than his treatment." 309 P.2d at 639.

83 *See, e.g.*, *Armstrong*, 47 P.2d at 744 (noting that the mother was "under an anesthetic," and thus, "as to why [a sponge] was left [in her abdominal cavity] or how it happened to be left, she has no information or means of information"); White v. Exec. Comm. of Baptist Convention, 16 S.E.2d 605 (Ga. Ct. App. 1941) (failing to use the res ipsa loquitur doctrine to prove that the head injuries plaintiff suffered while birthing in "twilight sleep" permitted an inference of negligence, because no reasonable deductions proved negligence); Lindsey v. Clinic for Women, 253 S.E.2d 304, 308 (N.C. Ct. App. 1979) ("The difficulty with plaintiff's theory is that, even if it be granted that the evidence would support a finding of the foregoing facts, still there is no evidence that anything which defendants did or failed to do in the course of their care of the plaintiff either caused or could have prevented the amnionitis, which plaintiff contends caused the death of her child and her own prolonged suffering.").

84 G. EDWARD WHITE, TORT LAW IN AMERICA: AN INTELLECTUAL HISTORY 3 (2003) (explaining how tort law was born "strikingly late in American legal history"). White notes that the first tort treatise appeared in 1859, the first subject matter course was in 1870, and the first casebook was in 1874. *Id.*

85 *See* Christopher J. Robinette, *Can There Be a Unified Theory of Torts? A Pluralist Suggestion from History and Doctrine*, 43 BRANDEIS L.J. 369, 390 (2005) (describing tort law as a residual category).

86 *See, e.g.*, *White*, 16 S.E.2d at 606 (noting only that the plaintiff "went to the hospital for the purpose of giving birth to a child"); *Hammer*, 210 N.W. at 667 (noting simply that "the child was delivered"). Even when a twin died in childbirth because the doctor did not discover the second child for twenty-three days, the court merely noted the first child, "which . . . is alive and one of the plaintiffs in this suit." *Edwards*, 107 S.W.2d at 729. Even in a lawsuit arising from brain injuries after a baby hit the table, the court only summarized the facts as follows: "There was a thud, caused by [t]he baby hitting the table." Garfield Mem'l Hosp. v. Marshall, 204 F.2d 721, 724 (D.C. Cir. 1953) (internal quotation marks omitted).

87 *See, e.g.*, Ragusano v. Civic Ctr. Hosp. Found., 19 Cal. Rptr. 118, 121 (Cal. Dist. Ct. App. 1962) ("Shortly thereafter the baby was born . . . ."); *Edwards*, 107 S.W.2d at 729–30 (describing

C. Fetal Harms Emerge in Modern Childbirth

1. The Fetus as a Patient

Childbirth was historically dominated by maternal harms. The increasing emotional bonds of maternal love combined with advances in medical technology have transformed modern childbirth. Today prevailing models of childbirth routinely involve hospital deliveries with trained obstetricians and the use of fetal monitoring technology. Medical texts in the 1970s revealed that ninety to ninety-five percent of childbirth is "normal without obstetric intervention," whereas today such risks would be intolerable.[88] Since the 1980s, childbirth has shifted to seeking a "perfect child," including a child free of birth trauma.[89]

This shift of focus onto fetal-harms is partially explained by the rise in fetal monitoring and the correlating modern quest for the "perfect baby."[90] Fetal monitoring was invented in the 1950s and by 1975 it was required in most deliveries.[91] This, in turn, has altered the risk equation for doctors, as "less and less [was] left to chance."[92] Obstetric medicine in the second half of the twentieth century has accordingly emphasized "prevention in labor and delivery and therefore treated each woman as though some freak occurrence might happen in her case."[93] Fetal monitoring has positioned the fetus more prominently in this decision-

---

the fetus as the "second child").

88 WERTZ & WERTZ, *supra* note 14, at 244.

89 *Id.* at 264. As childbirth has become a choice rather than a duty, parents are waiting longer to start having children and are having fewer children overall. JOAN ROTHSCHILD, THE DREAM OF THE PERFECT CHILD 3 (2005). As a result, each child has become a "priceless investment," and the success of the parents' investment is directly related to the success of the child. *Id.* at 3 (internal quotation marks omitted); *see also* Deborah Lupton, *Risk and the Ontology of Pregnant Embodiment*, *in* RISK AND SOCIOCULTURAL THEORY: NEW DIRECTIONS AND PERSPECTIVES 59 (Deborah Lupton ed., 1999). Many mothers of disabled children admit that they feel responsible for their child's disability. Gail H. Landsman, *Reconstructing Motherhood in the Age of "Perfect" Babies: Mothers of Infants and Toddlers with Disabilities*, 24 SIGNS 80 (1998). In addition to feelings of fault, many mothers experience diminished feelings of motherhood due to their inability to produce the "perfect child." *Id.* at 85–86.

90 COMM. TO STUDY MED. PROF'L LIAB. & DELIVERY OF OBSTETRICAL CARE, INST. OF MED., 1 MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 76–77 (1989); *see* Nancy Press et al., *Provisional Normalcy and "Perfect Babies": Pregnant Women's Attitudes Toward Disability in the Context of Prenatal Testing*, *in* REPRODUCING REPRODUCTION: KINSHIP, POWER AND TECHNOLOGICAL INNOVATION 46, 56–57 (Sarah Franklin & Helena Ragoné eds., 1998). The idea of the "perfect child" is less about a child who achieves perfection and more about a normal and healthy child.

91 Law, *supra* note 7, at 361 (citing data that by 1976, all but one obstetric residency program required use of the technology, and by 2002, ninety-three percent of women gave birth using fetal monitors).

92 WERTZ & WERTZ, *supra* note 14, at 235.

93 *Id.* at 165.

making. Yet, there are conflicting accounts regarding the consistency and reliability of electronic fetal monitoring.[94]

Birthing women today still seek births as "natural and humane as possible," and they also actively manage birthing strategies.[95] Most women simultaneously accept technological pregnancies and technological births, even operative births if necessary, "in the name of quality control to make the perfect child."[96] This yields a complex patient-physician dynamic: "throughout pregnancy the natural and the technological are juxtaposed in an ironic set of dance movements in which the partners—woman and doctor—bow to each other in turn, each trying not to get in the other's way."[97] While this is the normative vision of the decision-making model, the reality may, in fact, be quite different.

2. Tensions in the Medical Care Model

The emergence of the fetus as a dominant, data-delivering patient has created tensions in medical care that did not previously exist. Technological advances in ultrasounds, amniocentesis, and fetal monitoring,[98] have allowed doctors to "access" the fetal patient in ways that were previously dependent on the mother reporting complications to the doctor. The ability to assess fetal health independently, even if subject to temperamental and unreliable technology, has created tensions within the medical services delivery model.[99]

The modern rise in cesarean section rates, often referred to as the "unnecesarean epidemic,"[100] is a pronounced example of this modern emphasis on prevention. It is also one area in which the "dance movements" between the birthing woman and the doctor can be particularly strained. Cesarean sections were generally unheard of (absent the death of a mother) before the mid to late 1800s.[101] From the

---

94 Law, *supra* note 7, at 361–62 (citing data that doctors changed their own minds twenty-one percent of the time when reading the same data reports two months later).

95 WERTZ & WERTZ, *supra* note 14, at 235.

96 *Id.*

97 *Id.* at 243.

98 SEYMOUR, *supra* note 3, at 190, 196.

99 *Id.* at 194.

100 The "unnecesarean epidemic" refers to the high rate of medically unnecessary cesarean-section deliveries by pregnant women in established medical facilities. *See generally* THE UNNECESAREAN.COM, http://www.theunnecesarean.com (last visited Feb. 4, 2013).

101 The first documented account of a caesarian section in the United States was Dr. John Lambert Richmond's procedure in Newton, Ohio, on April 22, 1827. *See* J.P. Boley, *The History of Cæsarean Section*, 32 Can. Med. Ass'n J. 557 (1935), *reprinted in* 145 CAN. MED. ASS'N J. 319 (1991) (noting that the earliest account of the procedure was in a medical book from 1350). Franciscan monks performed cesareans to extract the fetus for religious recognition. Rosemary Keupper Valle, *The Cesarean Operation in Alta California During the Franciscan Mission*

beginning of its use, however, doctors understood the medical risks of uterine rupture presented by subsequent pregnancies.[102] The 1980s and 1990s marked a dramatic increase in the United States cesarean section rate. While five to ten percent of all births were cesarean births between 1965 and 1975, 24.4% of all births were cesarean by 1987.[103] Today, almost thirty-two percent of births are by cesarean, reflecting a concerning trend: a fifty percent increase between 1996 and 2006.[104] In response to these alarming rates, the medical community and birthing women have experienced vast swings in best practices.[105] The World Health Organization finds no medical justification for the rate exceeding ten to fifteen percent, suggesting that the United States has an "unnecessarean epidemic."[106]

Often tensions emerge over the delivery method—specifically, the decision of whether to birth vaginally or by cesarean—and the relative risks of each to the pregnant woman and to the fetus.[107] Cesarean sections today are often distinctly utilized to minimize fetal risks, while

---

Period (1769–1833), 48 BULL. HIST. MED. 265, 269 (1974) (stating that the procedure stemmed from religious "concern for the fate of the soul of the unborn infant in the womb of the dead pregnant woman."). There is at least one highly publicized conflicting account of the first cesarean. Arthur G. King, *The Legend of Jesse Bennet's 1794 Caesarian Section*, 50 BULL. HIST. MED 242–50 (1976) (refuting the accounts as hearsay). Early practices instead relied upon craniotomies (the extraction of the fetus) to save the mother's life.

The rise in cesarean section utilization rates was in part catalyzed by Pope Pius XI's encyclical directive that doctors should not sacrifice the fetus's life to save the mother. LEAVITT, *supra* note 14, at 105. This shows the religious underpinnings of a dramatic shift in emphasis to fetal survival over maternal survival.

102 In 1916, a Columbia University obstetrics and gynecology professor proclaimed a longstanding maxim of obstetrical medicine when he said "once a cesarean, always a cesarean." LEAVITT, *supra* note 14, at 128.

103 WERTZ & WERTZ, *supra* note 14, at 260.

104 Melonie Heron et al., Ctrs. for Disease Control & Prevention, *Births: Preliminary Data for 2007*, NAT'L VITAL STAT. REP., Mar. 18, 2009, at 3, *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_12.pdf (reporting preliminary births data for 2007). Part of the high cesarean rate is explained by sequential births; doctors fear the risks of uterine rupture to mothers and babies and impose strong preferences and policies discouraging or banning vaginal births after cesarean procedures (VBACs).

105 There have been cyclical shifts in medical policies regarding VBACs. After predominant disfavor, in 1988, the American Congress of Obstetricians and Gynecology (ACOG) issued an advisory opinion supporting vaginal births after cesareans. LEAVITT, *supra* note 14, at 128. The VBAC rate fell from 28.3% to 10.6% between 1996 and 2003 for a number of reasons. Law, *supra* note 7, at 357–58. The American Association of Obstetricians and Gynecologists published guidelines for offering VBAC in institutions with obstetric, anesthetics, and nursing personnel available in the event of uterine rupture, which pushed VBACs to major hospitals. *Id.* at 358. Today, hundreds of U.S. hospitals will not perform VBACs as a matter of policy. *Id.* at 368. The rise in malpractice liability has also been cited as a reason for the decline in VBACs. *Id.* at 368.

106 Fernando Althabe & José M. Belizán, *Caesarean Section: The Paradox*, 368 LANCET 1472 (2006). *See generally* Elizabeth Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN ST. L. REV 955 (providing a history of VBAC restrictions and outlining concerns with VBAC policies).

107 SEYMOUR, *supra* note 3, at 68.

they simultaneously increase maternal risks.[108] Most often, doctors perform cesarean sections due to the size of the fetus, indications of fetal distress revealed through fetal monitoring, fear of uterine rupture in a subsequent cesarean section, or poor obstetrical history.[109] As one court noted, "the proposed cesarean section was never suggested as necessary, or even useful, to the preservation of [the mother's] life or health. To the contrary, it would pose greater risk to her."[110] Indeed, cesarean sections are major abdominal surgeries with risks of postpartum complications.[111] They can increase maternal mortality rates,[112] or cause hysterectomies, hemorrhages, bowel trauma, and infections.[113] They can extend hospital stays, challenge maternal-infant bonding, and present other complications.[114]

Yet data supporting the relative benefits and risks between vaginal birth and cesarean section remain weak.[115] Medical decisions such as this one create complexities in tort where the doctor owes a duty to both the pregnant woman and the fetus and the decision-making involves risk assessments of each.

The paradigmatic shifts in childbirth described in Section I further aligned with vast expansions of tort liability generally. The number of tort cases filed from the 1960s to the 1980s tripled and average verdicts (adjusted for inflation) jumped from $50,000 to $250,000.[116] These numbers have continued to climb.[117]

Part II will examine the legal context of this paradigmatic shift toward fetal harms in modern childbirth. Parts III and IV will discuss the implications of the modern dominance of fetal harms to the tort claims of birthing women.

---

108 Clarke T. Edwards, *The Impact of a No-Fault Tort Reform on Physician Decision-Making: A Look at Virginia's Birth Injury Program*, 80 REV. JUR. U.P.R. 285, 290 (2011) ("[V]aginal births are associated with higher risk of postpartum hemorrhage and fetal trauma than with planned cesareans.").

109 FINEBERG, *supra* note 74, at 439.

110 "Further, even in cases where the rejected treatment is clearly necessary to sustain life, these factors alone are not sufficiently compelling to outweigh an individual's right to refuse treatment." SEYMOUR, *supra* note 3, at 214 (citing *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994)).

111 Krista Stone-Manista, *In the Manner Prescribed by the State: Potential Challenges to State-Enforced Hospital Limitations on Childbirth Options*, 16 CARDOZO J.L. & GENDER 469, 476 (2010).

112 *Id.* at 476–77 (noting that cesarean section maternal mortality rates are 3.5% higher than vaginal deliveries).

113 COMM. TO STUDY MED. PROF'L LIAB. & DELIVERY OF OBSTETRICAL CARE, *supra* note 90, at 76.

114 *Id.*

115 Law, *supra* note 7, at 349–50.

116 J.T.H. JOHNSON, OUR LIABILITY PREDICAMENT 13 (1997).

117 *Id.*

II. THE MODERN DOMINANCE OF FETAL HARMS AND MARGINALIZATION OF MATERNAL HARMS

This Part concludes that childbirth litigation today is framed around a fore-grounded fetal harms focus and a back-grounded maternal harms focus, marking an inversion of over two centuries of childbirth in America. Maternal harms claims are rare and relatively nominal, whereas fetal harms are more common, yield large verdicts, are exceedingly emotionally compelling, and are extensively studied as a vehicle in tort reform. This modern framing of childbirth is relatively new, under-theorized in tort, and, this Article argues, threatening to the interests of birthing women as patients and putative plaintiffs in the tort system.

A. *Fetal Harms Dominate Modern Childbirth*

Historical shifts toward a fetal focus, in turn, yielded renewed legal considerations of childbirth in tort. Doctors owe a separate and distinct duty to both the birthing woman and the fetus. Critically, the duty to the fetus is *not* recognized formally as a *dominant* duty, although this in fact appears to be the case, as explored in this Section.

The obstetric doctor owes a dual duty of care to consider the best interests of both the birthing woman and the child.[118] This duality yields complex decision-making dynamics against a tort backdrop that often "require[s] the doctor to consider the risks to the mother, the risks to the child, and the appropriate balance of those risks."[119] This creates a unique dynamic for the medical framework governing childbirth. The doctor is governed by the goal of "prolong[ing] life" while the birthing woman is simultaneously birthing *new* life. Stated in the tort context, a putative plaintiff is emerging. Indeed, in some birthing cases, courts have held that the fetus is "more than simply viable. It was ready to be born."[120] As one court colorfully articulated in a cesarean section case, "[a]ll that stood between the [fetus] and its independent existence, separate from its mother, was . . . a doctor's scalpel. In these circumstances, the life of the infant inside its mother's womb was entitled to be protected."[121]

Tort claims for birthing injuries to the child are daunting to doctors. Tort claims may arise on behalf of a deceased child,[122] a

118 *See, e.g.*, SEYMOUR, *supra* note 3, at 190.
119 *Id.* at 301.
120 *Id.* at 175.
121 *Id.*
122 *See id.* at 120 (explaining how wrongful death statutes are intended to deter harmful

disabled child,[123] or an injured child.[124] Indeed many of these claims are extremely emotionally compelling,[125] involve major disabilities such as cerebral palsy, and can yield high damage verdicts.[126] One study concluded that thirty-one percent of claims filed against obstetricians were on behalf of brain-injured children.[127] Many of these verdicts are in the eight figures.[128]

The duty to the fetus also results in longer liability exposure to the doctor. Claims can be plead when the child reaches the age of majority, creating a uniquely enduring risk of malpractice for fetal harms. In *Draper v. Jasionowski*, for example, the court reinforced the dual duties that doctors owe to both the birthing woman and the fetus.[129] In *Draper*, a child alleged an actionable claim for Erb's Palsy birthing injuries (a loss of movement or weakening of the arm) after reaching the age of majority.[130] The woman signed a form consenting to both a vaginal and a cesarean delivery, yet the doctor never actually informed her of the option to have a cesarean section instead of a vaginal birth.[131] The pregnant woman gave birth vaginally, but the child was born in the breech position,[132] resulting in bilateral Erb's Palsy to the child's shoulder.[133] The trial court denied relief to the plaintiff (the child at age of majority), concluding that the plaintiff did not have an independent cause of action because the fetus could not consent to the procedure.[134]

---

conduct and compensate for wrongdoing).

123 *Id.* at 68.

124 *Id.* at 112–13 (including the costs of caring for the child and the parents' own pain and suffering). Occasionally, women can recover for the damages or "distress occasioned by giving birth to an injured or disabled child" or the anxiety of waiting through the child's developmental years to determine if the child is are handicapped. *Id.* at 115. A smaller number of courts have allowed fathers to recover for the distress of seeing a stillbirth. *Id.* at 115–16.

125 *See, e.g.*, Kevin Burke, *A Nurse's Dramatic Story*, 44 TRIAL, no. 7, July, 2008, at 44, 46 (explaining how a trial lawyer used the sounds and presence of fetal monitoring technology, as testified to by the obstetric nurse, to make the jury feel and experience the harms to the fetus).

126 *See, e.g.*, OHIO DEP'T OF INS., OHIO 2009 MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORT 7 (2011), *available at* http://www.insurance.ohio.gov/Legal/Reports/Documents/2009ClosedClaimReport.pdf (reporting that birth injury claims yielded an average indemnity payout of $1,074,740: three times higher than average indemnity payments).

127 *See* SEYMOUR, *supra* note 3, at 348 (citing a 1987 study).

128 *Id.* at 348 n.39.

129 858 A.2d 1141 (N.J. Super. Ct. App. Div. 2004).

130 *Id.* at 1143 (noting that the parties are time-barred from bringing their own cause of action). The child must prove that the "warning was inadequate and that the harm would have been prevented by an adequate warning." *Id.* at 1144.

131 *Id.* at 1142.

132 Most babies are delivered headfirst. The breech delivery involves the fetus presenting itself in the birthing canal buttock first or feet first. It presents additional risks to the baby.

133 *Draper*, 858 A.2d at 1142. Erb's Palsy is the "turning out" of the arm. *See* SEYMOUR, *supra* note 3, at 380.

134 *Draper*, 858 A.2d at 1143–44 (noting that the lower court held that "because medical science recognizes that an infant is a distinct entity before birth, the law recognizes that the rights the child will enjoy when born cannot be violated before birth").

The trial court agreed with the defendant that the duty to disclose risks extended to the pregnant woman only because she consented for both herself and the fetus.[135]

To prevail at the appellate level, the plaintiff distinctly relied on the duality of the doctor treating *both* the pregnant woman and the fetus to establish a right to recovery. The plaintiff argued that the doctor owed a duty to both the infant *in utero* and the pregnant woman, such that failing to secure informed consent breached a duty to *both* the pregnant woman and the fetus.[136] The court agreed that there was an independent cause of action for the child to sue the obstetrician for prenatal injuries.[137] It upheld a line of cases recognizing that the obstetrician owed a duty to both the pregnant woman and the fetus, noting that certainly no case precedent *precludes* the child's recovery.[138]

In granting the child an independent cause of action from the pregnant woman's, the court emphasized the dual duties owed to both the pregnant woman and the fetus: "it is now beyond dispute that in the case of negligence resulting in prenatal injuries, both the mother and the child *in utero* may each be directly injured and *are each owed a duty, independent of the other.*"[139] It reasoned that "denying relief to the infant-patient would be tantamount to ignoring 'the realities of modern obstetrical practice' by denying the *in utero* infant 'independent protection against incompetent medical advice.'"[140] Since the fetus might suffer injury as a direct result of a doctor's failure to disclose risks to the pregnant woman, the infant was entitled to its own cause of action.[141] Noteworthy to the thesis of this Article, however, the court did not cite to tort authorities or doctrine to support this dual duty, but rather to reproductive rights.[142] The court held that the "unborn child is a distinct biological entity and many branches of the law afford an unborn child protection during various periods of gestation."[143]

Plaintiffs' lawyers keenly understand the value of fetal harms cases. Aggressive advertising campaigns abound of plaintiffs' lawyers seeking childbirth injury cases and advertising multi-million dollar damage verdicts.[144]

---

135 *Id.* at 1143.

136 *Id.*

137 *Id.* at 1142.

138 *Id.* at 1143, 1146–47 (providing a lineage of cases where courts allowed a child to recover from the doctor's refusal to offer the mother a cesarean section).

139 *Id.* at 1147 (quoting Hughson v. St. Francis Hosp. of Port Jervis, 459 N.Y.S.2d 814, 816 (App. Div. 1983)). The court further stated that "the only dependence by the child on the mother *in utero* is for sustenance." *Id.* at 1143–44.

140 *Id.* at 1148 (quoting *Hughson*, 459 N.Y.S.2d at 818).

141 *Id.*

142 *Id.* at 1141–48.

143 *Id.* at 1143 (citing Smith v. Brennan, 157 A.2d 497 (N.J. 1960)).

144 *See generally Milwaukee Birth Injury Lawyers*, AIKEN & SCOPTUR, http://www.plaintiffs

B. *Maternal Harms Are Marginalized in Modern Childbirth*

While the birthing woman still has the full range of tort remedies available to her, birthing women rarely sue for maternal harms arising out of childbirth.[145] While the maternal mortality rate is at historically low levels in developed countries,[146] maternal harms *do* still exist in childbirth. Indeed the maternal mortality rate has nearly doubled in the last two decades, hovering between twelve and fifteen deaths per 100,000 live births between 2003 and 2007.[147] Although maternal mortality declined dramatically over the last century, the ratio has increased over the last several decades.[148] In 1987, maternal death ratios hit an all-time low of 6.6 deaths per 100,000 live births.[149] However, the maternal mortality rate for 2007 was 12.7 deaths per 100,000 live births.[150] In addition, considerable racial disparities exist in maternal mortality rates. The maternal mortality rate for African American

law.com/milwaukee-wi-child-birth-injury-lawyer-attorney.html (last visited May 23, 2013); *Our Track Record*, REESLER & REESLER, http://www.resslerlaw.com/our_track_record.php (last visited May 23, 2013) (promoting multi-million dollar awards in obstetrical medical malpractice cases).

145 *See, e.g.*, SEYMOUR, *supra* note 3, at 62–63, 116–18 (noting successful maternal recoveries for cesarean-section injuries, fear for the mother's personal safety, and the pain and suffering associated with a doctor's failure to attend to the delivery). This phenomenon is particularly true in the cesarean-section context. Patients often sue physicians for *failing* to perform a cesarean section, but they rarely sue physicians for performing cesarean sections unnecessarily. Edwards, *supra* note 108, at 290. The Department of Health and Human Services reported in 1981, for example, that ninety percent of obstetric malpractice cases arose from physicians' alleged failure to perform a cesarean section or an alleged delay in performing one. *Id.*

Women also under-utilize the tort system in the domestic violence context as well. For example, many domestic violence victims can establish clear liability for assault, battery, and other intentional torts, yet victims rarely litigate these claims. *See, e.g.*, Camille Carey, *Correcting Myopia in Domestic Violence Advocacy: Moving Forward in Lawyering and Law School Clinic*s, 21 COLUM. J. GENDER & L. 220, 257 (2011).

146 Generally, maternal mortality statistics are attributed to impoverished countries. Specifically, "98% or more of deaths occur in resource poor countries," and the risk of dying during childbirth is high. R.J. Cook & B.M. Dickens, *Ethical and Legal Issues in Reproductive Health: Human Rights to Safe Motherhood*, 76 INT'L J. GYNECOLOGY & OBSTETRICS 226 (2002). The United States ranks "near bottom" in maternal mortality. Heather Joy Baker, "*We Don't Want to Scare the Ladies": An Investigation of Maternal Rights and Informed Consent Throughout the Birth Process*, 31 WOMEN'S RTS. L. REP. 538, 552 (2010).

147 Jiaquan Xu et al., Ctrs. for Disease Control & Prevention, *Deaths: Final Data for 2007*, 58 NAT'L VITAL STAT. REP. May 20, 2010, at 13, *available at* http://cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf.

148 MATERNAL & CHILD HEALTH BUREAU, 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 (last visited May 1, 2013).

149 *Id.*

150 *Id.*

women was 26.5, roughly 2.7 times the rate for white women (10 deaths per 100,000 live births).[151]

Notwithstanding their prevalence, cesarean sections are also nonetheless major abdominal surgeries.[152] Common injuries can include infections in the incision site,[153] blood loss, blood clots, and general discomfort associated with surgical procedures.[154] Cesarean deliveries can cause endometriosis, a painful condition where cells from the uterine lining may grow outside the womb.[155] Chances of a difficult future pregnancy and future reproductive problems are especially likely if the previous delivery method was cesarean section.[156] Cesarean deliveries also increase the recovery time for birthing women, prolong absences from employment, impede caring for older siblings due to lifting and driving restrictions, and yield other derivative harms.[157]

Even vaginal births can yield maternal harms. Major harms can include hysterectomies, strokes, infertility, and chronic pelvic pain.[158] Other harms include tearing, either complications from "natural" tearing or from episiotomies, such as fecal incontinence, stitching, and infections.[159] Both trauma symptoms and posttraumatic depression are also common amongst birthing women.[160]

Yet birthing women rarely sue for maternal harms. This is likely because the ultimate dollar value of these claims is relatively small,

---

151 Xu et al., *supra* note 147, at 13; *see also* MATERNAL & CHILD HEALTH BUREAU, *supra* note 148.

152 Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951, 1958 (1986) (discussing cesarean-section operations as major surgery).

153 *Risks of a Cesarean Procedure*, AM. PREGNANCY ASS'N, http://www.americanpregnancy.org/labornbirth/cesareanrisks.html (last visited Feb. 22, 2013).

154 Lisa L. Chalidze, *Misinformed Consent: Non-Medical Bases for American Birth Recommendations as a Human Rights Issue*, 54 N.Y.L. SCH. L. REV. 59, 72 (2010).

155 Henci Goer, *Do Cesareans Cause Endometriosis? Why Case Studies and Case Series Are Canaries in the Mine*, SCI. & SENSIBILITY (May 11, 2009), http://www.scienceandsensibility.org/?p=147.

156 *Id.*

157 *See generally Cesarean Delivery*, MDGUIDELINES, http://www.mdguidelines.com/cesarean-delivery (last visited Apr. 18, 2013) (describing rehabilitation treatment).

158 Fortunately major maternal harms such as death, hysterectomy, and stroke are rare and on the decline. CHILDBIRTH CONNECTION, VAGINAL BIRTH AND CESAREAN BIRTH: HOW DO THE RISKS COMPARE? (2006), *available at* http://www.freewebs.com/icanofrichmond/cesareanbookletsummary.pdf (describing the risks that are distinct to vaginal births); *Best Evidence: C-Section*, CHILDBIRTH CONNECTION, http://www.childbirthconnection.org/article.asp?ck=10166#physical (last visited May 1, 2013).

159 *See, e.g.*, Amy F. Cohen, *The Midwifery Stalemate and Childbirth Choice: Recognizing Mothers-to-Be as the Best Late Pregnancy Decisionmakers*, 80 IND. L.J. 849, 859–60 (2005) (discussing risks of birth injuries); Lauren Hoyson, Note, *Rape Is Tough Enough Without Having Someone Kick You from the Inside: The Case for Including Pregnancy as Substantial Bodily Injury*, 44 VAL. U. L. REV. 565 (2010).

160 NICETTE JUKELEVICS, UNDERSTANDING THE DANGERS OF CESAREAN BIRTH: MAKING INFORMED DECISIONS 60–65 (2008).

which in turn disincentivizes plaintiffs' lawyers to pursue these causes of action.[161] There may be other reasons as well. The traditional biblical roots framing childbirth as a distinct form of suffering expressed as "God's will" may explain some historical acceptance of maternal harms, but it may not persist in our medicalized framework today. The modern conception of childbirth as a distinctly joyous event might further explain the relative absence of maternal harm suits. Whatever the reason, the absence of maternal harms claims is noteworthy—even surprising—in the obstetric malpractice cases.[162]

In the few cases where birthing women have prevailed in maternal harms cases, it is generally through a fetal injury derivative claim where—even in these cases—courts still have to press heavily to maintain the viability of a stand-alone maternal harms claim and defense counsel remains incredulous.[163] For example, in *Abdallah v. Callender*, the parents of a stillborn fetus sued for wrongful death, negligent infliction of emotional distress, and malpractice arising from the birthing woman's uterine rupture and subsequent hysterectomy.[164] In defense counsel's summary judgment opposition brief, it merely *repeated* its defense to the wrongful death claim in response to the parents' negligent infliction of emotional distress argument; conveying incredulity regarding the prospect of stand-alone recovery for the parents.[165] The court swiftly rejected defendant's argument that wrongful death was the only possible legal theory at issue in the case, expressed dismay at the defendant's defense strategy, and affirmed that "we can perceive of no reason why this claim cannot be pursued without regard for the stillbirth" because of the birthing woman's separate injuries.[166]

Yet the birthing woman unequivocally maintains an independent right to sue for her injuries, separate from the fetus.[167] In *Haswell v.*

---

161 *See, e.g.*, Edwards, *supra* note 108, at 291 (defining the injuries in an unnecessary cesarean-section case to include the increased cost of the procedure itself, as well as longer maternal recovery time).

162 In *Baptist Medical Center Montclair v. Wilson*, 618 So. 2d 1335 (Ala. 1993), for example, the mother suffered a catastrophic uterine rupture. The court found that the doctor negligently delayed the cesarean section after the mother felt "ripping" in her uterus. *Id.* at 1337. The baby died from brain damage suffered at birth. *Id.* The parents recovered $600,000 damages for the deceased child, but notably missing from the case were any negligence claims involving the distinct harms to the mother. *Id.* at 1336.

163 *See, e.g.*, Modaber v. Kelley, 348 S.E.2d 233, 238 (Va. 1986) (denying defendant's argument that "it seems clear that the jury compensated Mrs. Kelley not for her own physical or emotional injuries, but for the death of the child" and that the high verdict was "either the result of the jurors' passion, corruption, or prejudice, or a misconception or misunderstanding of the facts or the law, or that it was not the product of fair and impartial deliberations" (internal quotation marks omitted)).

164 1 F.3d 141 (3d Cir. 1993).

165 *Id.*

166 *Id.* at 146.

167 Women who suffer either physical or mental injury during the course of childbirth may be eligible to receive damages based on the harm suffered. *See* Barbara J. Buchanan-Davidson &

Kramer, the court reaffirmed that the duties owed by the doctor to the birthing woman and the fetus are distinct and that each stands alone.[168] In *Haswell*, the doctor recommended that the pregnant woman birth vaginally after a prior cesarean section, but he then went out of town and made inadequate arrangements for obstetrical care coverage in his absence.[169] After the patient's uterus ruptured during the VBAC,[170] the fetus died and the birthing woman needed an emergency hysterectomy.[171] The doctor challenged the birthing woman's separate maternal harms malpractice claim brought under the Indiana Medical Malpractice Act, arguing that the Act's damage cap on liability prohibited her separate claim because she had already settled for $500,000 for the death of the fetus and there was only one single act of malpractice alleged in the complaint.[172] The court reaffirmed the dual duties that doctors owe, holding that "the Kramers suffered injury as a result of Dennis's death *and* an injury resulting from Donna's sterilization and loss of uterus which were caused by Dr. Haswell's negligence."[173] The court held that "[s]he sustained a separate injury which should be litigated separate and apart from the settlement pertaining to Dennis's death."[174]

Birthing women's malpractice claims have changed in several noteworthy ways from the trends seen in earlier cases—changes that reinforce the dominance of fetal harms and reveal the marginalization of maternal harms. Courts have personified the fetus and positioned it as a dominant player in maternal harms birthing litigation, specifically emphasizing the sex, size, and health of the fetus.[175] New rhetoric

---

David Polin, *Trauma in Pregnancy*, 41 AM. JUR. PROOF OF FACTS 2D 1 (1985); *see also* Gregory G. Sarno, *Tort Liability for Wrongfully Causing One to Be Born*, 83 A.L.R.3D 15 (1978).

168 659 N.E.2d 146 (Ind. App. 1996).

169 *Id.* at 147.

170 "Uterine rupture occurred at a rate of 1.6 per 1000 among women with repeated cesarean delivery without labor (11 women), 5.2 per 1000 among women with spontaneous onset of labor (56 women), 7.7 per 1000 among women whose labor was induced without prostaglandins (15 women), and 24.5 per 1000 among women with prostaglandin-induced labor (9 women)." Mona Lydon-Rochelle et al., *Risk of Uterine Rupture During Labor Among Women with a Prior Cesarean Delivery*, 345 NEW ENG. J. MED. 3, 5 (2001).

171 *Haswell*, 659 N.E.2d at 148.

172 *Id.* at 149 (limiting damages to a cap of either $500,000 or $750,000 depending on the date of the injuries). In the complaint, plaintiff argued that "as a direct and proximate result of the acts, negligence and malpractice of the Defendants, Dennis died and Mrs. Kramer has endured pain, mental anguish, permanent loss of bodily function, including traumatic sterilization, incurred medical expenses and Mrs. Kramer will be required in the future to endure pain and mental anguish." *Id.* at 150.

173 *Id.* at 151 (concluding that the ruptured uterus and the sterilization were separate acts).

174 *Id.* at 152.

175 *See, e.g.*, Domann v. Vigil, 261 F.3d 980, 981 (10th Cir. 2001) ("[A] healthy baby girl was delivered."); Morales v. Miller, No. 09-1717, 2011 WL 222527, at *1 (Iowa Ct. App. Jan. 20, 2011) (unpublished table decision) ("[The doctor] performed the C-section and delivered a healthy baby boy at 8:13 a.m."); LeBlanc v. Landry, 21 So. 3d 353, 356 (La. Ct. App. 2009)

villainizing maternal conduct has emerged, suggesting that the birthing woman's age, weight, health, sexual history, and attitude bear on the liability of doctors for birthing harms.[176] For example, one court described a birthing woman repeatedly as "exceptionally young" and then concluded that abscesses were probably due to "prior venereal disease."[177] Courts have specifically invoked these characterizations to minimize the damages that the birthing woman recovers, finding that some element of her post-delivery treatment would have occurred regardless of the negligent acts of the doctor.[178] In sum, courts handling maternal harms claims today express a discernable discomfort with maternal harms cases.[179]

Yet, notably, even as a fetal-focused narrative has entered the realm of maternal harms claims, there has remained an absence of meaningful engagement with the complexities of birthing in the tort context. Throughout the history of maternal harms tort litigation, courts have struggled with the issue of causation. Courts also wrestle with the complexity of excluding "natural harms" in childbirth from the scope of liability.[180] This element is challenging because the plaintiff must prove

---

(starting the first line of the judicial opinion with "Kimberly K. LeBlanc gave birth to a healthy baby boy, Austin, delivered by Caesarian section by her obstetrician . . . . Austin was the first child born to then twenty-seven-year-old Ms. LeBlanc and her husband" and affirming trial court's verdict for the defendant); Miles v. Tabor, 443 N.E.2d 1302, 1303 (Mass. 1982) (starting the first line of the judicial opinion with "Damon O. Miles, age two months, died on October 26, 1977" and repeatedly referring to the baby by name and sex).

176 *See, e.g.*, White v. Edison, 361 So. 2d 1292, 1294, 1296 (La. Ct. App. 1978) (emphasizing that the mother was "exceptionally young" and noting that abscesses are particularly likely when "as in this case it was due probably to prior venereal disease"). The court specifically invokes these characterizations to minimize the damages that the mother recovered, finding that some element of her post delivery treatment would have occurred regardless of the negligent acts of the doctor. *Id.* at 1297. In *Powell v. Mullins*, 479 So. 2d 1119 (Ala. 1985), *abrogated by* Breaux v. Thurston, 888 So. 2d 1208 (Ala. 2003), *as recognized in* Houserman v. Garrett, 902 So. 2d 670 (Ala. 2004), the court emphasized the plaintiff's obesity in addressing causation relating to a sponge left in the plaintiff's abdomen. *Id.* at 1120.

177 *White*, 361 So. 2d at 1294, 1296.

178 *See, e.g.*, *id.* at 1297. In *Powell v. Mullins*, the court repeatedly emphasized the plaintiff's obesity to complicate the element of causation when a sponge was left in the plaintiff's abdomen. 479 So. 2d at 1120, 1123.

179 *See, e.g.*, Sleavin v. Greenwich Gynecology and Obstetrics, 505 A.2d 436, 438 (Conn. App. Ct. 1986) (finding an error in the jury charge where the jury was instructed that the doctor may not be liable for errors in judgment: "He is not liable for a bona fide error in judgment provided he concludes as best he can and does what he thinks best after careful examination and acts in good faith subject to the rules of care, skill and diligence as I have defined that to you. . . . He is not judged by the result, nor is he necessarily to be held liable for an error in judgment." (emphasis omitted) (internal quotation marks omitted)).

180 *See, e.g.*, *LeBlanc*, 21 So. 3d at 362 (explaining that the doctor was "never able to give a definitive opinion as to the etiology of the bleeding, stating that it was 'a very mysterious and very unusual presentation'"); *Miles*, 443 N.E.2d at 1305–06 (finding that plaintiff's emotional distress was incurred by the death of her two-month-old son which was not temporally proximate to her seeing the responding doctor fail to try to resuscitate her son at delivery); Randolph v. City of N.Y., 501 N.Y.S.2d 837, 842 (App. Div. 1986) (finding that the "overwhelming evidence . . . failed to support the inference that [the birthing woman] could

that the defendant caused the harm, not the condition for which the patient is being treated.[181] This is particularly complicated in cesarean section cases when an underlying medical condition is the basis for the surgical delivery. In fact, considerable blurring has emerged whereby causation dominates and sidelines meaningful discussions of the standard of care.[182]

In stark contrast to the advertising for fetal injury claims, a birthing woman would struggle to find a plaintiffs' firm advertising to represent her in a suit for maternal injuries.[183] One website, for example, advertises that it represents birthing mothers in cases "involving bruises of the brain or skull fractures caused by a forced delivery, maternal/obstetric injuries and other delivery room injuries," but this is the exception rather than the norm.[184] More often, websites advertise for birthing harms cases, but exclusively describe claims relating to the child.

This Article concludes that the emphasis on fetal harms in modern childbirth threatens birthing women as patients and plaintiffs. This conclusion is explored further in Part III.

III. DISTORTED AND DIMINISHED TORT CLAIMS FOR BIRTHING WOMEN

The emerging dominance of fetal harms over maternal harms is particularly concerning when considered against the backdrop of how modern obstetric care is normatively delivered, suggesting problematic inconsistencies between law and praxis. This Part concludes that the dominance of fetal harms infiltrates the obstetric standard of care by prioritizing fetal patients over the birthing woman and by diminishing the birthing woman as a patient and a putative plaintiff.

---

have survived, even if she received a proper blood transfusion [sooner]"), *aff'd as modifed*, 507 N.E.2d 298 (N.Y. 1987); Gordon v. Bakare, No. 3445 S1997, 1998 WL 1108659, at *392 (Pa. Ct. Comm. Pl. May 6, 1998) (noting the trial court's observation that "during the course of natural delivery, as opposed to an operative or surgical procedure, the physician is present to assist nature and since labor is inevitable, the informed consent doctrine does not apply to the natural delivery process"). "The pivotal issue in this case was whether [at the time of the transfusion] . . . decedent's life could have been saved if blood had been properly transfused . . . ." 507 N.E.2d at 299.

181 SEYMOUR, *supra* note 3, at 51–52.

182 *See, e.g.*, Domann v. Vigil, 261 F.3d 980, 983 (10th Cir. 2001) (upholding a jury verdict where the jury concluded that there was no causation, but did not reach any verdict on duty).

183 Indeed, replicating a standard internet search that a birthing woman might conduct reveals only two firms that explicitly advertise for maternal harms claims as a distinct claim from birthing injuries to a child. *See, e.g.*, *Maternal Obstetrics/Birth Complications*, CARABIN SHAW, http://www.carabinshaw.com/lawyer-attorney-1199978.html (last visited Mar. 24, 2013); *Michigan Birth Injury—Maternal Injuries During Childbirth*, STROBLE LAW FIRM, P.C., http://stroble.com/birth-injury-maternal-injuries.html (last visited Mar. 24, 2013).

184 *See, e.g.*, *Milwaukee Birth Injury Lawyers*, AIKEN & SCOPTUR, *supra* note 144.

A. *Inherent and Persistent Tensions Positioning Birthing Women in the Standard of Care*

Birthing women are supposed to be the primary decision-makers regarding their medical care, but the modern fetal focus threatens this principle.[185] The obstetric decision-making model is normatively a dual decision-making model between the doctor and the birthing woman.[186] Yet in a dual decision-maker model, who has primacy when a doctor and a pregnant woman *disagree* about a reasonable medical decision? This is particularly relevant to the decision of whether to choose vaginal delivery or cesarean delivery; a decision for which "the medical evidence suggests that the choice is complex, but reasonable."[187] The answer to this question is, normatively, the pregnant woman; according to both judicial precedent[188] and medical texts.[189] This Article will explore that assumption further in light of the dominance of fetal harms. The reality is that the answer to the primacy question is rarely addressed in any

185 *See, e.g.*, MARTIN L. PERNOLL, BENSON AND PERNOLL'S HANDBOOK OF OBSTETRICS & GYNECOLOGY 1 (2001) (explaining how, historically, doctors followed more paternalistic models of care whereby they determined how much information a patient needed about her care, but modern care models respect patient autonomy through informed consent); Holly Goldberg, *Informed Decision Making in Maternity Care*, 18 J. PERINATAL EDUC. 32 (2009).

186 Importantly, just as the doctor owes a duty to both the mother and the fetus, the state may also intervene to challenge maternal conduct that jeopardizes the fetus. *See, e.g.*, Ikemoto, *supra* note 32, at 1221–85 (chronicling the modern vehicles available for the state to regulate pregnant women); Anna Hickman, Note, *Born (Not So) Free: Legal Limits on the Practice of Unassisted Childbirth or Freebirthing in the United States*, 94 MINN. L. REV. 1651 (2010) (considering whether liability would attach to a mother for harms resulting to the child if she births her child absent assistance of a midwife or physician). The mother likewise has obligations to the fetus and the state may intervene to enforce those obligations. For example, some courts have stepped in as parens patriae to act on behalf of a child and have ordered that the mother undergo some medical intervention or prenatal treatment. *See, e.g.*, SEYMOUR, *supra* note 3, at 210 (citing a line of cases involving members of Jehovah's Witness). This maternal duty, however, is not the focus of this Article.

187 Law, *supra* note 7, at 359. The decision between a vaginal birth and a cesarean birth, for example, is a deeply personal decision for birthing women. Women object to cesarean sections for a variety of reasons, including differing medical assessments, fear of surgery and maternal harm, childbirth preference, and religious beliefs. SEYMOUR, *supra* note 3, at 21. Birthing women may balance these risks differently than doctors. For example, an older mother may be unwilling to accept even a small risk of fetal injury, whereas a younger first-time mother might view the prospect of serial cesareans as more concerning. Law, *supra* note 7, at 351. Many mothers continue to view birth as a deeply spiritual event that connects them to their families and communities; they do not want to define it as a medical event. Law, *supra* note 7, at 352. Importantly, doctors, too, bring their own personal perspectives into the decision-making. *See, e.g.*, Stone-Manista, *supra* note 111, at 476 ("Physicians may have a low tolerance for many patients' refusals of medical treatment for what [are] considered to be low-risk invasive procedures, such as cesarean sections.").

188 *See, e.g.*, Gilbert v. Miodovnik, 990 A.2d 983, 991 (D.C. 2010) ("Of course [the doctor] could not 'order' surgery without the patient's consent.").

189 CHARLES R.B. BECKMANN ET AL., OBSTETRICS AND GYNECOLOGY 25 (6th ed. 2010); Gordon M. Stirrat, *Ethical Dilemmas in Obstetrics and Gynaecology*, in DEWHURST'S TEXTBOOK OF OBSTETRICS & GYNAECOLOGY 658, 665 (D. Keith Edmonds ed., 2007).

meaningful way and more often doctors are left to use their discretion by balancing the interests of the two patients.[190]

Doctors generally need the birthing woman's consent to perform any procedure, including childbirth interventions. Doctors should not replace their decisions with those of the birthing women.[191] In the high profile case of *In re A.C.*, for example, a terminally ill woman agreed to life-extending care, which presented risks to her fetus.[192] After the pregnant woman's illness incapacitated her, the hospital sought a court-ordered cesarean.[193] The lower court ordered the cesarean after finding that the fetus had a fifty to sixty percent chance of survival absent the cesarean, even though the surgery would hasten the pregnant woman's death.[194] Tragically, the baby died two and a half hours after delivery, and the mother died two days later.[195] The District of Columbia Court of Appeals later vacated the order, holding that the court should have enforced the mother's informed medical decision refusing the cesarean section. The court should not have conducted its own analysis in balancing the harms to the pregnant woman and the fetus.[196] The court reasoned that there must be "truly extraordinary or compelling reasons to override [the patient's wishes]."[197] The court explained that:

> [O]ur society refuses to force the donations of organs or tissues from cadavers to benefit or save the lives of the thousands in need of them . . . . We see no good reason why pregnant women should be treated with less respect than corpses. In fact, it seems bizarre that many persons should die for want of a vital organ that could be taken from a corpse, while a living pregnant woman can be forced to undergo major surgery that exposes her to a not insubstantial risk of harm or death.[198]

Similarly, in *In re Baby Boy Doe*, a birthing woman objected to a cesarean section on religious grounds, despite her doctor's recommendation that she undergo the procedure due to inadequate

---

190 *See, e.g.*, BECKMANN ET AL., *supra* note 189, at 25–27; Stirrat, *supra* note 189, at 665.

191 When the mother's decision is overridden by the doctor or a compelled intervention, it is often done by balancing the interests of the mother against those of the fetus. SEYMOUR, *supra* note 3, at 212. For example, in *In re Madyun Fetus*, 114 DAILY WASH. L. REP. 2233, 2239 (D.C. Super. Ct. 1986), a Muslim mother refused a cesarean section on religious grounds, but the court ordered the surgery because it found that that the fetus had a fifty to seventy-five percent chance of contracting fetal sepsis without a cesarean and the mother had a 100% chance of surviving the cesarean.

192 573 A.2d 1235 (D.C. 1990) (en banc).

193 *Id.* at 1238.

194 *Id.* at 1239.

195 *Id.* at 1238.

196 *Id.* at 1247.

197 *Id.*

198 Alicia Ouellette, *New Medical Technology: A Chance to Reexamine Court-Ordered Medical Procedures During Pregnancy*, 57 ALB. L. REV. 927, 952–53 (1994).

oxygen to the baby.[199] The court held that the woman's "competent choice to refuse medical treatment as invasive as a cesarean section during pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus."[200]

The focus on fetal harms is particularly concerning to the birthing woman in its diminishment and distortion of her role in the standard of care. Scholar Lisa Ikemoto notably concluded that the general effect of a "two-patient model for pregnancy is that attention shifts to the fetus."[201] She and other scholars have debunked the commonly accepted framing of "fetal-maternal" conflicts, explaining how these "conflicts" are instead culturally constructed.[202]

The decision of *Schreiber v. Physicians Insurance Co. of Wisconsin*[203] particularly reveals the standard of care difficulties governing the positioning of childbirth in tort. Standard of care decisions are generally judged on a standard of other competent members of the doctor's professional group.[204] This is an objective standard. Further, it does not explicitly contemplate the role of the birthing woman as a decision-maker in childbirth. In *Schreiber*, the doctor encouraged the mother to deliver via VBAC, which the mother did. The decision to pursue vaginal delivery unequivocally conformed to the standards of other competent members of the doctor's professional group as well as the then-prevailing medical standards.[205] The mother sued the doctor, alleging that he failed to adequately inform her of the option of a cesarean delivery. The trial court denied her claim, finding that she had consented to the VBAC and never properly withdrew that consent, despite evidence that she had requested a cesarean section three separate times.[206]

The appellate court overturned the trial court holding, reasoning that "a competent patient has the absolute right to select from among these treatment options after being informed of the relative risks and benefits of each approach."[207] The court asserted unequivocally that the

---

199 632 N.E.2d 326, 327 (Ill. App. Ct. 1994).

200 *Id.* at 326.

201 Ikemoto, *supra* note 32, at 1294.

202 *Id.*

203 579 N.W.2d 730 (Wisc. Ct. App. 1998).

204 *See, e.g.*, LeBlanc v. Landry, 21 So. 3d 353, 360 (La. Ct. App. 2009) ("[T]he appropriate standard of care for the medical specialty of obstetrics and gynecology is the degree of care ordinarily practiced by physicians within the specialty of obstetrics and gynecology . . . ."); SEYMOUR, *supra* note 3, at 34–37 (explaining the controversy over who sets the standard of care: experts, peers, independent entities, courts, etc.). Seymour notes that the risk in setting the standard of care based on "usual practices" is that it will perpetuate substandard care. *Id.*

205 *Schreiber*, 579 N.W.2d at 732.

206 *Id.* at 732–33.

207 *Id.* at 734 ("Basic to the informed consent doctrine is that a physician has a legal, ethical and moral duty to respect patient autonomy and to provide only authorized medical treatment.").

birthing woman had a right to choose between a cesarean section and a vaginal birth:[208] "There is nothing about pregnancy or the onset of the labor process that automatically renders a woman incapable of rational thought or unable to participate in competent decision-making [among viable options]."[209] The court explicitly chastised the doctor for disregarding the mother's decision-making authority:

> [T]his is a case involving a patient who has been given a free choice by her doctor between two medically viable treatment options prior to labor, initially chooses one, but then changes her mind in the face of an unexpected change of circumstances that is inconsistent with or outside the patient's previous experience in similar circumstances. The doctor, although perfectly able and willing to follow the patient's wishes, and although the patient chose a medically viable alternative that had been offered to her by this doctor earlier, nonetheless ignored his patient and substituted his own choice for hers.[210]

Thus the court held that when tensions in the dual decision-making model emerge, the mother's selection of a medically viable option must prevail.

Yet the court faced tension in squaring this holding with the objective standard of care in negligence cases. The defense argued that the trial court had properly applied an objective standard of care, considering what a reasonable patient would have done.[211] The appellate court explicitly limited its holdings to the facts, but it refused to apply this objective standard, explaining that

> where the patient clearly expressed her treatment choice, and where that choice was simply ignored . . . [w]e are unwilling to allow a doctor to hide behind the question of what a 'reasonable' patient would have done where the doctor fails to respect a patient's choice among medically viable treatment alternatives, and where that failure causes damages.[212]

In contrast, the dissent expressed discomfort with the application of the subjective standard in this case, stating that:

> By limiting its result to the facts, the majority gives little guidance to doctors with respect to this new duty. It is unclear when a doctor will have to follow a patient's demands for treatment, and the majority

208 *Id.* at 735.

209 *Id.*

210 *Id.* at 735–36.

211 *Id.* at 737.

212 *Id.* "Because the parties stipulated that [the baby] would have been born healthy and normal if [the doctor] had not refused [the mother's] request that afternoon, we conclude that damages resulted from this breach of the informed consent statute." *Id.*

> opinion establishes no criteria that will assist the doctor in making this determination.[213]

Tort authorities do little to resolve these inherent tensions. There is no mention of a doctor's duty to a mother or child during pregnancy or childbirth in the Restatement of Torts at all. For example, nowhere in the articulation of duties owed are there any discussions of the unique dualities of childbirth.

This duality is sometimes utilized in tort cases to *relieve* the doctor of liability. In *Brown v. Park Nicollet Clinic HealthSystem Minnesota*, the defense lawyers shrewdly leveraged this dynamic to avoid liability.[214] A mother who began with a VBAC delivery at her doctor's urging later sued, alleging that her doctor did not adequately inform her of the risks of uterine rupture and permanent brain damage to the baby.[215] In the informed consent context, the decision rested on whether the mother would have chosen a cesarean section had she understood the risks. The doctors testified for the defense that both a VBAC and a cesarean section were reasonable choices.[216] In closing, the lawyer made the following statement, which was the subject of the appeal:

> Do reasonable people every day make that decision and accept those risks and go forward? Absolutely. Would a reasonable person have refused VBAC under those circumstances? And I think the answer there again is no. No, reasonable women do that every day. They aren't negligent. Reasonable women do that every day.[217]

The court held that these statements were problematic because they suggest maternal negligence, but that ultimately they were not prejudicial.[218] Describing the risks, the court said:

> [T]he word [negligent] implies some kind of fault, which can range from illogical thinking or behavior to nearly a moral lapse. Thus, when defense counsel argued that if [appellants'] theory was correct, then anyone who chose VBAC would have to be negligent, the jury may have gone through the following though [sic] process: that negligence carries with it a negative connotation; they would not be

---

213 *Id.* at 739.

214 No. C0-00-1525, 2001 WL 506722 (Minn. Ct. App. May 15, 2001).

215 *Id.* at *2.

216 *Id.* at *4 (quoting testimony that "reasonable people may choose one, reasonable people may choose the other" (internal quotation marks omitted)). The court held that plaintiff had some knowledge of the risks of VBAC and that it was fair to conclude that if she knew more, she would have gone with VBAC anyway. *Id.* at *5.

217 *Id.* at *5 (arguing for the defense that "negligence applied only to the doctors' duty to disclose risks and not to Audrey Brown's decision whether to proceed with VBAC").

218 U.S. courts have generally avoided imposing liability on parents to avoid intervening in parental standards. *See, e.g.*, SEYMOUR, *supra* note 3, at 279. In some cases, children can sue their parents for negligence that caused harm. Damages are also deemed problematic because they are "at best pointless" and "at worst harmful." SEYMOUR, *supra* note 3, at 302.

> willing to brand Audrey Brown with that connotation (in part because she is a very sympathetic person who has undergone a terrible tragedy); therefore Audrey Brown was not negligent; therefore, reasonable people in the position of Audrey Brown are not negligent in making the same choice she did; and finally that a reasonable person in Audrey Brown's position would therefore not refuse VBAC.[219]

The court concluded that there was no risk of the jury conducting this logic, or, if so, it was cured.

Lingering and persistent tensions exist in positioning the normative duality of childbirth within the tort system. How is it that tort scholarship and jurisprudence have neglected the glaring complexities of childbirth in tort? This author posits that the absence of meaningful engagement with issues of primacy is explained by the shift in emphasis from maternal harms to fetal harms described in this paper. Historically, the primacy question was resolved in favor of minimizing maternal harms, perhaps due to the absence of fetal monitor technology, and the high fetal mortality rate. Today, the primacy question is resolved in favor of minimizing fetal harms.

B. *Judicial Decisions Subsume Fetal Harms in Maternal Harms*

Fetal harms also dominate obstetric judicial reasoning in problematic ways. When courts do examine maternal harms claims, they are often distinctly subsumed within the lens of fetal harms. This occurs in at least three ways—fetal consequentialism, the essentialization of maternal decision-making, and invited distortions in medical certainty.

First, case law suggests that courts engage in fetal consequentialism whereby the possibility of harms to the birthing woman is negated by the existence of a healthy baby. Thus, judicial reasoning suggests that the only *real* harm that a woman can suffer is a harmed child; anything else that a woman might endure is de minimis, at best, and acceptable at worst.

Strands of case law suggest that maternal harms are acceptable harms, regardless of the standard of care, if they result in healthy babies. In *Even v. Bohle*, for example, the mother sued for her own injuries and her husband and children collectively sued for loss of consortium.[220] The mother suffered severe injuries as a result of a forceps delivery

---

219 *Brown*, 2001 WL 506722, at *6 (third alteration in original).

220 No. 01-0061, 2002 WL 31640613, *1 (Iowa Ct. App. Nov. 25, 2002) (stating that the plaintiffs sued for negligence, lack of informed consent, and medical battery).

(instead of the cesarean delivery that she sought).[221] The court juxtaposed the healthy baby against the mother's harm in problematic ways, stating:

> After the forceps were removed, Even pushed the baby successfully, and Carolyn was delivered vaginally. She was born in perfect condition, without a mark or bruise. Even, however, suffered a fourth degree tear or laceration between her vagina and anus. The tear went all the way into the skin that lines the anus or anal mucosa. At the time of trial in this matter, she continued to suffer from urinary and bowel dysfunction, sexual dysfunction, and nerve and muscle damage, among other things, as a result of Carolyn's vaginal birth.[222]

Seemingly the court's entire analysis of the maternal harms claim began and ended with the phrase: "She was born in perfect condition." The mother was denied recovery.[223] The court's reasoning is problematic, not just in its disregard for maternal harms, but in its use of a healthy baby to negate even the *possibility* of maternal harms.

The trial court in *Harrison v. United States*, also engaged in fetal consequentialism, when the mother sued the physician for failing to perform a cesarean section.[224] The child suffered from Erb's Palsy after a vaginal delivery.[225] The doctor did not inform the mother of the relative risks of vaginal birth or the possibility of cesarean delivery, although she was obese and there were clear indications that it was a large baby.[226] The lower court balanced the risks of vaginal birth to the child (described as "more than negligible") against the risks to the mother of cesarean delivery and concluded that vaginal delivery was preferred.[227]

The appellate court corrected the consequentialist analysis, holding that that this balancing of risks to the child of vaginal birth and risks to the mother of cesarean was not proper, yet it upheld the outcome. The appellate court held that:

> The district court, in an effort to provide a 'complete record of factual findings,' analyzed the case backwards, starting with an assessment of damages, then proceeding to causation, negligence, and duty, in that order. Although we understand why the court engaged in this method of analysis, rather than simply concluding its ruling after finding there was no duty to disclose, such analysis resulted in extraneous factual findings. Therefore, because the district court did not need to reach the issue of damages, any findings

221 *Id.* at *1.
222 *Id.*
223 *Id.* (holding that the mother was adequately informed of the risks).
224 284 F.3d 293, 297 (1st Cir. 2002).
225 *Id.*
226 *Id.* at 296.
227 *Id.* at 297.

> regarding damages are dicta; the district court did not actually award any damages.[228]

This line of reasoning can also be seen in maternal harms claims involving hysterectomies. Where women sue for unnecessary hysterectomies or negligent hysterectomies, courts often note the number of children that the mother has already birthed, suggesting that the birthing of earlier healthy babies negates or minimizes the severity of this maternal harm claim.[229]

Second, courts essentialize maternal decision-making, concluding that maternal decision-making should always result in the minimization of fetal harms. In other words, courts purport to embrace the dual duties that doctors owe to birthing women and fetuses and the primacy of maternal decision-making by collapsing them: maternal decision-making *is* fetal decision-making and maternal *health is* fetal health. This essentializing sentiment was supported by the American Medical Association's statement that "pregnant women routinely choose" and "should" choose cesarean sections "for the benefit of their fetuses," notwithstanding the increased risks to the woman.[230] In *Draper v. Jasionowski*, for example, the plaintiff argued that the mother would have chosen the cesarean section to minimize harms to the baby.[231] The court notably accepted this line of reasoning, explaining that "[t]he patient's opportunity to perform this balancing may assume particular importance when the patient is a mother giving birth. In such a case, the mother may purposefully discount risks to herself in order to choose a treatment or procedure that will present the least risk to her newborn child."[232]

This framing is noteworthy and problematic because it endorses the fetal focus of medical decision-making and imports it to *supplant* maternal decision-making. It essentializes and over-simplifies women's decision-making, and marginalizes or even villainizes non-conforming mothers.

This line of judicial reasoning focused on fetal harms might suggest a particularly pronounced normality bias in childbirth. The principle of normality bias suggests that "people prefer the usual to the unusual, the arguments of the majority to those of the minority, the conventional to the unconventional, and the normal to the abnormal."[233] The dualities

---

228 *Id.* at 302.

229 *See, e.g.*, Morales v. Miller, No. 09-1717, 2011 WL 222527, *1 (Iowa Ct. App. 2011) (explaining that the mother had already birthed three children before she sued the doctor for malpractice relating to her profuse bleeding leading to a hysterectomy).

230 Draper v. Jasionowski, 858 A.2d 1141, 1147 (N.J. Super. Ct. App. Div. 2004).

231 *Id.* at 1146.

232 *Id.* at 1147.

233 Robert A. Prentice & Jonathan J. Koehler, *A Normality Bias in Legal Decision Making*, 88 CORNELL L. REV. 583, 595 (2003).

of childbirth require doctors to consider harms to the fetus and to the mother. Yet a normality bias may diminish adequate consideration of harms to the mother, relegating them to the natural or the normal. This complicates the standard of care for decision-making:

> [I]t is hard for us to see negative agency in normal conduct. To be normal is to be acceptable, right, and in step with the world. The bonds between harm and a set of normal conditions are likely to be viewed as tenuous at best. In contrast, to be abnormal is to be different, unacceptable, and perhaps even dangerous.[234]

This normality bias might further support the essentialization of maternal harms.

Third, these strands of fetal consequentialism and essentialized maternal decision-making also invite distortions in medical care and advice. Judicial signaling that fetal harm framing yields successful medical interventions incentivizes doctors to distort fetal harms in ways that in turn distort the standard of care at the expense of birthing women. Indeed in several cases doctors have done just that.

This view of maternal decision-making distorts the realities of obstetric decision-making. This decision-making framework and subsequent liability determinations are distinctly defined by the reality that obstetric decisions involve statistical calculations of risks that may or may not manifest themselves. John Seymour summarizes:

> It is only in rare obstetric situations that it can be asserted with certainty that harm will occur if intervention is not undertaken. It can never be asserted that medical intervention will inevitably prevent it. What can be demonstrated in a particular situation is the existence of a *statistically verifiable risk* to the woman or her fetus. The fact that it does not occur in this situation does not mean that it will never do so. The fact that medical advice is not always correct does not mean that it is never correct. Overlooking these obvious propositions can lead to the misuse of anecdotal evidence.[235]

In *Jefferson v. Griffin Spalding County Hospital Authority*, the doctors exaggerated that there was a ninety-nine percent chance that the baby would die if the cesarean section was not performed and a fifty percent chance that the mother would die if vaginal delivery continued.[236] Not surprisingly, the court authorized the medical procedure to "save the child."[237] Similarly, in *Pemberton v. Tallahassee Medical Center*, a forced cesarean section case, three doctors, all affiliated with the hospital, testified that Ms. Pemberton's desire to

---

234 *Id.*

235 SEYMOUR, *supra* note 3, at 208.

236 274 S.E.2d 457, 458 (Ga. 1981).

237 *Id.* at 460.

deliver the baby vaginally created a "substantial risk of uterine rupture and resulting death of the baby."[238] Although relegated to a footnote in the opinion, *Pemberton* noted that the final formal order actually exaggerated (if not misrepresented) the testimony that the hospital doctors had provided to the judge in the emergency hearing.[239] The formal order, prepared by the hospital, distorted the medical testimony from a "substantial and unacceptable risk of death" to a finding that "if a C-Section is not done, then this viable fetus at term would die based upon competent medical testimony."[240] This is problematic in compelled intervention cases, but also in framing the physician-patient relationship for all birthing women.

When the doctor invokes fetal harms to request court-ordered interventions, courts often import a reproductive rights line of cases to support the intervention. Doing so further reinforces the fetal harms focus. This fetal harms framework positions the doctor to nearly always prevail in decision-making disputes.[241]

For two and a half centuries of childbirth in America, fetal harms were accepted as "normal" in childbirth, and maternal harms dominated. Yet, the modern quest for the "perfect baby" has inverted the analysis to position the less-than-perfect fetus as "unusual" and any maternal harms as normal. If courts allow the *absence* of harms to the fetus to trump the inquiry of maternal harms, they are in turn reinforcing a distorted standard of care that improperly subsumes standards of maternal care within positive fetal outcomes.

C. Valorized Medical Uncertainty and Villainized Maternal Uncertainty

The fetal-focused framework of medical decision-making co-opts the uncertainties of obstetric decision-making by valorizing medical responses to medical uncertainty and villainizing maternal uncertainty. A concerning judicial narrative of heroic medicine and reckless motherhood further distorts and diminishes the birthing woman.[242] While many scholars and the media have documented the "ideal

238 66 F. Supp. 2d 1247, 1250 (N.D. Fla. 1999).

239 *Id.* at 1250, n.2.

240 *Id.*

241 *See, e.g.*, Kim, *supra* note 16, at S82 (citing scholars who describe modern physicians as "fetal champions").

242 Many scholars have previously examined the discriminatory invocation of "idealized motherhood," whereby motherhood is framed in narrow and exclusive terms along class and race lines in ways that marginalize non-conforming motherhood. Many of these idealized portrayals have been leveraged to support forced interventions in pregnancy and childbirth. *See, e.g.*, Ikemoto, *supra* note 32, at 1207–08. Society often essentializes the motherhood experience as "nurturing" and "self-sacrificing." *Id.* at 1219.

mother" standard and its implications for women,[243] the judicial narrative described here is distinctly problematic in its direct impact on the standard of care.

Consider, for example, the court's characterization of the birthing woman in *Ortego v. Jurgelsky*, where the baby died days after an emergency cesarean delivery following VBAC complications.[244] The court explained "[e]ach prior delivery was initially attempted as vaginal births but failed for different reasons, with Caesarean sections being the ultimate result. For her third delivery, Plaintiff again wanted to attempt a vaginal delivery, and she insisted that she be allowed a trial of labor."[245] The court characterizes the mother as stubborn, at best; reckless at worse. The court neglects to articulate *why* the mother sought this method of delivery, what the relative risk assessments were for this child, and what the relative risks were to the mother. In contrast, the court describes the doctor in a heroic fashion: "Defendant allowed Venise to attempt a [VBAC]. The vaginal delivery attempt failed, and [the baby] was delivered via Caesarean section."[246] This heroic medicine and reckless motherhood narrative is particularly problematic judged against the plaintiff's case theory in which she alleged that she did not fully understand *why* she had the previous cesarean sections.[247]

In another case, the court explained that the birthing woman "wanted a VBAC and did not change her mind about wanting a VBAC at subsequent prenatal visits."[248] Another case explained that the mother "desired to have her third child . . . by vaginal delivery."[249] Again, mothers are characterized as stubborn, perhaps reckless, and their medical preferences are framed as emotional wants or desires, rather than medical preferences. In each of these cases, the birthing woman is denied recovery. Shockingly, this narrative is present in nearly every case arising out of a VBAC lawsuit.

This judicial narrative is problematic because it distorts the dualities of childbirth at the birthing woman's expense. It undermines the mother's perspective as a dual decision-maker and positions the doctor as a heroic rescuer. It also undermines the dualities of both the fetus and the birthing woman as patients. It suggests that the mother is

---

243 *See, e.g.*, *id.* at 1206 (describing the "Code of Perfect Pregnancy" that is premised on the "social good of 'fetal interests'"); *see also* KJ Dell'Antonia, *The Eternal, Internal Mommy Wars*, N.Y. TIMES MOTHERLODE BLOG, (Apr. 23, 2012 11:59 AM), http://parenting.blogs.nytimes.com/2012/04/23/the-eternal-internal-mommy-wars.

244 732 So. 2d 683 (La. Ct. App. 1999).

245 *Id.* at 685.

246 *Id.*

247 *Id.* at 686.

248 Blevins v. Clark, 740 N.E.2d 1235, 1237 (Ind. Ct. App. 2000).

249 Lavender v. Am. Physicians Assurance Corp., No. 2003-CA-001544-MR, 2004 WL 2755878, at *1 (Ky. Ct. App. Nov. 16, 2005) (finding no liability). The mother suffered a uterine rupture and subsequent hysterectomy, and the baby had brain injury. *Id.*

making decisions in the abstract, out of emotion, or irrationally. It does not ground her decision-making in a consultation with medical authorities, in the appropriate standard of care, or in a broader understanding of her decision-making matrix. In contrast, it positions the doctor to "protect" the fetus using science and data to expand the rights and duties to the fetus.[250]

This is further problematic because it erases the historical experiences of women in childbirth. It erases the historical centrality of women to birthing decisions, even in medicalized childbirth. It erases the centrality of birthing historically to women's life experiences. It erases the reality that birthing is often contemplated in a much broader context of a particular woman's life, depending on her age, her fertility, her risk factors, her prior children, her prior birth experiences, etc. It is not a standalone medical decision for birthing women. It also erases the extent to which doctors historically acknowledged candidly their own weaknesses in medical decision-making. It ignores the relative recency of fetal harms as a dominant focus within the tort framework.

IV. RESTORING THE DUALITIES OF CHILDBIRTH TO POSITION ADEQUATELY BIRTHING WOMEN AS PATIENTS AND PLAINTIFFS

There is considerable work to be done to adequately position the birthing woman in the tort framework and restore the dualities of childbirth. While normatively mothers and doctors function as dual decision-makers and doctors owe a dual duty of care to both the mother and the fetus, this Article reveals that the reality of these dualities are muddled and distorted, ultimately resolved in a fetal harms–focused framework at the expense of birthing women.

Surprisingly and concerningly, childbirth is deeply under-theorized in tort,[251] leaving a patchwork of court cases to cobble together applications of the standard negligence analysis to the dualities of childbirth. The results are problematic. Mothers rarely bring negligence cases for maternal harms. Rather, fetal harms predominate the litigation claims and damage verdicts. This reality is problematic on several levels. Judicial interpretations similarly engage in fetal consequentialism, allowing the absence of fetal harms to subsume the inquiry of maternal harms.

---

250 *See, e.g.*, Ikemoto, *supra* note 32, at 1294–95 (concluding that "[s]cientifically acquired information translates too quickly into additional rights or duties when we default" and the woman's interest becomes "only a secondary thought").

251 *But see generally* Hilary E. Berkman, *A Discussion of Medical Malpractice and Cesarean Section*, 70 OR. L. REV. 629 (1991) (exploring whether a malpractice cause of action should be available for unnecessary cesarean sections); Stone-Manista, *supra* note 111 (examining the maternal-fetal conflict and considering the tort and constitutional implications of these bans).

The implication of this focus on fetal harm infiltrates the standard of care as well. It distorts the duality of the doctor and the mother functioning as dual decision-makers. The fetal focus is distinctly used—infused with a reproductive rights overlay—to override the reasonable choices of birthing women responding to medical uncertainty. Problematic maternal essentializing occurs whereby mothers are universally assumed to make decisions exclusively to reduce harms to the fetus, without a more robust consideration of maternal decision-making and risk assessment. This romanticized, idealized, and grossly simplified view of maternal decision-making creates a fictitious "reasonable mother" standard that is not grounded in the facts or the historical roots of childbirth and is used to supplant a meaningful duality of childbirth decision-making. This valorizes medical decision-making and villainizes non-conforming maternal decision-making.

Restoring the dualities of childbirth to the obstetric malpractice framework is critical, particularly as new technologies threaten to push fetal-focused decision-making to new limits.[252] Janice Raymond summarizes the risks:

> If the fetus becomes the primary 'patient' while still in the womb, how much more so when it is detached from the woman's body in procedures where fetuses can be grown, frozen, and thawed technologically. Modern obstetrical practice has confirmed the pregnant woman as mere maternal environment for the fetus.[253]

This Article offers three preliminary recommendations to begin to restore these dualities. First, substantial empirical gaps exist that complicate the development of meaningful scholarship in this area. Empirical work is necessary to understand and isolate maternal harms: when are they pleaded, when are they awarded, when are they denied, and which specific recoveries predominantly endure?[254]

Second, absent more substantial and transformative reforms to the obstetric tort framework, in the current paradigm, more pursuits of maternal harms claims are necessary. Even if the ultimate damage verdicts are nominal, the pursuit of damages will push courts to consider more carefully the harms to mothers and perhaps influence the standard of care. Advocacy groups such as the National Advocates for

---

252 *See, e.g.*, Pam Belluck, *Spina Bifida Study Is a Success, Opening a Door for Fetal Surgery*, N.Y. TIMES, Feb. 10, 2011, at 1.

253 JANICE G. RAYMOND, WOMEN AS WOMBS: REPRODUCTIVE TECHNOLOGIES AND THE BATTLE OVER WOMEN'S FREEDOM 64, 65 (1993) ("[F]athers' rights are articulated under the heading of fetal rights, and women's rights are diminished under this same banner.").

254 This author hypothesizes that the results of such empirics would be profoundly revealing and concerning. This author speculates based on the conclusions in this Article that it is likely the *loss* of reproductive capability that is pursued most aggressively and successfully, suggesting a very distinct view of childbirth and motherhood.

Pregnant Women, clinical law programs, and other reproductive rights organizations are uniquely positioned to select and pursue these cases successfully.[255]

Third, tort scholarship has long debated the plausibility of and a definition for a unified theory of torts.[256] Tort jurisprudence has sought to apply a coherent, consistent set of rules to all negligence cases. The Restatement, for example, handles all negligence claims together. Tort historians have described the "unexpected persistence of negligence," noting that for the past twenty years negligence has been the "dominant model of tort liability" despite expansive rhetoric and discussion of reform and alternative models in the preceding decades.[257] Robinette challenges the plausibility of this framework by analyzing medical malpractice and automobile accidents and revealing how these areas of law have remarkable differences in the rationales that support them, their doctrinal applications, and their litigation trends.[258] Robinette concludes that the history of tort law is too ad hoc to support a unified theory of tort; he instead advocates for a pluralist approach and the disaggregation of torts on a "case-by-case basis."[259] The analysis presented here revealing the complexities of childbirth in the tort context underscores Robinette's conclusion.

This Article suggests the need for a transformational analysis of childbirth. This body of law would benefit distinctly from an American Law Institute–style forum to survey and refine the positioning of childbirth in the tort framework. The Restatement-style survey of common law would tee up the existing placement of childbirth within the tort framework and recommend a workable regime. This workable regime may involve moving beyond the tort framework entirely to consider a statutory or specialized class of childbirth negligence cases.

For over half a century, modern childbirth has sat awkwardly and tenuously in our tort framework. This Article concludes that a more sophisticated and lasting restoration of the dualities of childbirth is necessary, indeed imperative, to protect birthing women as patients and as putative plaintiffs. Absent a robust and certain resolution, the trolley driver seems to be barreling down the tracks towards birthing women.

---

255 The National Advocates for Pregnant Women continues to do pioneering work revealing the pervasive and systematic implications of personhood proposals. *See, e.g.*, Paltrow & Flavin, *supra* note 5.

256 *See* Robinette, *supra* note 85, at 370 (describing a camp of legal theorists who regard deterrence as the rationale for tort liability).

257 WHITE, *supra* note 84, at 244–90.

258 *See* Robinette, *supra* note 85, at 399–412.

259 *See id.* at 413 (promoting tort analyses that are "detailed, descriptive, and normative analy[ses] highly sensitive to context").