Best Laid Birth Plans:
a relational analysis of the legal rights of birthing people in Canada

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ABSTRACT

While it is trite law in Canada that patients have the right to make their own medical decisions, news reports, regulatory complaints, and civil claims indicate that this right is failing to translate to delivery rooms. This thesis examines the gaps between the legal rights of birthing people in Canada as they exist "on the books" and the way those rights are experienced, using the critical theory of Law in Action. Building on feminist critiques of the traditional liberal conception of autonomy, this thesis conceptualizes childbirth as an experience deeply embedded in relations to others and concludes that to close the gaps between legal rights and lived experiences, we must craft law and policy in a manner that accounts for the broader relational context in which childbirth occurs.

To James.

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LIST OF ABBREVIATIONS

ADR	alternative dispute resolution
CDMR	Caesarean delivery on maternal request
CHA	*Canada Health Act*
CPSO	College of Physicians and Surgeons of Ontario
C-section	Caesarean section
IDD	intellectual and developmental disability
IVF	*in vitro* fertilization
MMIWG	Missing and Murdered Indigenous Women and Girls
ONCA	Ontario Court of Appeal
NSCA	Nova Scotia Court of Appeal
PRCS	planned repeat Caesarean section
RT	respiratory therapist
SCC	Supreme Court of Canada
SOGC	Society of Obstetricians and Gynaecologists of Canada
TOLAC	trial of labour after Caesarean
TRC	Truth and Reconciliation Commission
VBAC	vaginal birth after Caesarean
WHO	World Health Organization

CHAPTER 1: Introduction

Although it is trite law in Canada that a fetus is not a legal person until born alive,[1] reported accounts of people's experiences giving birth in hospitals commonly describe medical actions taken by care providers contrary to the stated wishes of the birthing person, in the purported interests of the fetus.[2] Such actions include vaginal examinations, inductions of labour, and even episiotomies (surgical incisions of the perineum), performed without consent.[3]

Despite the existence of constitutional safeguards including the right to autonomy in medical decision-making[4] and the right to informed consent,[5] it appears such rights frequently fail to translate to the reality of the delivery room.[6] Coercion is well-documented in Canadian obstetrical care, with reports of clinical care providers playing the so-called "dead baby card"—asking birthing people, "You don't want your baby to die, do you?"—to induce patients to "consent" to medical intervention.[7] While such clinical actions are clearly inappropriate, they reveal something deeper about the nature of childbirth, and why conventional autonomy rights are a poor fit in the delivery room—because, of course, the birthing person typically does *not* want their baby to die.

In examining these issues, I build on a rich body of commentary on the tension between the interests of birthing people and fetuses,[8] as well as on robust feminist discussion of autonomy in health care.[9] I

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[1] *Tremblay v Daigle,* 1989 CanLII 33 (SCC), [1989] 2 SCR 530 [*Tremblay v Daigle*]; *R v Sullivan,* 1991 CanLII 85 (SCC), [1991] 1 SCR 489 [*R v Sullivan*]; *Dobson (Litigation Guardian of) v Dobson,* 1991 CanLII 698 (SCC), [1999] 2 SCR 753 [*Dobson*].

[2] "The Legal Infrastructure of Childbirth," (2021) 134 Harv L Rev 2209 ["The Legal Infrastructure of Childbirth"]; Annie Burns-Pieper, "'Stop! Stop!': Canadian women share stories of alleged mistreatment in the delivery room" *CBC News* (7 November 2016) [Burns-Pieper, 'Stop! Stop!'].

[3] Annie Burns-Pieper, "'A scene from a horror movie': 9 mothers speak out about alleged mistreatment during childbirth" *CBC News* (7 November 2016) [Burns-Pieper, "A scene from a horror movie"]; *Ontario (College of Physicians and Surgeons of Ontario) v. Shuen,* 2018 ONCPSD 31.

[4] *Carter v Canada (Attorney General),* 2015 SCC 5 at para 67 [*Carter*].

[5] *Reibl v Hughes,* [1980] 2 SCR 880, 1980 CanLII 23 (SCC) [*Reibl*]; *Malette v Shulman* (Ont CA), 72 OR (2d) 417; [1990] OJ No 450 [*Malette*]; *R v Parker,* 2000 CanLII 5762 (ON CA) at para 135.

[6] Erin Nelson, "Reconceiving Pregnancy: Expressive Choice and Legal Reasoning" (2004) 4 McGill LJ 593 at 609 [Nelson, "Reconceiving Pregnancy"].

[7] Wendy A Hall et al, "Canadian Care Providers' and Pregnant Women's Approaches to Managing Birth: Minimizing Risk While Maximizing Integrity" (2012) Qual Health Res 22:5 575 [Hall, "Minimizing Risk While Maximizing Integrity"]; P Mimi Niles et al, "'*I fought my entire way'*: Experiences of declining maternity care services in British Columbia" (2021) PLOS One 1 [Niles, "*I fought my entire way*"].

[8] See, for example: Sandra Rodgers, *"Winnipeg Child and Family Services v DFG: Juridical Interference with Pregnant Women in the Alleged Interest of the Fetus"* (1998) 36:3 Alta L Rev 711; Susan Alter Tateishi, "Apprehending the Fetus *En Ventre Sa Mere*: A Study in Judicial Sleight of Hand" (1989) 53:1 Sask L Rev 113; Deborah Lupton, "'Precious cargo' foetal subjects, risk and reproductive citizenship" (2012) 22:3 Critical Public Health 329; Deborah J Krauss, "Regulating Women's Bodies: The Adverse Effect of Fetal Rights Theory on Childbirth Decisions and Women of Color" (1991) 26:2 Harv CR-CL L Rev 523.

[9] Susan Sherwin, "A Relational Approach to Autonomy in Health Care" in Susan Sherwin, ed, *The Politics of Women's Health: Exploring Agency and Autonomy* (Philadelphia: Temple University Press, 1998) 19 [Sherwin, "A Relational Approach to Autonomy"]; Erin Nelson, "Autonomy, Equality, and Access to Sexual and Reproductive Health Care" (2017) 54:3 Alta L Rev 707; Jennifer Nedelsky, *Law's Relations: A Relational Theory of Self, Autonomy, and Law* (Oxford: Oxford University Press, 2011) [Nedelsky, *Law's Relations*]; Jocelyn Downie & Jennifer J Llewellyn, *Being Relational: Reflections on Relational Theory and Health Law* (Vancouver: UBC Press, 2012).

contribute to this discussion a novel legal analysis of first-hand accounts of childbirth drawn from health sciences literature and professional regulatory decisions. My methodology is shaped by Law in Action theory, which examines the ways law is experienced by its subjects, outside the pages of textbooks or law reports.[10] Law in Action theorists focus on the impacts and effects of laws in people's lives, as a means of examining how those laws may be improved.[11]

To discern why legal rights are seemingly breaking down in the delivery room, Chapter 2 sets out the existing legal framework of childbirth in Canada, focusing on two broad themes: legal entitlement to publicly funded childbirth care and the right to medical self-determination. Following this, Chapter 3 provides a detailed examination of the lived experiences of birthing people in Canada, focused through two case studies. The first examines experiences of the right to choose one's mode of birth, considering "Caesarean delivery on maternal request" or "CDMR" as a care option, as well as on the disproportionate use of Caesarean deliveries for birthing people with intellectual and developmental disabilities (IDD). The second case study examines lived experiences of the right to choose one's place of birth, focusing on the experiences of Indigenous birthing people living in rural and remote regions of Canada and the operation of so-called "birth evacuation" policies. Finally, Chapter 3 includes a narrative synthesis of recent professional disciplinary decisions regarding complaints of rights infringements in childbirth, in order to gain a greater understanding of the harms experienced by birthing people in childbirth and existing legal responses. Through this juxtaposition of legal rights "on the books" and accounts of rights as they are experienced "in action," I seek to identity where and how the legal rights of birthing people in Canada are stymied in practice. The final chapter, Chapter 4, examines current responses to rights violations in intrapartum care and proposes novel policy solutions for "closing the gaps" between legal rights and lived experiences.

Throughout this work, I examine the scope and extent of autonomy in childbirth decision-making through the lens of relational autonomy. Relational autonomy is a feminist theory that challenges conventional liberal understandings of autonomy and takes as its starting point, instead, that our relations with others are the *source* of our autonomy.[12] The conventional model of autonomy that pervades Canadian law centres around the idea of the "in-control agent,"[13] who makes rational, independent decisions in their own self-interest. In contrast, a relational model of autonomy posits that people "all fundamentally and

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[10] Roscoe Pound, "Law in Books and Law in Action," (1910) 44 Am L Rev 12; Rebecca L Sandefur, "When Is Law in Action?" (2016) 77 Ohio St LJ Furthermore 59 at 59.
[11] G W Paton, "Pound and Contemporary Juristic Theory," (1944) 22:6 Can Bar Rev 479 at 483.
[12] Nedelsky, *Law's Relations*, *supra* note 9 at 55.
[13] Jennifer K Walter & Lainie Friedman Ross, "Relational Autonomy: Moving Beyond the Limits of Isolated Individualism" (2014) 133 Pediatrics S16 at S18.

ineradicably exist in relation to others"[14] and, by extension, autonomy or independence is realized *through*—not in spite of—our relationships to others.[15]

Applying a relational lens to decision-making in pregnancy and childbirth, I conclude that autonomy rights "break down" in the delivery room, because the current articulation of medical self-determination in Canadian law represents a traditional liberal conception of autonomy that fails to account for the highly relational nature of childbirth.[16] Despite popular discourse around "unassisted" birth, childbirth is never a solo endeavour. There is always at least one other person (-to-be)—the fetus—who waits in the wings and who, at some point in the process, makes their on-stage debut. Indeed, most experiences of childbirth involve much larger supporting casts. In Canada, birth has historically been and continues to be embedded in community,[17] and family members, friends, and care providers such as physicians, midwives, and nurses play key roles in navigating and making real the rights of birthing people during intrapartum care. In addition, a relational understanding makes clear that a birthing person's "identities, interests, ends, and beliefs [are] fundamentally dynamic, continually constructed and reconstructed in dialogic processes with others"[18]—including in their relationships to their unborn children.

Establishing the conditions wherein a birthing person may meaningfully exercise their autonomy means accounting for this entire context through the implementation of system-wide changes both in the ways we understand and navigate the exercise of patient choice in childbirth, as well as in the legal strategies we use to respond to rights infringements and other harms experienced by birthing people during childbirth.

Terminology

Although included quotations often use the language of "women" or "mother," I use the terms "birthing people" or "birthing person" throughout this work to describe all people who give birth, including women, transgender men, and non-binary people. I make this choice deliberately, acknowledging that "ideology operates *through* language, and language is an essential constituent *of* all discourses."[19] Furthermore, I do so because gender inclusive writing "is a matter of justice and professionalism."[20]

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[14] *Ibid* at S19.
[15] Nedelsky, *Law's Relations*, *supra* note 9 at 39; 55; 120-123.
[16] Nelson, "Reconceiving Pregnancy", *supra* note 6 at 614.
[17] Wendy Mitchison, "Agency, Diversity, and Constraints: Women and Their Physicians, Canada, 1850-1950" in Susan Sherwin et al, eds, *The Politics of Women's Health: Exploring Agency and Autonomy* (Philadelphia: Temple University Press 1998) 122 at 128 [Mitchison, "Agency, Diversity & Constraints"]; Leslie Dawson & Terri Suntjens, "Only Then Will the Buffalo Return": Disrupting Obstetric Violence through Indigenous Reproductive Justice" in Angela N Castañeda, Nicole Hill & Julie Johnson Searcy, eds, *Obstetric Violence: Realities and Resistance from Around the World* (Toronto: Demeter Press, 2022) 227 at 235.
[18] Walter & Ross, *supra* note 13 at S19.
[19] Eileen V Fegan, "'Fathers' Foetuses and Abortion Decision-Making: The Reproduction of Maternal Ideology in Canadian Judicial Discourse" (1996) 5:1 Soc Leg Stud 75 at 77.
[20] British Columbia Law Institute, "Gender Diversity in Legal Writing: Pronouns, Honorifics, and Gender-Inclusive Techniques" (June 2022), online: https://www.bcli.org/wp-content/uploads/Gender-Diversity-in-Legal-Writing-1.pdf.

In choosing this terminology, I recognize that "[n]o language is neutral"[21]—rather, it is necessarily political. I also recognize that there is presently no clear consensus regarding terminology to describe people giving birth.[22] Nevertheless, "[a]t present, 'pregnant people' and 'birthing people' provide a neutral ground to pause and recognize gender-inclusive descriptors in obstetrics" in a manner that avoids harmful binary language.[23]

Situating Myself

Throughout this thesis, I use the personal pronoun "I," and make references to my own experiences of pregnancy and childbirth. I do so deliberately, to acknowledge that all experiences of pregnancy and childbirth are necessarily subjective,[24] and to avoid essentializing the childbirth experience. In this section, I seek to "situate" myself in my work. Drawing on the work of feminist scholar Donna Haraway,[25] feminist theorist Erin Wunker provides the following summary of what it means to "situate" oneself:

> Situating yourself enacts the deliberate practice of locating your own identity and experiences as coming from somewhere and being mediated by certain things such as your race, gender, and class. Laying these things out for yourself locates your way of being in the world—your knowledge—within larger systems of knowing.[26]

The practice of situating yourself is the act of acknowledging your perspective has been shaped by your own subjective history, experiences, and external cultural and social forces. It also means, as Wunker explains, acknowledging "the truth that you don't have access to every experience."[27] In describing her own "obstetric history" as a means of situating herself, law professor Celia Wells explains:

> What we write is a product of a complex of personal, historical and social factors. It might be neither sensible nor feasible to preface every piece of work with an autobiographical account, but never to reflect on the possible influences on our core values would be shortsighted. Thus, my rather uneventful obstetric history is given a small part in the drama, both because it is one of the significant factors in how I define myself and because, without it, my audience might wonder whether there is some significant personal explanation of the views I express here to which they are not privy. […].[28]

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[21] Dionne Brand, *No Language is Neutral* (Toronto: McClelland & Stewart 1998).
[22] Kinnon R MacKinnon et al, "Recognizing and renaming in obstetrics: How do we take better care with language?" (2021) 14:4 Obstetric Medicine 201; Emma Green, "The Culture War Over 'Pregnant People'" *The Atlantic* (17 September 2021), online: https://www.theatlantic.com/politics/archive/2021/09/pregnant-people-gender-identity/620031/; "NIH Style Guide: Inclusive and Gender-Neutral Language," *National Institutes of Health* (website), online: https://www.nih.gov/nih-style-guide/inclusive-gender-neutral-language#:~:text=Both%20pregnant%20women%20and%20pregnant,)%2C%20present%20an%20inclusive%20alternative; Harmeet Kaur, "The language we use to talk about pregnancy and abortion is changing. But not everyone welcomes the shift" *CNN* (4 September 2022). Regarding the harms of binary language in the context of pregnancy and childbirth, see also: Amber Leventry, "Trans and Nonbinary People Can Be Pregnant Too" *Parents* (5 January 2023).
[23] MacKinnon, *supra* note 22 at 202.
[24] Celia Wells, "On the Outside Looking In: Perspectives on Enforced Caesareans" in Sally Sheldon & Michael Thomson, eds, *Feminist Perspectives on Health Care Law* (London: Cavendish Publishing, 1998) 237 at 239.
[25] Donna Haraway, "Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective" (1988) 14:3 Feminist Studies 575.
[26] Erin Wunker, *Notes from a Feminist Killjoy: Essays on Everyday Life* (Toronto: BookThug, 2017) at 31-32.
[27] *Ibid* at 32.
[28] Wells, *supra* note 24 at 23.

My experiences shape how I view, interpret, and present information. My situatedness also shapes how I am perceived by others during my pregnancies and when giving birth, which feeds back into my own experiences.

With this preface, I situate myself as follows: I am a cisgender, able-bodied, White woman. I am the mother of one son, born in hospital via emergency Caesarean section when I was 28 years old, and I am currently pregnant with my second child. I am married to a cisgender, able-bodied White man, who is a medical doctor. I was born and raised in a middle-class household in Nova Scotia, where my son was also born. I have an undergraduate degree and a law degree and was working as a law clerk during my first pregnancy, and at the time my son was born. While I was pregnant, I read voraciously about childbirth and the right to refuse certain medical treatments and to request others. I met with the family physician who followed my pregnancy and with my doula to discuss my goals and plans, and to ask many questions. I researched possible outcomes, read scientific studies, and drafted a birth plan.[29]

On the morning of May 1, 2021, at 39 weeks pregnant, my labour started spontaneously and progressed very quickly. I laboured at home with my husband until my water broke, at which point I went to the nearby maternity hospital and was admitted, with my birth plan in hand. Significant COVID-19 restrictions were in place in Nova Scotia at the time, meaning I was only permitted to have one person accompany me in the hospital. I chose my husband. As the result of organized advocacy on the part of doula organizations earlier in the pandemic, I was also permitted to have my doula join me, though hospital policy meant she was only permitted in the birthing room (not in the early labour unit, the operating room, nor on the “Family Newborn Care Unit” following the birth). I laboured in a bathtub in my birthing room without any pharmaceutical pain management, consistent with my wishes, until my son’s umbilical cord suddenly prolapsed, causing his heart rate to fall dangerously low. The ensuing chaos—teams of specialists sprinting into the room, repeated failed attempts to insert a fetal scalp monitor, frantic calls to my doctor, and an emergency C-section—was overwhelming and has had a lasting impact on me and the ways I think of and understand patient rights. These factors and experiences unavoidably colour my analysis, though I endeavour throughout this thesis to craft a nuanced understanding of patient experiences of childbirth, drawing from individual qualitative accounts.

[29] The term “birth plan” refers to a birthing person’s stated expression of their preferences and wishes for labour and delivery, typically recorded in written form. Birth plans vary in detail and scope, but often include information regarding the birthing person’s goals for pain relief or procedures they wish to avoid. My birth plan for my upcoming second birth is provided as an example at Appendix A.

CHAPTER 2:
Law on the Books

To assess the state of rights protections during childbirth, it is necessary, first, to set out the existing legal framework of childbirth in Canada. Rights and entitlements are not limited or prescribed by law "on the books," but developed and given meaning through the ways those laws work in the lives of their subjects, and how they are interpreted and applied by state actors. Writing in the context of abortion, legal scholar Joanna Erdman argues that rights "are not forged in legal text or doctrine, but by those who claim and organize around them and the institutions of the state that give meaning and expression to them."[30] I take up this idea in the context of childbirth, examining the ways reproductive rights are negotiated beyond the reach of written law.

Nevertheless, it is necessary, first, to engage directly with legal doctrine, as it provides the backdrop against which autonomy rights are navigated in Canadian delivery rooms today. Thus, this chapter provides an overview of existing legal rights relevant to childbirth divided into two broad themes: legal entitlement to publicly funded childbirth care and the right to medical self-determination.

2.1 Legal entitlement to publicly funded childbirth care

The vehicle through which many of the health care rights that exist in Canada are realized is the legal entitlement to publicly funded health care, shaped in large part through the operation of the *Canada Health Act (CHA)*.[31] The *CHA* is a piece of federal legislation that derives its jurisdiction from the federal spending power.[32] In terms of scope, legal entitlement to publicly funded health care in Canada is limited under the *CHA* to "medically necessary" hospital services and "medically required" physician services.[33] Legal scholars Colleen Flood and Bryan Thomas explain:

> Section 2 of the *CHA* notionally limits medicare dollars to "medically necessary" hospital services and "medically required" physician services. But there is no rigour in the application of these limitations—as Nuala Kenny puts it, "medical necessity is what doctors decide needs to be done or what doctors actually do." The main stricture here is that physicians require a fee code when billing medicare for a specific service, and the menu of fee codes is renegotiated annually between provincial medical associations and provincial health insurers […].[34]

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[30] Joanna Erdman, "Constitutionalizing Abortion Rights in Canada" 49:1 (2017) Ottawa L Rev 221 at 228 [Erdman, "Constitutionalizing Abortion Rights"].
[31] *Canada Health Act,* RSC 1985, c C-6.
[32] *The Constitution Act, 1982, Schedule B to the Canada Act 1982 (UK)*, 1982, c 11 at ss 91(1A), 91(3) and 106 [*The Constitution Act*].
[33] *Canada Health Act,* RSC 1985, c C-6, s 2; Colleen Flood & Bryan Thomas, "Modernizing the *Canada Health Act*," (2016) 39:2 Dal LJ 397 at 402.
[34] Flood & Thomas, *supra* note 33 at 403.

The process by which governments determine the "menu of fee codes" has been criticized as lacking in both rigour and transparency.[35] The question of which services are "medically necessary" or "medically required" is determined at the discretion of each province administering the provincial health plans, with significant input from professional medical bodies. Thus, the question of what aspects of childbirth care are publicly funded is, paradoxically, both open-ended (funding considerations are not set in stone, and there is flexibility for governments to reassess which services they will fund annually) and narrow (funded services under the *CHA* regime are limited to hospital-based or physician-administered services, and courts have accorded significant deference to governmental budgetary considerations in the health care sector.)[36]

Writings from the development of the medicare system suggest that the *Canada Health Act*'s protections for "medically necessary hospital and physician services" were originally intended "only as the foundation of a more comprehensive public system," which architects envisioned would eventually expand to include things such as prescription drug coverage.[37] Nonetheless, in the decades since the *CHA* was enacted, courts have been "highly deferential" to lawmakers' health spending decisions.[38]

In *Cameron v. Nova Scotia,*[39] for example, the Nova Scotia Court of Appeal (NSCA) heard a claim for financial reimbursement for medical services the claimants sought and paid for out-of-province. The medical services in issue were a specialized form of *in vitro* fertilization (IVF) which was, at the time, considered the "treatment of choice" for male factor infertility.[40] In assessing the constitutionality of Nova Scotia's decision to exclude the treatment from the list of publicly funded services, the NSCA conducted a detailed analysis of how provincial governments determine funding eligibility, quoting at length from a 1994 Canadian Bar Association report:

> A non-exhaustive review of provincial legislation reveals that provinces simply classify services as "medically required" by regulation, without reference to any substantive or policy-based definition of that term. […] While this procedure is flexible, it is arguably susceptible to political and economic winds, as it does not seem to be grounded in any principled definition. […]
>
> There is an expressed or implied right to health insurance under provincial health insurance acts, but this does not constitute a right to health care because there is no guarantee of content of health insurance (i.e., provinces may de-insure services as they choose). Further, there is no guarantee of procedural fairness in how insured services are selected or delisted (de-insured).[41]

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[35] *Ibid*.
[36] *Auton (Guardian ad litem of) v British Columbia (Attorney General),* 2004 SCC 78 at para 41; *Cameron v Nova Scotia (Attorney General),* 1999 NSCA 14 [*Cameron*].
[37] Flood & Thomas, *supra* note 33 at 402.
[38] *Ibid* at 404.
[39] *Cameron, supra* note 36.
[40] *Ibid* at para 6.
[41] Canadian Bar Association Task Force on Health Care Reform, *What's Law Got To do with It?: Health Care Reform in Canada* (Ottawa: The Canadian Bar Association, 1994) at 31; 37.

The NSCA accepted the above as an "accurate description of the policy established" under the *CHA* and its regulations, stating: "Clearly, there is room for differing opinions on whether a given procedure is 'medically required.'"[42] Though the above description is from 1994, it continues to reflect the way services are funded or de-funded today.

By making health care funding a matter of governmental policy, the *CHA* insulates health care spending decision-making from significant judicial scrutiny.[43] The Supreme Court of Canada (SCC) has remarked on this tension; in *Chaoulli v Quebec,* the majority and dissent differed on the appropriate degree of deference to accord to health care spending decisions, with the majority noting: "The fact that the matter is complex, contentious or laden with social values does not mean that the courts can abdicate the responsibility vested in them by our Constitution to review legislation for *Charter* compliance when citizens challenge it."[44]

Nonetheless, by virtue of its characterization as a matter of policy, health care spending has been largely exempted from serious judicial scrutiny.[45] This is troubling, as health care spending decisions often implicate *Charter* rights. When such decisions are made behind closed doors, neither electors nor the judiciary have the opportunity to hold lawmakers to account regarding the fairness of their decision-making. By choosing which services they fund, governments signal which care priorities they value as a matter of public interest, and which they do not. As political science scholar Alana Cattapan describes: "the concept of medical necessity is itself malleable—contingent on the health care service in question and the seeming importance of its use."[46] This dynamic is clearly illustrated through the facts of *Cameron*, which dealt with the question of whether fertility treatment required to conceive a child is "medically necessary." However, one need not look very far to see such values at play in provincial health care spending decisions every day. Chronic underfunding of long-term care throughout Canada reveals a systemic devaluing of the elderly.[47] Prince Edward Island's decision not to fund surgical abortion care on the island provides a stark example of the way religious conservatism shapes access to health care.[48] Health funding decisions shape norms and access to care far beyond hospital or clinic rooms, and childbirth is not exempt from this dynamic.

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[42] *Cameron, supra* note 36 at para 80.
[43] *Ibid* at para 236.
[44] *Chaoulli v Quebec (Attorney General),* 2005 SCC 35 at para 107 [*Chaoulli*]. For a detailed discussion of the SCC's disagreement on this point, see: Lorian Hardcastle, "*Douglas v Independent Living Center*: Litigating Access to Publicly Funded Health Services in the United States and Canada," (2013) 7:1 McGill LJ 67 at 83.
[45] Legal scholar Sarah Burningham explains: "At common law, administrative actors owe a duty of procedural fairness to individuals whose rights or interests are affected by specific, individualized decisions. No duty is owed for general, policy decisions. Most often, decisions about which medical services should be funded will be policy decisions, involving the apportionment of resources among competing groups, and thus no duty of procedural fairness will attach" (Sarah Burningham, "Courts, Challenges, and Cures: Legal Avenues for Patients with Rare Diseases to Challenge Health Care Coverage Decisions" (2015) 1 CJCCL 317 at 335). See also: *Canada v Inuit Tapirisat,* [1980] 2 SCR 735.
[46] Alana Cattapan, "Medical Necessity and the Public Funding of In Vitro Fertilization in Ontario" (2020) 53 Can J Political Science 61 at 67.
[47] André Picard, "Long-Term Carelessness" in *Neglected No More: The Urgent Need to Improve the Lives of Canada's Elders in the Wake of a Pandemic* (Toronto: Penguin Random House, 2021) 44 at 46.
[48] Kate McKenna, *No Choice: the 30-year fight for abortion on Prince Edward Island* (Halifax: Fernwood Publishing, 2018); Emily Baron Cadloff, "How PEI Became One Of The Most Accessible Places For Women's Health Care In Canada" *Chatelaine* (19 November 2019).

To be eligible for federal cash contributions (an increasingly essential component of provincial health care delivery),[49] provinces and territories must provide their residents health care coverage that is: comprehensive, universal, portable, publicly administered, and accessible.[50] However, the *CHA*'s enforcement mechanisms render these goals largely aspirational. Though the federal government is authorized to withhold health transfer payments from provinces and territories that violate the *CHA*, in recent years "federal governments have persuaded themselves that it is politically unfeasible to impose these financial penalties."[51]

This dynamic is clearly illustrated through ongoing efforts to improve abortion access in the Maritimes. In Prince Edward Island, the provincial government declined to fund abortion care on the island for over 30 years, instead requiring islanders to travel off-island to access care. During this period, various federal governments took steps to warn PEI of potential consequences of their failure to comply with the principles of the *CHA*, but no government actually withheld transfer payments.[52] Abortion access on PEI was secured in 2016, not through the *CHA*'s enforcement mechanisms, but through the efforts of a grassroots advocacy group who announced it would be pursuing a legal challenge to PEI's abortion policy.[53]

More recently, the federal government withheld over $140,000 in health transfer payments to New Brunswick in response to the province's regulation precluding out-of-hospital abortions, which results in extra-billing charges for people seeking abortion care.[54] However, it quietly reimbursed that amount weeks later to assist the province in its COVID-19 response.[55] In March 2023, the federal government announced it will once again "claw back" transfer payments to New Brunswick, as a result of its continued noncompliance. New Brunswick has not yet taken any action in response.[56] These examples demonstrate the ways in which the politically charged nature of health care in Canada leads to selective enforcement, and results in a limited ability on the part of the federal government to ensure provinces adhere to the requirements of the *Act*.

Is childbirth care "medically necessary"?

When it comes to entitlement to publicly funded childbirth care, the question of what is "medically necessary" is more contentious than may first appear. Many critics of the current "medical model" of

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[49] Ismail Shakil & Anna Mehler Paperny, "Canada pledges C$46.2 bln in new funding to fix strained healthcare system" *Reuters* (7 February 2023).
[50] *Canada Health Act,* RSC 1985, c C-6, s 7; Martha Jackman, "Constitutional Jurisdiction Over Health in Canada" (2000) 8 Health LJ 95.
[51] Flood & Thomas, *supra* note 33 at 399.
[52] For a detailed description, see: Erdman, "Constitutionalizing Abortion Rights", *supra* note 30 at 251-252, footnote 103.
[53] Women's Legal Education & Action Fund, News Release, "LEAF Proudly Supports Abortion Access Now PEI's Legal Challenge to Prince Edward Island's Discriminatory Abortion Policy" (5 January 2016); Women's Legal Education & Action Fund, News Release, "LEAF and AANPEI Welcome Announcement that PEI Government Will End Its Discriminatory Abortion Policy" (31 March 2016).
[54] Julianne Stevenson & Jennifer Taylor, *Access to Choice: The Legal Framework for Abortion Access in Nova Scotia* (Toronto: LEAF 2020) at 4.
[55] Hadeel Ibrahim, "Feds penalize province for lack of abortion access, but reimburse payments because of COVID-19" CBC News (April 9, 2020).
[56] "Federal government to claw back $1.3M of New Brunswick health funding" *CBC News* (10 March 2023).

childbirth point out that childbirth in Canada has not always been viewed as a medical event. Historically, births in Canada were attended by lay midwives or women in the community, who informally assisted birthing people in their homes.[57] Traditional childbearing practices in Indigenous communities throughout Canada often involved skilled birth attendants who assisted people in childbirth and held Indigenous Knowledge about pregnancy, labour, and birth ceremonies.[58] Early settlers to Canada similarly viewed childbirth as an event that took place at home, attended by neighbours or midwives.[59] Some settler birth attendants had formal midwifery or nursing training in their countries of origin, and others had knowledge gleaned from life experience.[60] Knowledge was shared informally during this time; childbirth care was not viewed as specialized or professional but, rather, "formed part of a popular birth culture, which women learned by participating at births or by giving birth themselves."[61]

Over the course of the 20th century, cultural norms around birth in Canada shifted such that birth came to be viewed as a medical event, requiring the "professional" assistance of doctors. This shift is attributable to a wide range of factors, including sexist and misogynistic beliefs about women's intellectual capabilities;[62] concerns about midwives' lack of formal training;[63] advancements in pharmacological pain management,[64] deliberate lobbying efforts on the part of the medical profession,[65] and "women's demand for physician services, which, no doubt, represented a mixture of accepting the propaganda about midwives and desiring 'the new, modern way of birth.'"[66] Indeed, historian Wendy Mitchinson explains, "evidence abounds that many women *wanted* physicians involved in their childbirth."[67] Through a combination of legislative action and criminal prosecution, midwives were prohibited from assisting in childbirth, and birth became the sole jurisdiction of the medical profession. The ideological and practical shift of childbirth from an everyday event to a medical one is often referred to in the literature as the "medicalisation of childbirth." Health researcher Christina Young defines the term as follows:

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[57] Cristina Mattison et al, "Understanding the conditions that influence the roles of midwives in Ontario, Canada's health system: an embedded single-case study" (2020) 20:197 BMC Health Services Research 1 at 2.
[58] Rachel Olsen, Charlotte Moores and Kathleen Cranfield, *Born into my Grandmother's Hands: Honouring First Nations' Birth Knowledge and Practice in North Yukon* (Vancouver: The Firelight Group 2019) at 13-27; Erika Lee, Bryarre Gudmundson & Josée G Lavoie, "Returning childbirth to Inuit communities in the Canadian Arctic" (2022) 81:1 Int J Circumpolar Heath 1 at 1; Ashley Hayward & Jaime Cidro, "Indigenous Birth as Ceremony and a Human Right" (2021) 23:1 Health and Hum R J 213 at 215.
[59] M Joyce Relyea, "The rebirth of midwifery in Canada: an historical perspective" (1992) 8 Midwifery 159 at 160.
[60] Lesley Biggs, "Rethinking the History of Midwifery in Canada" in Robbie Davis-Floyd, Ivy Lynn Bourgeault & Cecilia Benoit, eds, *Reconceiving Midwifery* (Montreal & Kingston: McGill-Queen's University Press 2004) 17 at 20-21.
[61] *Ibid*. See also: Mitchison, "Agency, Diversity & Constraints", *supra* note 17 at 127-128.
[62] Biggs, *supra* note 60 at 29-30, citing Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto 1991) at 164.
[63] *Ibid*.
[64] Whitney L Wood, *Birth Pangs: Maternity, Medicine, and Feminine Delicacy in English Canada, 1867-1950* (PhD Thesis, Wilfred Laurier University Faculty of Arts, 2016).
[65] Relyea, *supra* note 59 at 161; 163; Biggs, *supra* note 60 at 29; Whitney Wood, "'Put Right Under': Obstetric Violence in Post-war Canada" (2018) 31:4 Social History of Medicine 796 at 798 [Wood, "Put Right Under"].
[66] Biggs, *supra* note 60 at 30.
[67] Mitchison, "Agency, Diversity & Constraints", *supra* note 17 at 130.

> The medicalisation of childbirth refers to the process by which traditional models of woman-to-woman support were replaced with physicians approaching birth as a pathological event that required management and intervention [citations omitted].[68]

This ideological transformation has had a lasting impact, shaping the way Canadians view childbirth care today.[69] However, it is not unchallenged.

There is a documented history of patient dissatisfaction with the "medical model" of childbirth in Canada, particularly in the period immediately following the Second World War, during which time hospital overcrowding, the limited authority of obstetric nurses, and unavailability of trained and licensed midwives combined to create a culture of "managing" birth through the use of anaesthesia and restraints to prevent "'untimely' deliveries beyond physician control."[70] Many Canadians considered the treatment they received in hospitals during their labours and births to be abusive, and began to seek out alternative options for respectful care.[71] The counter to the "medical model" of childbirth is rhetorically styled as the "natural" childbirth movement, which characterizes childbirth as a normal physiological process and "posits women as naturally capable and strong, their bodies perfectly designed to carry a fetus and to give birth successfully without the high-tech surveillance and interventions of physicians in a hospital setting."[72]

The natural birth movement represented a resistance to the increasing use of childbirth "interventions"[73] in medical settings, such as forceps usage, Caesarean section, and (more recently) continuous electronic fetal monitoring.[74] Many birthing people consider "natural" childbirth to be an empowering process, through which they "experience a sense of control and accomplishment that positively informs their sense of self."[75] However, some critics have argued that both the medical and natural childbirth models are problematic in their rigid adherence to their principles, and consequent lack of regard for the actual desires and interests of the birthing person[76]—desires and interests which may change radically during the course of labour and birth.

From the growing "natural" childbirth movement, a new model of midwifery began to take hold in Canada, leading to the regulation of midwifery first in Ontario in 1994,[77] with most other provinces following suit.[78] This movement was "driven by mostly white, educated women who sought more

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[68] Christina Young, "Fading into the woodwork: Doula work and hospital-based practice" (2022) 59 Can Rev of Sociology 395 at 397.
[69] Lisa Jezioranski, "Towards a New Status for the Midwifery Profession in Ontario" (1987) 33 McGill L J 90 at 92.
[70] Wood, "Put Right Under", *supra* note 65 at 797-798.
[71] *Ibid* at 799.
[72] Margaret MacDonald, "Gender Expectations: Natural Bodies and Natural Births in the New Midwifery in Canada" (2006) 20:2 Med Anthropology Quarterly 235 at 236 [MacDonald, "Gender Expectations"].
[73] Margaret MacDonald, "The cultural evolution of natural birth" (2011) 378 The Lancet 394 [MacDonald, "The cultural evolution of natural birth"].
[74] Lauren Jansen et al, "First Do No Harm: Interventions During Childbirth" (2013) 22:2 J Perinatal Education 83 at 84.
[75] MacDonald, "Gender Expectations", *supra* note 72 at 236.
[76] MacDonald, "The cultural evolution of natural birth", *supra* note 73.
[77] Vicki Van Wagner, "Why Legislation?: Using Regulation to Strengthen Midwifery" in Davis Floyd, Bourgeault & Benoit, *supra* note 60, 71.
[78] "Midwifery in Canada: Legal Status," *Canadian Midwifery Regulators Council* (website), online: https://cmrc-ccosf.ca/midwifery-canada#:~:text=Midwifery%20is%20regulated%20in%20Ontario,Reg [“Midwifery in Canada: Legal Status”].

respectful, less invasive, women-centered maternity care."[79] Today, midwifery exists as a self-regulated profession in every province and territory[80] except Prince Edward Island, where the regulation process is ongoing.[81] Midwives complete training through recognized programs at several Canadian universities, write a national accreditation exam, and register to practice with their provincial or territorial regulatory colleges,[82] which define and enforce the relevant standards, scopes of practice, and ongoing training requirements. In this way, midwives provide an alternative care option within the existing medical model, prioritizing "the promotion of normal birth" and with the goal of working "in partnership with women."[83]

More recently, however, dissatisfaction with care options within the medical model of childbirth has contributed to a growing interest in "free birth" or "unassisted home birth," in which people give birth at home without the assistance of trained medical professionals.[84] Stricter rules and fewer choices offered within hospital settings in response to the risk of COVID-19 transmission led to a documented increase in interest in home birth across Canada, both with[85] and without[86] professional medical assistance. Arguably, societal views on home birth have shifted from the periphery to somewhere closer to the mainstream.[87] This context demonstrates a significant public interest in reconceptualizing birth as something other than a matter of medical necessity.

Though alternative birth options (including midwife assistance during home births, and the option to give birth in non-hospital "birthing centres") are available to many Canadians through midwifery services, the current patchwork nature of the midwifery regime makes it difficult for most Canadians to meaningfully access alternative birth care. While midwifery is regulated and publicly funded in all provinces and territories[88] (except Prince Edward Island[89]), availability varies widely by geographical region within each province and territory, as each took different approaches to implementing the

[79] Kellie Thiessen et al, "Delivering Midwifery: A Scoping Review of Employment Models in Canada" 42:1 (2020) J Obstet Gynaecol Can 61 at 61.
[80] "Midwifery in Canada: Legal Status" *supra* note 78.
[81] HealthPEI, "Midwifery Services" (5 December 2022), *Government of Prince Edward Island* (website), online: https://www.princeedwardisland.ca/en/information/health-pei/midwifery-services ["'HealthPEI' Midwifery Services"].
[82] "How to Become a Midwife," *CAM ACSF* (website), online: https://canadianmidwives.org/becoming-a-midwife/.
[83] British Columbia College of Nurses & Midwives, *Midwifery scope and model of practice,* Vancouver: BCCNM 2021 at 1.
[84] Alison Motluk, "Canadian Women Are Giving Birth At Home—Without Maternity Care" *Chatelaine* (3 April 2023); "Why some women are choosing freebirth over hospital delivery rooms" *CBC Radio* (2 January 2019) ["Why some women are choosing freebirth"]; "Pregnant women drawn to 'unassisted childbirth'" *CBC News* (8 April 2011); Sharon Kirkey, "Rise of the 'free birthers': These women are choosing to give birth without medical help—and at least one baby has died" *National Post* (22 November 2018).
[85] Christina Memmott et al, "'Forgotten as first line providers': The experiences of midwives during the COVID-19 pandemic in British Columbia, Canada" (2022) 113 Midwifery 1; Sarah Rudrum, "Pregnancy During the Global COVID-19 Pandemic: Canadian Experiences of Care" (2021) 6: 611324 Frontiers in Sociology 1 at 3; Nicole Crescenzi, "Pregnant in a pandemic: Expectant BC moms change birth plans due to COVID-19" *Surrey Now-Leader* (20 March 2020); Desmond Brown, "Pandemic drives up home birth numbers, highlights sacrifices made by Ontario midwives" *CBC News* (29 December 2022); Colin Perkel, "COVID-19 fears spark increased interest in home births, midwives say" *CBC News* (20 December 2020); Kathleen F Rice & Sarah A Williams, "Making good care essential: The impact of increased obstetric interventions and decreased services during the COVID-19 pandemic" (2022) 35:5 Women and Birth 484.
[86] Nebal Snan, "Expectant mothers consider unassisted childbirth after home births suspended" *The Chronicle Herald* (16 April 2020); Brooklyn Connolly, "When NS shut down home births amid COVID-19, a covert mission began" *CBC News* (30 August 2020).
[87] See, for example: Motluk, *supra* note 84.
[88] "Midwifery in Canada: Legal Status" *supra* note 78; Thiessen, *supra* note 79 at 64; Yukon, News Release, "Midwifery care expanded to Yukoners across the territory" (23 September 2022) ["Midwifery care expanded to Yukoners"].
[89] "'HealthPEI' Midwifery Services," *supra* note 81.

profession.[90] In New Brunswick, for example, midwifery services are only available in Fredericton.[91] Similarly, Newfoundland and Labrador has only one midwifery clinic, located in Gander.[92] In Ontario, pregnant people have the option of giving birth at publicly-funded "birth centres," which feature "large, private" rooms and "special amenities" such as birthing tubs and suspended birth slings. Such centres provide a great option for people who would prefer not to give birth in a hospital, but "aren't sure about a home birth"[93]—but only if they live in Toronto or Ottawa.[94]

Additional factors such as socioeconomic status and culture "have a profound impact in limiting equitable access to quality maternity care, including midwifery services," particularly for Indigenous and marginalized pregnant people.[95] There are few existing programs across Canada aimed at enhancing access to midwifery for marginalized populations, even though "one of the original aims of publicly funding midwifery service across the country was to address access and equity."[96] Moreover, regulatory restrictions on midwives' scope of practice limit the option of midwifery care to people who are experiencing low risk pregnancies and spontaneous vaginal births, meaning many people may only have the option of giving birth in a hospital setting.[97] Lastly, demand for midwifery care significantly exceeds the supply, with the result that many people seeking midwives find themselves on waitlists.[98]

Therefore, while many Canadians may nominally be entitled to publicly funded midwifery care, inequalities in access make a *right* to midwifery care in Canada merely aspirational. The *CHA* has contributed to and perpetuated the "medical model" of childbirth by limiting coverage to hospital-based and physician-provided medical services, thus cementing physician-attended childbirth as a cultural norm.[99]

Security of the person

The *Charter* right to security of the person is also pertinent to the scope and content of the entitlement to publicly provided childbirth care, as it is directly relevant to the state's obligations. As Erdman describes,

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[90] Thiessen, *supra* note 79 at 61.
[91] "Find a midwife" (2021), *Association des sages-femmes du Nouveau Brunswick / New Brunswick Midwives Association* (website), online: https://www.nbmidwives.ca/en/find-a-midwife; Raechel Huizinga, "Unable to meet demand, New Brunswick midwives call for greater access to service" *CBC News* (5 March 2022).
[92] Darrell Roberts, "2 years after first clinic opened, NL midwives and clients say profession has been forgotten" *CBC News* (14 June 2022).
[93] "Why Give Birth at a Birth Centre?" (2023), *Association of Ontario Midwives* (website), online: https://www.ontariomidwives.ca/why-give-birth-birth-centre; "Birth Centres" (23 November 2017), *Ontario Ministry of Health* (website), online: https://www.health.gov.on.ca/en/public/programs/ihf/birthcentres.aspx#:~:text=Births%20at%20the%20birth%20centre,Health%20and%20Long%2DTerm%20Care.
[94] For further discussion of inequalities in maternal health care delivery, see: Emma Knight, "We expect childbirth to hurt, but it should not kill. Canada must do more to reduce maternal deaths", *The Globe and Mail* (8 May 2021).
[95] Laurel Hanson, Deborah Mpofu & Laura Hopkins, "Toward Equity in Access to Midwifery: A Scan of Five Canadian Provinces" 12:2 (2013) Can J Midwifery Research & Practice 8 at 10.
[96] Thiessen, *supra* note 79 at 61.
[97] College of Midwives of Ontario, *Midwifery Scope of Practice,* Toronto: CMO, 2021, at 4.1.
[98] Hanson, Mpofu & Hopkins, *supra* note 95 at 9; Mattison, *supra* note 57 at 2; Laura Beaulne-Steubing, "Call the midwife, get on a waitlist" *University Affairs* (3 March 2021); Erica Natividad, "Demand for midwife care in Ontario high among racialized persons but access is difficult" *CityNews* (10 August 2022).
[99] Karen Born, "Midwifery in Canada," (2003) 7 McGill Med J 71 at 72.

"[t]o provide abortion services, or any other health care service in ways that deny or delay safe access, or otherwise breeds conditions for unsafe access, infringes on the right to security of the person."[100]

The right to security of the person is the primary foundation of the majority's reasoning in *R v Morgentaler*,[101] in which the Supreme Court of Canada struck down the then-existing criminal prohibition on abortion. The criminal law on abortion in place at the time prohibited all abortions, except those performed in a hospital and authorized in advance by a "therapeutic abortion committee." The majority held the infringement to security of the person caused by the regime was twofold: it threatened both the physical health of pregnant people (by delaying their access to treatment) and their psychological health, through factors such as stigma caused by the criminal prohibition, loss of privacy, and "stress and anxiety resulting from a multitude of factors, including possible disruption of family, social life and work, legal costs, [and] uncertainty as to the outcome and sanction."[102]

The right to security of the person also factored prominently in the majority decisions of *Chaoulli v Quebec*[103] and *Carter v Canada (Attorney General)*.[104] *Chaoulli* considered the impact of delays in the public health care system, which led people to seek funding for private health care options through insurance.[105] In her analysis, Deschamps J noted: "Canadian jurisprudence shows support for interpreting the right to security of the person generously in relation to delays."[106] In *Carter*, the Court found that, "by leaving people [experiencing irremediable illness] to endure intolerable suffering," the criminal prohibition on physician-assisted dying impinged on their right to security of the person.[107]

While the right to security of the person does not guarantee a right to state-provided medical care, it is relevant to the content and quality of the care the state elects to provide. In providing medical services related to childbirth, therefore, the state must not deny or delay access, nor otherwise create conditions that result in unsafe access to care.

Entitlement to health care outside the public system

People in Canada are not prohibited from seeking health care outside the public system if provincially or territorially provided health care options do not meet their needs.[108] In *Chaoulli v Quebec*,[109] the Supreme Court of Canada struck down a prohibition in Quebec on private health care insurance on the basis that it infringed the right to security of the person under the Quebec *Charter*. The decision is widely considered

[100] Erdman, "Constitutionalizing Abortion Rights", *supra* note 30 at 260.
[101] *R v Morgentaler,* [1988] 1 SCR 30, 1988 CanLII 90 (SCC) [*Morgentaler* 1988].
[102] *Ibid* at 55.
[103] *Chaoulli, supra* note 44; Erdman, "Constitutionalizing Abortion Rights", *supra* note 30 at 249.
[104] *Carter, supra* note 4 at para 66.
[105] *Chaoulli, supra* note 44 at para 111.
[106] *Ibid* at para 43.
[107] *Carter, supra* note 4 at para 66.
[108] *Chaoulli, supra* note 44 at para 106.
[109] *Chaoulli, supra* note 44.

to expand the potential for private health care in Canada.[110] Therefore, it is important to note that Canadians are free to seek out private health care options as part of their pregnancy and childbirth care.

One such example is doula care. Doulas are "persons who support women during pregnancy and childbirth."[111] They do not provide medical advice, but offer "emotional support," "physical support" in the form of comfort measures such as massage, "informational support" in the form of education, and "advocacy," by supporting their clients in conveying their wishes during labour and childbirth.[112] They may be hired privately by birthing people for assistance during births both within the conventional, hospital-based model, as well as in midwife-attended births. Though doula training programs exist throughout the country,[113] the profession is presently unregulated in Canada.[114]

The positive benefits and cost effectiveness of professional doula accompaniment during labour are well-established in both physician- and midwife-assisted births.[115] Systematic reviews have demonstrated that birthing people with continuous support during labour "had higher rates of spontaneous vaginal birth and lower odds of cesarean birth, lower rates of regional anesthesia (such as epidural), lower rates of assisted vaginal birth (such as forceps, vacuum), shorter labors, and higher levels of satisfaction" as compared to birthing people with intermittent support.[116] However, doula services are not covered by any provincial or territorial health plan.[117] The cost of trained doula accompaniment during labour varies in Canada, but basic birth support "packages" typically start at around $1,000.[118] While some providers offer sliding scale fee models or *pro bono* services,[119] the benefits of doula accompaniment are largely reserved for people who have the financial means, education, and ability to seek out and hire doulas to assist them in their pregnancies, labours, and post-partum periods.

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[110] Erdman, "Constitutionalizing Abortion Rights", *supra* note 30 at 249; "*Chaoulli* decision resonates one year later," (2006) 175:1 CMAJ 17.
[111] C Young, *supra* note 68 at 396.
[112] Sandra L Meadow, "Defining the doula's role: fostering relational autonomy" (2014) 18 Health Expectations 3057 at 3058.
[113] See, for example: "Certification Courses & Tuition Fees," *Doula Canada* (website), online: https://doulatraining.ca/; "About Us," *Doula School* (website), online: https://doulaschool.ca/about-us/; "Doula Studies," *Fanshawe College* (website), online: https://www.fanshawec.ca/programs/dla1-doula-studies/next.
[114] Carmen Wong, "Guelph woman calls for fraud training in doula programs after falling victim to province-wide doula fraud" *CTV News* (16 March 2023).
[115] Laura Lucas and Erin Wright, "Attitudes of Physicians, Midwives, and Nurses About Doulas: A Scoping Review" (2019) 44:1 Am J Maternal/Child Nursing" 33 at 34; Kenneth J Gruber, Susan H Cupito & Christina F Dobson, "Impacts of Doulas on Healthy Birth Outcomes" (2013) 22:1 J Perinatal Education 49; Meghan A Bohren et al, "Continuous support for women during childbirth" (2017) 7 Cochrane Database Syst Rev 1; Tara Halle, "What Is a Doula? And Do You Need One?", *The New York Times* (15 April 2020).
[116] Gillian Hanley & Lily Lee, "An Economic Model of Professional Doula Support in Labor in British Columbia, Canada" (2017) 62:5 J Midwifery & Women's Health 607.
[117] *Ibid*. See also: Wendy Glauser & Irfan Dhalla, "Birth doulas: The benefits and the tensions" (11 June 2015), *Healthy Debate* (blog).
[118] See, for example: "Doula FAQs," *Doula Services Association of BC* (website), online: http://www.bcdoulas.org/doulafaqs.html; "Frequently Asked Questions," *Calgary Doula Association* (website), online: https://www.calgarydoulas.ca/faqs.
[119] "Doulas and Support During Childbirth" (19 January 2023), *HealthLinkBC* (website), online: https://www.healthlinkbc.ca/pregnancy-parenting/labour-and-birth/planning-your-delivery/doulas-and-support-during-childbirth; "Doulas and Support During Childbirth" (23 February 2022), *MyHealth.Alberta.ca* (website), online: https://myhealth.alberta.ca/Health/Pages/conditions.aspx?hwid=tn9822.

What are birthing people entitled to ask of their care providers?

The question of entitlement to childbirth care also necessitates discussion of the individuals providing such care, and what birthing people are entitled to ask of them. Physicians, midwives, and other clinical care providers may experience conflict between their own values, ethical obligations, clinical judgment, and the wishes of their patient.[120] Perhaps the most well-known example of such ethical conflict is the issue of blood transfusions for Jehovah's Witnesses. Adherents to the Jehovah's Witness faith refuse transfusion of whole blood or its major components, based on their interpretation of scripture and teachings.[121] Because physicians are trained to "First do no harm," patient refusal of life-saving treatment may be distressing to doctors whose beliefs or views do not align with those of their patient.[122] Nonetheless, the law is well-settled in this respect: a competent person is entitled to make medical decisions pertaining to their own body, "even if harmful consequences may result and even if the decision is generally regarded as foolhardy."[123] This right to medical self-determination (discussed further below) may be considered negative in nature, in that it serves to protect an individual from interference with their bodily integrity—for example, the right to be free from an unwanted blood transfusion. However, as these rights are navigated in everyday clinical practice, they gain new meaning and content.

In clinical care provider-patient interactions, needs and interests are navigated with regard to the goals of the patient and resources available, and not simply as a matter of obedience to established law. For example, the *Charter* right to medical self-determination applied in the context of patient care for a member of the Jehovah's Witnesses may simply require that a physician respect the patient's stated wish not to receive a blood transfusion. In practice, however, physicians will likely take positive steps to adjust their care plans (such as by reducing the frequency or volume of otherwise standard blood draws)[124] or seek out alternative care options to meet the patient's needs (such as offering synthetic blood products that are acceptable according to the individual's faith,)[125] in accordance with established hospital standards.[126] In the context of childbirth, leading clinical guidance suggests care providers who know their pregnant patients would not accept blood products consider referring their patients "to a center that routinely cares for patients

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[120] Atul Gawande, "Whose Body is it Anyway?" in *Complications* (London: Profile Books, 2002) 208; Bernard M Dickens, "Conscientious objection and the duty to refer" (2021) 155:3 Int J Gynecology & Obstetrics 556 [Dickens, "Conscientious Objection"]; Andrew Kotaska, "Informed consent and refusal in obstetrics: A practical ethical guide" (2017) 44 Birth 195 [Kotaska, "Informed consent and refusal"].
[121] The Hospital for Sick Children, *Guideline: Jehovah's Witnesses and Blood Products,* version 2, Toronto: SickKids 2021 ["Sick Kids Guideline"]; K Sazama, "The ethics of blood management" (2007) 92 Vox Sanguinis 95 at 98.
[122] Sazama, *supra* note 121 at 98; Daphne Gilbert, "Let Thy Conscience Be Thy Guide (But Not *My* Guide): Physicians and the Duty to Refer" (2017) 10:2 McGill JL & Health 47 at 88, footnote 115.
[123] *Malette, supra* note 5 at para 25, affirmed in *Carter, supra* note 4 at para 67.
[124] Kendall P Crookston, "Approach to the patient who declines blood transfusion" (7 March 2023) *UpToDate* at 10, online: https://www.uptodate.com/contents/approach-to-the-patient-who-declines-blood-transfusion.
[125] Sazama, *supra* note 121 at 99; Canadian Medical Association Expert Working Group, "Guidelines for red blood cell and plasma transfusion for adults and children" (1997) 156 Can Med Assoc J S1 at S5.
[126] See, for example: SickKids Guideline, *supra* note 121; "Blood Refusal – Management of" (October 2017), *Department of Health Victoria* (website), online: https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/r/rch-management-of-blood-refusal--pdf.pdf.

who do not accept transfusions, especially if there is any doubt as to whether the procedure may be performed safely without blood."[127] The content of the right is, therefore, developed through practice, which, over time, informs the relevant standard of care. Hospital guidelines, policies, and everyday patient-provider interactions influence what an individual is entitled to ask for from their clinical care provider, beyond the principles of governing case law.

Another example of practice-based expansion of rights entitlement is the emerging standard of "effective referral." It remains ethically challenging to navigate the autonomy interests of both patients and providers in the clinical setting. From this mire, ethical guidance regarding the concept of "conscientious objection" has emerged in recent years, requiring care providers in provinces throughout Canada to make an "effective referral" if their religious beliefs or convictions preclude them from providing requested care.

In practice, this means that physicians who object to participating in a particular medical procedure (such as abortion, assisted death, and gender affirming care) may refuse to do so, but must make an effective transfer of the patient's care to another care provider, who is willing and able to provide the care requested.[128] In effect, the policies mean physicians "can object to 'hands-on' conduct of procedures they find objectionable, but cannot deny referral on the grounds of complicity in what other care providers do."[129] In Ontario, for example, College of Physicians and Surgeons of Ontario (CPSO) Policy states that "physicians must not end the physician-patient relationship solely because the patient wishes to explore a care option that conflicts with the physician's conscience or religious beliefs."[130] Failure to adhere to such policies may lead to professional discipline by regulatory bodies.[131]

In *Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario*,[132] the Ontario Court of Appeal (ONCA) considered the constitutional validity of the CPSO policies requiring physicians to provide an effective referral to another care provider in the event of "conscientious objection" on the part of the physician. The ONCA upheld the divisional court's decision finding the policies violated section 2(a) of the *Charter*, but that the violation was justified under section 1 of the

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[127] Crookston, *supra* note 124.

[128] See, for example: College of Physicians and Surgeons of Ontario, *Human Rights in the Provision of Health Services* (Toronto: CPSO, 2023) ["CPSO Human Rights Policy"]; College of Physicians and Surgeons of Ontario, "Advice to the Profession: Human Rights in the Provision of Health Services" online: https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies/Human-Rights-in-the-Provision-of-Health-Services/Advice-to-the-Profession-Human-Rights ["Advice to the Profession"]; College of Physicians and Surgeons of British Columbia, *Practice Standard: Access to Medical Care Without Discrimination*, Vancouver: CPSBC, 2023 ["CPSBC Practice Standard: Medical Care Without Discrimination"]; College of Physicians & Surgeons of Nova Scotia, *Professional Standard Regarding Transfer of Care*, Halifax: CPSNS, 2016 and College of Physicians & Surgeons of Nova Scotia, P*rofessional Standard Regarding Medical Assistance in Dying (MAiD),* Halifax: CPSNS, 2021; College of Physicians and Surgeons of New Brunswick, *Moral Factors and Medical Care*, Rothesay: CPSNB, 2017, online: https://cpsnb.org/en/medical-act-regulations-and-guidelines/guidelines/445-moral-factors-and-medical-care; College of Physicians and Surgeons of Prince Edward Island, *Policy on Conscientious Objection to Provision of Service,* Charlottetown: CPSPEI, 2019, online: https://www.cpspei.ca/wp-content/uploads/2019/12/Conscientious-Objection-to-Provision-of-Service-Nov-2019.pdf; College of Physicians and Surgeons of Saskatchewan, *POLICY – Conscientious Objection*, Saskatoon: CPSS: 2020), online: https://www.cps.sk.ca/imis/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/Conscientious_Objection.aspx.

[129] Dickens, "Conscientious Objection", *supra* note 120 at 556.

[130] "Advice to the Profession", *supra* note 128.

[131] *Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario,* 2019 ONCA 393 at para 17.

[132] *Ibid*.

Charter.[133] The policies in issue were determined to be "prescribed by law," as they were enacted by the College pursuant to its legislative authority, in the performance of an activity that was governmental in nature.[134] The Ontario Court of Appeal explained:

> The Policies are not "regulations", nor are they a "code, standard or guideline relating to standards of practice of the profession" […] However, the Policies establish expectations of physicians' behaviour and are "intended to have normative force."[135]

It is not through legislation or case law that the right to an effective referral has crystallized, but, rather, through negotiation at the patient-provider level, which informs professional standards and influences the development of guidance, norms, and policies. In this way, effective referral policies provide an example of the ways in which everyday patient-provider interactions shape the content of legal rights, beyond doctrinal law.

In situations short of conscientious objection, uncertainty remains regarding appropriate responses from clinical care providers when patients make "special requests."[136] I have grouped such requests into five main categories, which I discuss using examples specific to childbirth: (i) requests based on protected grounds; (ii) resource-related requests; (iii) requests that bear on the rights or interests of others; (iv) illegal requests; and, (v) other requests to deviate from standard practice.

Requests falling into the first category include accommodations for patient needs that are based on protected grounds under provincial human rights legislation. Such a request may include, for example, a pregnant Muslim woman who requests female care providers for reasons of religious modesty.[137] In the disability context, a pregnant wheelchair user may require accommodations to clinical equipment, such accessible scales for routine weighing during prenatal care, height adjustable examination tables to facilitate ease of transfer, or a bassinet with side access to allow them to pick up their baby without assistance.[138] Accommodation to the point of undue hardship will typically be required in such situations.[139]

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[133] *Ibid*.
[134] *Ibid* at para 99.
[135] *Ibid* at paras 16-17.
[136] "When patients make special requests, how should you respond?" (February 2021), *The Canadian Medical Protective Association* (webpage), online: https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2019/when-patients-make-special-requests-how-should-you-respond ["When patients make special requests"]; Jacob A Blythe and Farr A Curlin, "How Should Physicians Respond to Patient Requests for Religious Concordance?" (2019) 21:6 AMA J of Ethics E485.
[137] This issue is discussed further below, in the context of the right to dignity in health care. In addition, I note the CPSO updated its policy *Human Rights in the Provision of Health Services* in September 2023 to require physicians to take reasonable steps to accommodate good faith requests to receive care from a physician with a particular identity ("CPSO Human Rights Policy", *supra* note 128).
[138] Amanda Blair et al, "Access to, and experiences of, maternity care for women with physical disabilities: A scoping review" (2022) 107:103273 Midwifery 1 at 8; Jenny Hall et al, "Dignity and respect during pregnancy and childbirth: a survey of the experience of disabled women" (2018) 18:328 BMC Pregnancy and Childbirth 1 at 8; Elaine M Carty, "Disability and childbirth: meeting the challenges" (1998) 159 CMAJ 363 at 367-368.
[139] "When patients make special requests", *supra* note 136. I note the irony of the use of the term "special request" in professional guidance to Canadian physicians, as these examples describe situations involving necessary rights-based accommodations. Health care providers are professionally obligated to comply with provincial human rights legislation in the provision of care. See, for example: "CPSO Human Rights Policy", *supra* note 128; College of Physicians & Surgeons of Nova Scotia, *Obligations for Services for Patients,* Halifax: CPSNS, 2022; "CPSBC Practice Standard: Medical Care Without Discrimination", *supra* note 128.

Other requests may be based on interests, motivations, or goals other than religious or deeply held beliefs. The right to medical self-determination is not limited to decisions based on religious belief, or on any other protected ground.[140] Some of these requests may be rejected chiefly on resource considerations.[141] For example, a labouring patient who requests an exercise ball to sit on in a hospital setting may be provided one or not, depending on whether the hospital has enough exercise balls for everyone who wants one.

Some requests may be difficult or impossible to fulfill in full, because of the implications for the rights or interests of others. For example, labouring and giving birth in bathtubs is a popular option for childbirth, especially for people who choose to give birth without an epidural. At the hospital where I gave birth, there were bathtubs available in each birthing suite, and birthing people were encouraged to labour in the water if they wished. However, labouring people were required to exit the bathtubs prior to giving birth, because the areas surrounding the bathtubs did not have adequate non-slip infrastructure to provide a safe working space for clinical care providers. Another example is the recent "suspension" of gas and air, a popular option for pain relief during labour, in several hospitals in the United Kingdom due to concerns about unsafe levels of nitrous oxide in the air posing potential health risks to hospital staff.[142] Similar considerations apply to limits on the number of people who can be present in a delivery room, which led to tension and frustration during COVID-19 related lockdowns.[143] Consistent with guidance provided by their professional organizations, care providers may withdraw from the provision of care if they believe continuing to care for a patient would place themselves or their patient(s) at an "unacceptable level of risk," such as situations involving violence, risk of infection or transmission of disease, or physical, verbal, or sexual abuse.[144]

Some patient requests may be impossible for providers to fulfil due to illegality. The Supreme Court of Canada explained in *Rodriguez v British Columbia*:

> [T]he scope of self-determination with respect to bodily integrity in our society is never absolute. While there may be no limitations on the treatments to which a patient may refuse or discontinue, there are always limits on the treatment which a patient may demand, and to which the patient will be legally permitted to consent.[145]

[140] *Lewis v Alberta Health Services,* 2022 ABCA 359.
[141] *Ibid*.
[142] Gaby Hinsliff, "'I kept begging for pain relief': the women forced to give birth without gas and air" *The Guardian* (16 March 2023); Anna Bawden, "Essex hospital pulls gas and air for pregnant women amid concerns for staff" *The Guardian* (25 January 2023).
[143] Dakshana Bascaramurty, "For women waiting to give birth COVID-19 adds several other issues to worry about" *The Globe and Mail* (5 April 2020); Christopher Connors, "Pregnant pause: COVID-19 delivery room limits raise concerns in Nova Scotia" (7 January 2022).
[144] See, for example: British Columbia College of Nurses & Midwives, *Duty to Provide Care: Practice Standard for Nurse Practitioners*, Vancouver: BCCN&M; College of Nurses of Ontario, *Practice Guideline: Refusing Assignments and Discontinuing Nursing Services*, Toronto: CNO 2017; College of Licensed Practical Nurses of Manitoba, College of Registered Nurses of Manitoba & College of Registered Psychiatric Nurses of Manitoba, *Duty to Provide Care*, Winnipeg: CLPNM, CRNM & CRPNM 2019; Nurses Association of New Brunswick, *Practice Guideline: Duty to Provide Care*, Fredericton: NANB/AIINB 2020.
[145] *Rodriguez v British Columbia (Attorney General*), 1993 CanLII 75 (SCC), [1993] 3 SCR 519, decision overruled in *Carter*, *supra* note 4, but not on this point.

In the childbirth context, for example, a labouring patient would not be entitled to request (or "demand") care providers administer or otherwise provide them with prohibited substances for purposes of pain relief during childbirth.

The final category is less clearcut. It includes situations where patients make requests for care that deviate from standard clinical practice, such as requests for elective Caesarean sections,[146] or requests for "lotus birth" (the practice of leaving the umbilical cord connected to the placenta after birth and allowing it to detach naturally, instead of cutting it).[147] In situations where clinical guidance does not dictate a definitive approach, the care provider has significant say in the outcome of a birthing person's requests—and, by extension, in the realization of an individual's right to medical self-determination.[148]

The framework of duties and liabilities relevant to doctors and other care providers bears heavily on the content of birthing people's legal rights, in terms of the scope of what, exactly, patients are entitled to ask for from their doctors. Such entitlement is not static, but subject to continual evolution as it is navigated and negotiated amidst the realities of everyday state, provider, and patient interactions.

2.2 The right to medical self-determination

Erdman argues "[constitutional] rights carry multiple meanings, some dominant and others marginal, and […] this mix of meaning changes over time."[149] The right to medical self-determination encompasses multiple distinct rights deeply important to childbirth, which shift and volley in prominence depending on health care trends, conditions, and patient interests. This section provides an overview of the elements of medical self-determination most relevant to childbirth today: the right to make decisions about one's own medical treatment; the right to informed consent; and the right to dignity.

The right to make decisions about your own health care

The Supreme Court of Canada's decision in *Carter* represents a strong endorsement of the right to autonomy in personal health care decision-making, reaffirming decades of protections for the right to

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[146] The question of entitlement to non-medically indicated elective Caesarean sections is discussed in detail below.
[147] Kimberly Monroe & Maria S Skoczylas, "When parents say 'no' to newborn nursery protocols" *Contemporary Pediatrics* (1 January 2018).
[148] Regarding elective Caesarean sections, see: Eman Alsayegh et al, "SOGC Committee Opinion: No 361-Caesarean Delivery on Maternal Request" (2018) 40:7 J Obstet Gynaecol Can 967 ["SOGC Committee Opinion No 361"], which directs:

> After exploring the reasons behind the patient's request, and discussing the risks and benefits, if a patient insists on her choice a physician may pursue one of the following two options: 1) Agree to perform the CS after 39+0 weeks gestation; 2) Disagree and refer the patient for a second opinion.

See also: Pauline McDonagh Hull & Bonnie Lashewicz, "Requests for caesarean birth brushed aside, despite guidelines to respect maternal choices" *UCalgary News* (25 June 2021); Sharon Kirkey, "C-sections on demand: Doctors say pregnant women don't need a valid medical reason to avoid labour" *National Post* (26 June 2018). Regarding requests for lotus birth, see, for example: D Ann Noseworthy, Suzanne R Phibbs & Cheryl A Benn, "Towards a relational model of decision-making in midwifery care" (2013) 29 Midwifery e42 at e46: "Her plan for a lotus birth and tying the cord with flax did not happen as staff declined the request."
[149] Erdman, "Constitutionalizing Abortion Rights", *supra* note 30 at 227.

medical self-determination.[150] The Court's decision unanimously endorsed the "tenacious relevance in our legal system of the principle that competent individuals are—and should be—free to make decisions about their bodily integrity."[151] The Court described this right to "decide one's own fate" as grounded in section 7 of the *Charter*.[152]

The right to medical self-determination extends to protect decisions that others might deem foolish or ill-advised, including the right to decline potentially life-saving medical treatment.[153] In *Starson v Swayze,* a key decision on involuntary treatment, the majority adopted the comments of Justice Quinn of the Ontario Superior Court in *Koch (Re)*, stating: "The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake."[154] Justice Wilson explores this principle in detail in her reasons in *Morgentaler*, in which she quotes philosopher John Stuart Mill: "Liberty in a free and democratic society does not require the state to approve the personal decisions made by its citizens; it does, however, require the state to respect them."[155] More recently, the Alberta Court of Appeal described: "As an aspect of medical self-determination, it is well understood that a patient's decisions can result in serious risks or consequences, including death."[156]

In the Canadian childbirth context, a key element of the right to personal health care decision-making is the fact that a fetus is not a legal person until it is born alive.[157] Until it is born alive, a fetus is *part of* the birthing person's body and that person has complete control and direction over their body, including control over the decision to induce an abortion at any point in pregnancy.[158] The law recognizes

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[150] *Carter, supra* note 4 at para 67.
[151] *Ibid*, citing *AC v Manitoba (Director of Child and Family Services),* 2009 SCC 30 at para 39 [*AC v Manitoba*].
[152] *Carter, supra* note 4 at para 67.
[153] *Fleming v Reid* (1991), 1991 CanLII 2728 (ONCA), 4 OR (3d) 74 (CA) [*Fleming*], *B(R) v Children's Aid Society of Metropolitan Toronto,* 1995 CanLII 115 (SCC), [1995] 1 SCR 315 [*B(R) v Children's Aid Society*]; *Malette, supra* note 5; *Carter, supra* note 4.
[154] *Starson v Swayze,* 2003 SCC 32 at para 76 [*Starson*], citing *Koch (Re),* 1997 CanLII 12138 (ONSC).
[155] *Morgentaler* 1988, *supra* note 101 at 167.
[156] *Lewis*, *supra* note 140 at para 47.
[157] *Criminal Code,* RSC 1985, c C-46, s 223(1); *Winnipeg Child and Family Services (Northwest Area) v G (DF)*, [1997] 3 SCR 925 [*Winnipeg Child and Family Services*]; *Dobson, supra* note 1; *R v Sullivan, supra* note 1.
[158] *R v Levkovic,* 2013 SCC 25; *R v Levkovic,* 2014 ONSC 5544. The English Court of Appeal has articulated this principle explicitly, stating in *Re MB (Medical Treatment),* [1997] EWCA Civ 3093 at para 30:

> [A] competent woman who has the capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death.

Though there is no law in Canada prohibiting abortion later in pregnancy (including self-induced abortions using medication, herbs, or homemade suction devices), surgical abortions may be difficult or impossible for many pregnant people to obtain later in pregnancy. The following information was compiled by the author and Jennifer Taylor through unpublished interviews with obstetricians Dr. Melissa Brooks and Dr. Jocelyn Stairs, conducted in November 2020:

> Later surgical abortions are more complex to perform and require training, equipment, and resources that may not be available at all health care facilities. As a result, hospitals and care providers set individual policies regarding when they are willing to perform "social abortions"—elective abortions carried out for non-medical reasons. For example, throughout Nova Scotia, surgical abortion is available without a medical indication up to 16 weeks' gestation. In parts of Ontario, surgical abortion is available without a medical indication up to 24 weeks' gestation. Pregnant people from other provinces may be referred to care providers in Ontario for care later in their pregnancies. After 23 weeks' and 6 days' gestation, pregnant people seeking surgical abortions may be referred to clinics in the United States.

the "primacy of maternal autonomy concerning choices made regarding pre-conception and pre-natal medical treatment."[159] As a result, birthing people are immune from criminal and civil liability respecting action or inaction resulting in injury sustained by the fetus during pregnancy.[160] This doctrine is integral to rights protections for abortion in Canada and, despite legislative efforts by conservative politicians, has remained constant for decades.[161]

The right to medical self-determination—for all its "tenacious relevance"[162]—is constrained during childbirth in two key respects: first, by the care providers' duty to and interest in preserving the health of the fetus; and second, by the pregnant person's own interest in the well-being of their unborn child. I consider each of these factors in turn.

First, Canadian law has long recognized "that an infant, once born alive, may sue for damages sustained as a result of the negligence of health care providers during labour and delivery."[163] Thus, care providers such as physicians, midwives, and nurses owe a duty of care to both the pregnant or birthing person and to the fetus with respect to their conduct during the process of childbirth.[164] Though legal commentators have raised concerns that the point in time at which the duty crystallizes is unclear,[165] the duty is well-entrenched in Canadian law. It provides a route for infants injured during childbirth to recover against negligent care providers, which is especially important in light of the doctrine of maternal immunity. Health law scholars Alana Cattapan, Roxanne Mykitiuk and Mark Pioro explain:

> Recognizing the pre-eminence of the right to reproductive autonomy, the Supreme Court of Canada has refused to permit claims of prenatal harm brought by a child, once born, against his or her mother.[166]

Surgical abortion is available throughout Canada at any time in the case of medical indications for the pregnant person and/or the fetus, such as fetal anomalies. Termination later in pregnancy is site-dependent and generally not codified; it involves the exercise of clinical judgment within multi-disciplinary care teams. (See: Canadian Medical Association, Policy Summary, "Induced Abortion" (1988), online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1268491/pdf/cmaj00181-0059.pdf: "Elective termination of pregnancy after fetal viability may be indicated under exceptional circumstances.") For this reason, what is considered to be a medically-indicated abortion after 16 weeks' gestation varies by jurisdiction and by health care facility.

[159] *Liebig v Guelph General Hospital,* 2010 ONCA 450 at para 18 [*Liebig*], citing *Winnipeg Child and Family Services, supra* note 157 at paras 37-39.
[160] *Dobson, supra* note 1.
[161] There have been a series of Conservative bills before Parliament seeking to enhance the rights of the fetus using the criminal law, notably: Bill C-484 ("Cassie and Molly's law") and Bill C-291 (Canada, Bill C-484, *An Act to amend the Criminal Code (injuring or causing the death of a preborn child while committing an offence),* 1st Sess, 42nd Parl, 2016 (defeated at second reading in the House of Commons 19 October 2016); Canada, Bill C-291, *An Act to amend the Criminal Code (injuring or causing the death of a child before or during its birth while committing an offence)* 1st Sess, 39th Parl, 2006 (not proceeded with by the House of Commons 14 June 2006). No such bill has become law, and it remains a "general proposition that the law of Canada does not recognize the unborn child as a legal or judicial person" (*Winnipeg Child and Family Services, supra* note 157 at para 11.)
[162] *Carter, supra* note 4 at para 67, citing *AC v Manitoba*, *supra* note 151 at para 39.
[163] *Liebig, supra* note 159 at para 6, citing *Crawford v Penney*, 2003 CanLII 32636 (ON SC) at para 210, aff'd *Crawford v Penney,* 2004 CanLII 22314 (ON CA), 26 CCLT (3d) 246; *Commisso (Guardian of) v. North York Branson Hospital*, 2003 CanLII 48421 (ON CA), 48 OR (3d) 484 (CA) at para 23.
[164] *Liebig, supra* note 159 at para 6, affirmed in *Florence v Benzaquen,* 2021 ONCA 523, leave to appeal refused, [2021] SCCA No 335.
[165] See, for example: Erin L Nelson, "Prenatal Harm and the Duty of Care" (2016) 53:4 Alta L Rev 933 at 940 [Nelson, "Prenatal Harm and the Duty of Care"]; Erin Nelson, *Law, Policy and Reproductive Autonomy* (Portland: Hart Publishing 2013) at 205-234.
[166] Alana Cattapan, Roxanne Mykitiuk & Mark Pioro, "Notions of Reproductive Harm in Canadian Law: Addressing Exposures to Household Chemicals as Reproductive Torts" (2015) 1 CJCCL 79 at 134.

As a result, infants who sustain injuries during labour and childbirth cannot take legal action against their birth parents, making claims against care providers the most obvious form of recourse. Given the often-catastrophic nature of such injuries and the extent of resulting care needs,[167] successful medical negligence claims in the Canadian obstetrics context often result in significant payouts.[168]

Against this backdrop, care providers may be understandably hesitant to deviate from conventional recommendations in clinical care delivery. However, a claim of provider negligence resulting in harm to a fetus during pregnancy or childbirth is not decided by the existence of a duty of care alone—once a duty is established, the care provider's actions will be assessed according to the relevant *standard* of care, which does not require perfection. Nelson describes:

> A physician owes a duty to his or her patient to exercise reasonable care and skill 'in all that is done to and for the patient.' The duty requires reasonableness, not perfection, on the part of the physician. […] It does not require the physician to guarantee an optimal outcome for the patient; as with all defendants, the expectation is that the physician act reasonably with regard to the interests of those to whom he or she owes a duty of care. If a duty of care is owed to a future child, the duty will be framed in the same terms as that owed to the female patient: as an obligation to exercise reasonable care and skill in all that is done to and for the patient. […][169]

Given the health care provider's duty to both the birthing person and the fetus, there will inevitably be situations in which a provider "will feel conflicted in his or her ability to look after the best interests of both the woman and her future child."[170] However, as Nelson argues, the inability to reconcile the sometimes-competing interests of the birthing person and the fetus "is a result of biological reality, not the existence (or lack thereof) of tort duties—whether or not a duty is owed, there will be cases in which the competing interests cannot be reconciled."[171] Such cases include situations where, as a result of the "biological reality" of pregnancy, a care provider cannot intervene in the interests of the fetus without infringing on the autonomy of the pregnant person.

Perhaps the most acute example of this "biological reality" occurs when an emergency Caesarean section is indicated to save the life of the fetus, and the birthing person refuses. Canadian courts have recognized that they have no jurisdiction to compel a competent pregnant person to undergo medical treatment for the benefit or protection of their unborn child.[172] If intervening in the interest of the fetus is not possible without interfering with the pregnant person's bodily integrity (for instance, through a

[167] Robert Cribb et al, "The high cost of OB/GYN mistakes in Ontario" *Toronto Star* (28 November 2015); Jack Julian, "Antigonish boy, 7, receives $6M settlement for brain damage at birth" *CBC News* (25 June 2018).
[168] Roberta Cardoso et al, "Evaluative reports on medical malpractice policies in obstetrics: a rapid scoping review" (2017) 6:181 Systematic Reviews 1 at 2; Sharon Kirkey, "Millions paid to Canadian families for 'catastrophic' baby deliveries, malpractice insurer finds" *National Post* (15 September 2016).
[169] Nelson, "Prenatal Harm and the Duty of Care", *supra* note 165 at 941.
[170] *Ibid* at 940.
[171] *Ibid* at 941.
[172] *Winnipeg Child and Family Services, supra* note 157 at paras 49-57. See also: Nelson, *Law, Policy and Reproductive Autonomy, supra* note 165 at 188-189, discussing *Baby R, Re*, 30 BCLR (2d) 237, 53 DLR (4th) 69 (1988) (BCSC) and *A (in utero) (Re) (UFC),* 1990 CanLII 6702 (ONSC).

compelled Caesarean section), biological reality precludes care providers from intervening. As legal scholar Camilla Pickles states: "Women and their bodies cannot be bypassed, ignored or made invisible: They are essentially a *sine qua non* for the existence of prenatal life."[173]

A care provider will meet the relevant standard of care if they inform the birthing person of the risks of refusing the surgery and take steps to mitigate the risk, if any exist and subject to the consent of the birthing person. Nelson describes:

> [As] explained by Justice Holmes of the British Columbia Supreme Court, to the extent that a conflict of interests exists, "it is answered by the simple reality that mothers make decisions — both as to medical care and in other areas — for their unborn children. As to the conflict of interests (mother's versus unborn child's) implicated in that decision, it is for the mother, and not the physician, to resolve."
>
> Provided that the physician appropriately informs the woman about the benefits and risks of a proposed treatment to her and to the fetus or future child, and presents her with all of her options and their potential prognoses, the physician will have discharged his or her duty to both.[174]

Misconceptions about the scope of their authority, duties, and the relevant standard of care in such situations may lead health care providers to mistakenly believe they are required to take all action necessary to ensure the health of the unborn child. However, as obstetrician and researcher Andrew Kotaska explains: "Neither medical professionals nor the State have ethical or legal authority over a woman based on the presumption that they care more for her fetus than she does."[175] Such misconceptions are likely driven in part by care providers' child welfare obligations, which crystallize once a child is born.

Once a child is born alive,[176] health care providers are "legally required to report immediately and directly to child protective services when a child has experienced, or is at risk of experiencing, harm from a caregiver's action or inaction" in the context of medical care.[177] In some cases, a child may be apprehended by the state for the purpose of administering lifesaving treatment, contrary to the wishes of the child's parent.[178] However, until such time as a child is born alive, the physician's legal obligations to the fetus will be satisfied by taking prudent care to inform the birthing person of the risks and benefits of the various care options available to them, whether or not the pregnant person follows the care provider's advice.[179]

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[173] Camilla Pickles, "Approaches to pregnancy under the law: a relational response to the current South African position and recent academic trends" (2014) 47:1 De Jure 20 at 35-36.
[174] Nelson, "Prenatal Harm and the Duty of Care", *supra* note 165 at 943.
[175] Kotaska, "Informed consent and refusal", *supra* note 120 at 195.
[176] This crystallization of rights is spelled out with precision in the *Criminal Code*, which provides at section 223(1):

> A child becomes a human being within the meaning of this *Act* when it has completely proceeded, in a living state, from the body of its mother, whether or not (a) it has breathed; (b) it has an independent circulation; or (c) the navel string is severed.

[177] Canadian Paediatric Society, Position Statement, "Medical neglect: Working with children, youth, and families" (23 September 2022), online: https://cps.ca/en/documents/position/medical-neglect ["CPS Position Statement: Medical Neglect"].
[178] *Ibid*.
[179] Nelson, "Prenatal Harm and the Duty of Care", *supra* note 165 at 944.

A pregnant person's refusal to consent to a procedure may be overruled in very limited circumstances, including where the person lacks capacity to make medical decisions,[180] or in emergency situations in which the pregnant person is incapacitated.[181] Consent to medical treatment in emergency situations may only be presumed when care must be administered urgently, the wishes of the patient are unknown or not known to be inconsistent with the proposed treatment, and there is no possibility of consultation with a substitute decision maker.[182] Legal scholars Bernard Dickens and Rebecca Cook explain "implied consent" only applies to interventions that are necessary, not "merely convenient": "The law regarding medical necessity requires a genuine perception of emergency, and a reasonable response."[183] Finally, where a competent pregnant person refuses a treatment or intervention, their refusal must be respected, even if they have not been fully informed of the risks and benefits; there is no requirement for "informed refusal" in Canadian law.[184]

While patient refusal may be relatively straightforward in legal terms, both patients and care providers describe it as challenging to navigate.[185] Kotaska explains that when a birthing person "declines recommended treatment or requests treatment that a clinician believes is unsafe," differing values and priorities between birthing people and their providers can result in conflict, which "can impede communication, compromise care, and contribute to poor outcomes."[186]

In particular, care providers may be motivated by their own perception or understanding of their legal duties, which may not reflect legal reality. Kotaska explains that "[b]y accepting a woman's refusal, caregivers commonly believe they incur ethical and legal liability."[187] Health care providers' perception of risk of liability has significant implications for patient care and experience. In response to believed legal or ethical risk, Kotaska explains care providers "may withdraw care or coerce women to accept intervention."[188] Such action may be driven by many factors, including hospital policies,[189] professional

[180] *Starson, supra* note 154; *Malette*, *supra* note 5; "Is this patient capable of consenting?" (March 2021) *CMPA* (website), online: https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2011/is-this-patient-capable-of-consenting.
[181] *Malette, supra* note 5 at para 20; Bernard M Dickens & Rebecca J Cook, "Types of consent in reproductive health care" (2015) 128 Int J Gynecology & Obstetrics 181 at 182.
[182] *Malette, supra* note 5 at para 20; Dickens & Cook, *supra* note 181 at 182; "Consent: A guide for Canadian physicians: Emergency treatment" (April 2021) *CMPA* (website), online: https://www.cmpa-acpm.ca/en/advice-publications/handbooks/consent-a-guide-for-canadian-physicians#Emergency%20treatment.
[183] Dickens & Cook, *supra* note 181 at 182.
[184] *Malette, supra* note 5 at para 14. However, note: the issue of "how far" the patient's refusal may go to protect a negligent health care provider from liability is unresolved: Dickens & Cook, *supra* note 181 at 183.
[185] Niles, "*I fought my entire way*", *supra* note 7; Bec Jenkinson, Sue Kruske & Sue Kildea, "Refusal of recommended maternity care: Time to make a pact with women?" (2018) 31 Women and Birth 433; Kotaska, "Informed consent and refusal", *supra* note 120 at 195; Bec Jenkinson, Sue Kruske & Sue Kildea, "The experiences of women, midwives and obstetricians when women decline recommended maternity care: A feminist thematic analysis" (2017) 52 Midwifery 1; Michele Megregian & Marianne Nieuwenhuijze, "Choosing to Decline: Finding Common Ground through the Perspective of Shared Decision Making" (2018) 63:3 Journal of Midwifery & Women's Health 340.
[186] Kotaska, "Informed consent and refusal", *supra* note 120 at 195.
[187] *Ibid.*
[188] *Ibid.*
[189] *Ibid* at 197.

guidance,[190] and provider experience,[191] and may result in damage to provider-patient relationships,[192] and associated negative impacts on patient care and long-term patient wellbeing.[193] The authors of a recent Canadian study, Saraswathi Vedam et al, explain:

> [T]he experience of mistreatment by providers (eg. non-consented care, loss of patient autonomy, or poor provider-patient communication) during pregnancy and childbirth has been linked to reduced adherence to care, psychosocial distress, and adverse maternal newborn health.[194]

In many cases, such mistreatment is not carried out in bad faith, but, rather, out of sincere concern for the well-being of the fetus and birthing person.[195] Providers' own moral, ethical, and professional interests in ensuring safety may drive them to seek to reduce what they consider to be unreasonable risk.[196]

Moreover, provider perceptions of safety and risk vary widely, both intra- and interprofessionally.[197] Such variation in care provider risk tolerance has a significant effect on how pregnant people experience prenatal and childbirth care. Vedam et al explain:

> Divergence in provider attitudes, leading to variance in models of practice, exerts a cascading and iterative effect on maternal experience of autonomy when choosing options for birth care, including choice of birth place and obstetric interventions.[198]

Individual provider risk tolerance is often influenced by "previous experiences with emergency situations and poor maternal and perinatal outcomes related to delivery method."[199] For example, the authors of a Canadian qualitative study of care provider perspectives on method of delivery describe a participant physician who "tearfully recounted a maternal death due to complications of an elective repeat [Caesarean section]." [200] This experience influenced the physician's preference for trial of labour after Caesarean section ("TOLAC"), rather than planned repeat Caesarean section ("PRCS"). The provider described: "*my only* [maternal] *death was somebody who refused a TOLAC and had a [PRCS].*"[201] In the same study, providers "who tended to prefer PRCSs had experienced a uterine rupture in their practice," with one provider describing: "[uterine rupture] *kind of influences you a bit. … I've probably seen more positive experiences around elective repeat [Caesarean section].*"[202] Moreover, "[f]ear of uterine rupture was a

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[190] Andrew Kotaska, "Commentary: Routine Cesarean Section for Breech: The Unmeasured Cost" (2011) 38:2 Birth 162 at 163 [Kotaska, "The Unmeasured Cost"].
[191] Christine Kurtz Landy et al, "Factors obstetricians, family physicians and midwives consider when counselling women about a trial of labour after a caesarean and planned repeat caesarean: a qualitative descriptive study" (2020) 20:367 BMC Pregnancy and Childbirth 1.
[192] Niles, "*I fought my entire way*", *supra* note 7 at 10.
[193] *Ibid* at 12.
[194] Saraswathi Vedam et al, "Patient-led decision making: Measuring autonomy and respect in Canadian maternity care" (2019) 1032 Patient Education and Counseling 586 at 587.
[195] Kotaska, "Informed consent and refusal", *supra* note 120 at 198.
[196] "ACOG Committee Opinion No 664: Refusal of Medically Recommended Treatment During Pregnancy" (2016) 127: e175 -82 Obstet Gynecol 1 at 2 ["AGOC Opinion No 664"].
[197] Kurtz Landy, *supra* note 191 at 8; "AGOC Opinion No 664" *supra* note 196 at 2.
[198] Vedam, "Patient-led decision making", *supra* note 194 at 592.
[199] Kurtz Landy, *supra* note 191 at 8.
[200] *Ibid*.
[201] *Ibid.*
[202] *Ibid*.

major factor many obstetricians" identified as driving care preferences.[203] These accounts illustrate how prior experience with poor outcomes resulting from patient refusal may significantly shape the way providers respond to patient refusal in future.

The role that providers play in shaping the way care options are presented to birthing people must not be understated,[204] and the way care providers respond to and manage "risky" choices made by birthing people has significant ramifications for patient care. Consider, for example, the following case study:

> A woman with two previous deliveries, one vaginal and one cesarean section, was found to have a breech presentation at term. She was referred by her midwife to an obstetrician who advised external cephalic version [manual attempts to turn the fetus by pressing on the belly], which was unsuccessful. Cesarean section was advised. The woman refused and was sent by her midwife to another obstetrician for a second opinion, who also recommended cesarean section, which the woman again refused. Despite previous experience with vaginal breech birth, neither obstetrician "offered" a trial of labor in hospital.
>
> The woman returned to her midwife steadfast in her wish to labor. The College of Midwifery guidelines in the province of British Columbia clearly state that breech birth is outside the midwifery scope of practice and advise withdrawal of care rather than attendance in labor. The woman was informed of this policy. She chose to labor unattended at home, where she spontaneously delivered a normally grown baby boy. Shortly after birth, an ambulance was called and paramedics found an apneic newborn on the floor. Initial resuscitation was successful; however, the infant died 24 hours later of multisystem hypoxic organ failure.[205]

In this tragic case, the woman was able to give birth at home unassisted, in a manner arguably consistent with a strict reading of her right to medical self-determination. The health care workers assessed the potential risk, refused to provide care they deemed too high-risk, and, in doing so, successfully avoided liability. Kotaska explains:

> A Coroner's inquiry determined that the midwife had correctly followed her college's policy by withdrawing care that was outside her scope of practice. No mention was made of the possible causal role of this policy in the death or the failure of either obstetrician to ''offer'' a trial of labor in hospital.[206]

However, in seeking to minimize risk of liability, the care providers in this case may have inadvertently increased the risk of harm to the woman and the fetus. Kotaska argues care providers faced with such situations must strive to maintain the therapeutic relationship in order to mitigate the risk of harm that flows from the birthing person's choices.[207] For example, in this case, permitting the woman to labour in hospital following an explanation of the risks and benefits of a trial of labour may have increased the chances of the

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[203] *Ibid*.
[204] Dominiek Coates et al, "What are women's mode of birth preferences and why? A systematic scoping review" (2019) Women and Birth 1 at section 3.2.4.
[205] Kotaska, "The Unmeasured Cost", *supra* note 190 at 163.
[206] *Ibid*.
[207] Kotaska, "Informed consent and refusal", *supra* note 120 at 198.

fetus's survival, as the woman and fetus would have had rapid access to medical care in the event of an emergency. Such an approach would also serve to minimize the risk of liability on the part of care providers, who fulfil their legal and ethical duties by advising the patient of the risks and benefits of her choice and by diligently documenting her refusal.

Kotaska also recommends exploring the reasons behind a person's refusal. In this case, the woman's "steadfast" wish to labor may be viewed by many as foolish. However, as set out above, the right to medical self-determination protects health care decisions others may consider foolish or ill-advised. Social, cultural, and personal beliefs are key driving factors behind preferences and choices during childbirth.[208] Studies indicate birthing people may be willing to make certain risk "trade-offs" in favour of other benefits or goals that are personally important to them, such as "experiencing uninterrupted bonding in the immediate postpartum, avoiding emotional trauma, feeling cared for and respected by one's care providers," and "having a quicker recovery," among other factors.[209]

Moreover, mode of birth may hold deep personal significance, including regarding one's self-perceived identity as a mother. A midwife interviewed in a recent Canadian study on trial of labour after Caesarean section explained: "*Women who have [Caesarean sections] they didn't want … end up feeling like they somehow failed, that they are not true mothers… as stupid as that is, it is a very hard feeling to shake.*"[210] Though all parties involved in childbirth undoubtedly wish to maximize the health of the baby, birthing people and their care providers may differ significantly as to whether certain risks are justifiable during childbirth. For example, an obstetrician interviewed in the same study questioned: "*A ruptured uterus during labour is a big deal. Why would anyone risk a rupture during labour given a CS is no big deal?*"[211] In many cases, failure on the part of health care providers to understand the range of motivations underlying birthing peoples' preferences and choices during childbirth directly and profoundly impacts patient autonomy.[212]

Kotaska argues that at least some of this tension may be resolved through an expanded understanding of the doctrine of informed consent (including the right to refuse) on the part of providers, patients, hospital administrators, policymakers, and legal actors:

> If a medical complication arises because of a patient's informed refusal […], the clinician is ethically bound to continue providing competent care, sometimes under very difficult circumstances. <u>If despite good care an adverse outcome occurs, the clinician has not been negligent. Instead, he has honoured his professional duty to provide care in accordance with the patient's beliefs, values and choice</u> [emphasis added].[213]

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[208] Coates, *supra* note 204 at section 3.2.5; Sarah Munro et al, "Seeking control in the midst of uncertainty: Women's experiences of choosing mode of birth after caesarean" (2017) 30 Women and Birth 129 at 133.
[209] Munro, *supra* note 208 at 133.
[210] Kurtz Landy, *supra* note 191 at 6.
[211] *Ibid* at 8.
[212] Niles, "*I fought my entire way*", *supra* note 7 at 10.
[213] Kotaska, "Informed consent and refusal", *supra* note 120 at 197. This proposal is consistent with some existing professional clinical guidance. See, for example: "The Legal Status of the Fetus," (June 2018), *Canadian Nurses Protective Society* (website), online: https://cnps.ca/article/the-

Therefore, legal liability (both real and perceived) constrains actions of health care providers, restricting autonomy of birthing people with respect to factors such as method of birth and birthplace, as well as the level of surveillance (including testing and fetal monitoring during childbirth) that is acceptable to the patient. Education and the implementation of clearer policy frameworks to establish the acceptable standard of care in situations of refusal may assist in creating contexts where providers can continue to provide care following a refusal (rather than abandoning patients), thereby minimizing risk to the greatest degree possible. This issue is explored in greater detail in Chapter 4.

Second, the right to autonomy in medical decision-making is further complicated for pregnant and birthing people, because, while the law may consider the pregnant person to be one, autonomous person, this characterization fails to capture the way many pregnant and birthing people perceive themselves in relation to the fetuses they carry.

Birthing people frequently describe experiences of being pressured or coerced into making choices for the benefit of their unborn child.[214] This is often described as care providers playing the "dead baby card"—asking patients who decline a recommended treatment: "You don't want your baby to die, do you?"[215] Common forms of coercion in childbirth care may include magnifying or exaggerating risks or benefits of particular care options, disparaging birthing people for choosing riskier options, threatening to contact child protective services, or threatening to withdraw care or abandon a patient if they refuse to follow a provider's recommendations.[216] Though such clinical actions are both legally and ethically inappropriate,[217] they expose something deeper about the nature of the right to self-determination in childbirth settings—because, of course, the birthing person typically does *not* want their baby to die.

In this way, the legal right to autonomy in medical decision-making is constrained by pressure from clinical care providers, but also by the birthing person's own perception of and relationship to the fetus—beyond the scope of legal doctrine. While a pregnant person and fetus are legally considered one person, the lived experiences of the pregnant person are, in many cases, much more nuanced than this.[218] Though

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legal-status-of-the-fetus/: "Against this legal backdrop [of maternal primacy], health professionals provide care despite the emotional responses these delicate issues generate."

[214]Niles, "*I fought my entire way*", *supra* note 7; "The Legal Infrastructure of Childbirth," *supra* note 2 at 2218; Hazel Keedle et al, "From coercion to respectful care: women's interactions with health care providers when planning a VBAC" (2022) 22:70 BMC Pregnancy and Childbirth 1.

[215] Hall, "Minimizing Risk While Maximizing Integrity," *supra* note 7; Niles, "*I fought my entire way*", *supra* note 7.

[216] Kotaska, "Informed consent and refusal", *supra* note 120 at 197.

[217] Dickens & Cook, *supra* note 181 at 182; Kotaska, "Informed consent and refusal", *supra* note 120 at 197.

[218] In describing a state of connectedness between a pregnant person and their fetus, I do not intend to detract from the legitimacy of the right to abortion in Canada but, rather, to focus on the rights, interests, and experiences of people who choose to continue their pregnancies through to childbirth, most often with the intention of parenting the child. As philosopher Iris Marion Young describes:

> The analysis presupposes that pregnancy […] be chosen by the woman, either as an explicit decision to become pregnant or at least as choosing to be identified with and positively accepting of it. Most women in human history have not chosen their pregnancies in this sense. For the vast majority of women in the world today, and even for many women in this privileged and liberal society, pregnancy is not an experience they choose. So I speak in large measure […] for those pregnant women who have been able to take up their situation as their own. (Iris Marion Young, "Pregnant Embodiment: Subjectivity and Alienation" in *On Female Body Experience: "Throwing Like a Girl" and Other Essays* (Oxford: Oxford University Press 2005) 46 at 47).

current legal doctrine does not capture this dynamic, it is a phenomenon well-recognized in scientific literature, known commonly as "maternal fetal attachment"[219]—a term used to describe "the emotional bond between a mother and her unborn child during pregnancy."[220] Outside the realm of scientific papers, published first-hand accounts of pregnancy commonly discuss pregnant people connecting with their unborn babies. For example, legal scholar Jennifer Nedelsky recounts her experiences:

> Almost immediately upon finding out that I was pregnant I began to feel fiercely protective of the baby growing inside me. I knew that miscarriage in the first three months was very common, and I desperately wanted *this* baby to be all right, to grow safely within me.[221]

Nedelsky describes a palpable relationship to her unborn child, though she had not yet met him. Such feelings of connection to one's fetus are not universal, but they are common.[222] Consider, for example, tennis player Serena Williams's account of her experience of pregnancy:

> I was nervous about meeting my baby. Throughout my pregnancy, I'd never felt a connection with her. […] I kept waiting to feel like I *knew* her during pregnancy, but the feeling never came. Some of my mom friends told me they didn't feel the connection in the womb either, which made me feel better but, still, I longed for it.[223]

Williams's comments speak to the prevalence of the idea of a connection to or relationship with one's fetus, even if the feeling is not universally shared.

Despite its pervasiveness, this relationship exists outside the scope of Canadian legal frameworks. This omission is understandable, given the critical importance of insulating the right to abortion from the threat of "fetal rights" development.[224] However, a more nuanced vision of medical self-determination in childbirth may assist in giving the rights of birthing people greater meaning in practice. In this respect, legal scholar Isabel Karpin's proposes: can't pregnant people be "not-one-but-not-two?"[225] Karpin emphasizes the intimate, embodied connections between a pregnant person and their fetus, contrary to legal and popular

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I additionally acknowledge that, even for people who choose to become pregnant and/or to continue their pregnancies, pregnancy may be experienced more as an of "invasion" than a state of connectedness (Emma L Hodgkinson, Debbie M Smith & Anja Wittkowski, "Women's experience of their pregnancy and postpartum body image: a systematic review and meta-synthesis" (2014) 14:330 BMC Pregnancy and Childbirth 1 at 8.

[219] See, for example: Josephine McNamara, Michelle L Townsend & Jane S Herbert, "A systemic review of maternal wellbeing and its relationship with maternal fetal attachment and early postpartum bonding" (2019) 14:7 PloS ONE 1; Jessica L Hruschak et al, "Maternal-fetal attachment, parenting stress during infancy, and child outcomes at age 3 years" (2022) 43 Infant Ment Health J 681.

[220] McNamara, Townsend & Herbert, *supra* note 219 at 2-3.

[221] Jennifer Nedelsky, "Dilemmas of passion, privilege, and isolation: reflections on mothering in a white, middle-class nuclear family" in Julia E Hanigsberg & Sara Ruddick, eds, *Mother Troubles: rethinking contemporary maternal dilemmas* (Boston: Beacon Press 1999) at 306 [Nedelsky, "Dilemmas of Passion"].

[222] IM Young, *supra* note 218 at 49.

[223] Serena Williams, "Fighting to Be Heard" in Amy Schumer & Christy Turlington Burns, eds, *Arrival Stories: Women Share Their Experiences of Becoming Mothers* (New York: The Dial Press 2022) at 6.

[224] Celia Wells & Derek Morgan, "Whose Foetus Is It?" (1991) 18:4 JL & Soc'y 431 at 443.

[225] Isabel Karpin, "Legislating the Female Body: Reproductive Technology and the Reconstructed Woman" (1992) 3 Colum J Gender & L 325 at 329.

discourse, which often casts them in opposition to one another.[226] Legal scholar Sara Fovargue describes Karpin's model:

> The 'not-one-but- not-two' model focuses on the *nature* of the relationship between the woman and her fetus, and recognises that a pregnant woman, as with all competent adults, has rights which must be respected, but her autonomy, in certain situations, is not absolute.[227]

In this way, Karpin invites an alternative way of thinking about the relationship between a pregnant person and their fetus, and the various rights and responsibilities that flow therefrom.

In conclusion, pregnant and birthing people in Canada have the right to make medical decisions about their own bodies and health care, even if those decisions result in harm to or death of the fetus they carry. However, the right to medical self-determination is restricted in several respects—notably, through birthing people's relationships with their care providers, as well as through their own relationships to their unborn children. Both of these factors are important examples of what legal theorist Susan Sherwin describes as the "invisible dimensions of [patients'] lives that limit their degrees of control,"[228] thus attenuating the right "on the books" to make decisions about one's own health care (despite law's "tenacious"[229] commitment to the principle).

Informed consent

The doctrine of informed consent is a key element of the right to medical self-determination, which is intended to give meaning to the choices available to an individual by guaranteeing them the information required to understand the relative risks and benefits of the options available to them. As defined by legal scholar Wendy K Mariner: "The legal doctrine of informed consent imposes on a physician an affirmative duty to disclose information to enable a patient to make a knowledgeable decision about a proposed treatment or procedure."[230] An understanding of informed consent is considered a key competency for Canadian physicians.[231]

In Canada, the leading decision on the doctrine of informed consent is *Reibl v Hughes*.[232] In *Reibl*, the patient plaintiff suffered a stroke following a non-urgent surgery, resulting in paralysis. The surgeon did not advise the plaintiff of the associated risk of paralysis, though he did inform him that the likelihood

[226] Karpin, *supra* note 225. Regarding pregnant people's perceptions of pregnancy, see also: Elena Neiterman, "Sharing Bodies: The Impact of the Biomedical Model of Pregnancy on Women's Embodied Experiences of the Transition to Motherhood" (2013) 9 Healthcare Policy 112 at 121-122; Nedelsky, "Dilemmas of Passion", *supra* note 221.
[227] Sara Fovargue, "Review: The Law's Response to Pregnancy and Childbirth: Consistency, Conflict, or Compromise?" (2002) 65:2 Mod L Rev 290 at 291.
[228] Susan Sherwin, "Relational Autonomy and Global Threats" in Downie & Llewellyn, *supra* note 9, 13 at 15 [Sherwin, "Relational Autonomy and Global Threats"].
[229] *Carter, supra* note 4 at para 67, citing *AC v Manitoba*, *supra* note 151 at para 39.
[230] Wendy K Mariner, "Review: Informed Consent in the Post-Modern Era" (1988) 13:2 Law & Social Inquiry 385 at 400.
[231] Daniel E Hall, Allan V Prochazka & Aaron S Fink, "Informed consent for clinical treatment" (2012) 184:5 CMAJ 533 at 533.
[232] *Reibl, supra* note 5. See also: *Hopp v Lepp,* 1980 CanLII 14 (SCC), [1980] 2 SCR 192 [*Hopp*].

of him becoming paralyzed was greater if he did not have the surgery. At trial, the plaintiff recovered damages in negligence and battery based on the surgeon's failure to adequately inform him of the risk of paralysis. The SCC endorsed the decision of the trial judge and found that a reasonable person in the plaintiff's position, properly informed of the risks, would have declined the surgery at that particular time.[233]

Informed consent is recognized within medicine as "the primary paradigm for protecting the legal rights of patients and guiding the ethical practice of medicine."[234] However, informed consent in clinical practice "rarely achieves the theoretical ideal."[235] Often, the "informed consent process" is distilled to a standardised form presented for signature:

> For the sake of compliance, the informed consent document serves the administrative purpose of a systems-level check to ensure that a consent process has occurred. Patients simply do not advance to the operating room, for example, without a signed consent form. Unfortunately, pressures for efficient workflow may shift the focus of the informed consent process from robust conversation to the mere requirement of getting a signature.[236]

This problem is exemplified in the childbirth context by the documented practice of requiring labouring people to sign consent forms on their way to emergency C-sections, without meaningful verbal discussion of the risks or benefits of surgery.[237]

After my care team and I made the decision that I would undergo an emergency C-section for the delivery of my son, I was asked to sign a form consenting to the surgery. I have no recollection of signing anything, though I did sign the form on the way to the operating room. I was experiencing the very significant pain that accompanies late-stage labour and focusing all my available attention on my baby's dangerously low heart rate. No one verbally discussed the risks of the surgery with me, and I did not read the paperwork presented to me for signature (which, I assume, listed the risks of the surgery.) Moreover, I had recorded my desire to go straight to surgery in the event of indication in my birth plan, which every member of my care team had seen. Why, then, go through the trouble of having me sign a form? As it turns out, this is not an atypical practice in emergency C-sections (though it is not without critique.)[238]

This scenario provides a useful (if acute) example of Susan Sherwin's theory of the ways in which the doctrine of informed consent fails to account for the invisible dimensions that constrain autonomy:

> Within bioethics, autonomy is generally used to set a standard of self-determination through rational deliberation that is thought to be achieved by setting adequate procedures of informed consent. <u>As such, it is typically used in a generic way, as if the basic requirements for informed consent (information, competence, and voluntariness) will</u>

[233] *Reibl, supra* note 5 at 886; 927.
[234] Hall, Prochazka & Fink, *supra* note 231 at 533.
[235] *Ibid*.
[236] *Ibid* at 534.
[237] See, for example: Andrea Landry, "As an Indigenous woman, I was scared to have my baby in a hospital" *Today's Parent* (3 May 2021); *MacGregor v Potts,* 2009 CanLII 44720 (ONSC) at para 42; Royal College of Obstetricians & Gynaecologists, *Obtaining Valid Consent: Clinical Governance Advice No. 6*, London: RCOG, 2015, at 5-6.
[238] Helen Bolton, "The perils of taking written consent for operative delivery during labour" (2015) 122:9 BJOG 1251; Martha K Smith, Karen S Levy & Mark Yudin, "Informed Consent During Labour: Patient and Physician Perspectives" (2018) 40:5 J Obstet Gynaecol Can 614 at 614.

guarantee autonomy in similar ways for all patients or research subjects. This usage ignores important differences among patients and subjects and renders invisible dimensions of their lives that limit their degrees of control [emphasis added].[239]

Intrapartum obstetrical inventions such as emergency C-sections, forceps usage, and episiotomies significantly limit a patient's degree of control.[240] Written documentation of a patient's consent in such situations does not truly serve the autonomy interests of the patient, but, rather, serves to provide a record for purposes of physician liability protection.

The doctrine of informed consent has been subject to longstanding feminist critique. Critics point out that the doctrine fails to account for the contextual factors that limit a patient's choices, meaning the patient's consent is informed only by the information presented to them by the doctor. Sherwin explains: "[T]he set of available options is constructed in ways that may already seriously limit the patient's autonomy by prematurely excluding options the patient might have preferred."[241] Options presented to a patient are narrowed down through a series of forces which structure and influence research priorities, publication of results, medical school curriculums, and resource allocation decisions at a systems level.[242]

In the childbirth context, choices made available to patients are often limited by the practice of "defensive medicine."[243] As outlined above, Canadian obstetricians are the subject of high rates of malpractice claims, resulting in documented reluctance to permit patients to make choices deemed to carry unnecessary risk.[244] For example, although the safety of a vaginal delivery following a previous C-section birth is well-established,[245] patients are sometimes not presented with the option to attempt a vaginal delivery following a previous C-section (commonly referred to as a "TOLAC" or "trial of labour after Caesarean") or dissuaded from doing so, in the interests of reducing risk of harm to the fetus.[246] Such practices constrain the range of choices available to patients, directly limiting their ability to exercise their autonomy. As legal scholar Celia Wells describes: "Individuals are allowed little say about the contents of the menu but are then expected to make appropriate choices from it."[247]

In addition, the doctrine of informed consent only protects what a "reasonable person" would want to know—a doctor cannot be "held responsible for damages attributable to a plaintiff's idiosyncrasies."[248] Beyond necessary critiques that the construct of the "reasonable person" does not reflect the gendered

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[239] Sherwin, "Relational Autonomy and Global Threats", *supra* note 228 at 15.
[240] Karen S Levy et al, "Patient Satisfaction with Informed Consent for Cesarean and Operative Vaginal Delivery" (2022) 44:7 J Obstet & Gyane Canada 785; Marit van der Pijl, "The ethics of consent during labour and birth: episiotomies" (2023) J Med Ethics 1; Kavin Senapathy, "Giving Birth Made Me Question the Informed Consent Process During Childbirth" *Self* (14 May 2018).
[241] Sherwin, "A Relational Approach to Autonomy", *supra* note 9 at 26.
[242] *Ibid* at 26-27.
[243] Hindi E Stohl, "When Consent Does Not Help: Challenges to Women's Access to a Vaginal Birth After Cesarean Section and the Limitations of the Informed Consent Doctrine" (2017) 43 Am J L & Med 388 at 423; Cardoso, *supra* note 168 at 1.
[244] Cardoso, *supra* note 168.
[245] Elizabeth Miazga & Eliane Shore, "Five things to know about … Trial of labour after caesarean delivery" (2022) 194:1 CMAJ E13.
[246] Stohl, *supra* note 243 at 424.
[247] Wells, *supra* note 24 at 249-250.
[248] *Arndt v Smith*, 1997 CanLII 360 (SCC), [1997] 2 SCR 539 at para 14 [*Arndt v Smith*].

experience of women,[249] it is important to consider the ways in which the birthing person defies "rationality." Sherwin explains that traditional conceptions of autonomy view individuals as "separate, independent, and 'fully rational.'"[250] However, Sherwin points out: "actual people are not independent, and their decision-making does not always meet the norms that define rationality. They do not, for example, always act in accordance with their own best interests."[251]

While some pregnant people may be willing to accept risk that their doctors would not, others may be more risk-averse, and be interested in options that may provide an increased likelihood of safety for their fetus, at a detriment to themselves. For example, in the event an irregular fetal heartbeat is noted, a more "risk-averse" birthing person may prefer to immediately proceed to a C-section, when the doctor's idea of a "reasonable" patient would wait to see whether the problem resolved on its own. If a provider only presents to a birthing person the information they feel a reasonable person would want to know, the birthing person may be unaware of the availability of options that would most consistent with their wishes.

Although the doctrine of informed consent was designed to solve the problem of paternalism in medicine, some critics argue it perpetuates it. In *Arndt v Smith,* a majority of the Supreme Court of Canada described *Reibl* as follows:

> *Reibl* is a very significant and leading authority. It marks the rejection of the paternalistic approach to determining how much information should be given to patients. It emphasizes the patient's right to know and ensures that patients will have the benefit of a high standard of disclosure.[252]

Kotaska describes how this shift works in practice: "Historically, 'informed' consent meant the doctor *informed* a patient of his plan. In modern health care, informed consent involves the bidirectional sharing of *information*."[253]

However, some argue, vestiges of the old regime linger through the inequality of information between doctor and patient. Although this inequality is often accepted as part of the professionalized structure of medicine—doctors are holders of specialized information, whom we trust to heal us—the inequality of information between doctor and patient perpetuates an uncomfortable dynamic in which the doctor is often perceived as more important than the patient. Sherwin points out that although the informed consent process (performed properly) provides the patient the opportunity to ask questions, "patients often feel too intimidated to ask or even formulate questions, especially when they feel socially and intellectually

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[249] See: Susan Dimock, "Reasonable women in the law" (2008) 11:2 Critical Review of International Social and Political Philosophy 153.
[250] Susan Sherwin, *No Longer Patient: Feminist Ethics & Health Care* (Philadelphia: Temple University Press, 1992) at 137 [Sherwin, *No Longer Patient*].
[251] *Ibid* at 137.
[252] *Arndt v Smith, supra* note 248 at para 15.
[253] Kotaska, "Informed consent and refusal", *supra* note 120 at 196.

inferior to their physicians and when the physicians project an image of being busy with more important demands."[254] Moreover, Sherwin explains:

> Often, one needs some information in order to know what further questions to ask, and large gaps in perspective between patients and their health care providers may result in a breakdown in communication because of false assumptions by either participant.[255]

Additionally, Mariner points out that the doctrine of informed consent "does not guarantee that patients make autonomous choices; it merely requires that they have the *opportunity* to do so."[256] The meaningfulness of such an opportunity depends, in large part, on the information available to the patient decision-maker. Moreover, Mariner argues, the doctrine fails to adequately account for whether patients understand the information and options presented to them.[257] Despite these barriers, informed consent forms an important aspect of existing rights in childbirth, and one that holds significant potential for reform and improvement.

In particular, I note the existence of the distinct concept of "informed choice," a key tenet of Canadian midwifery care.[258] Through a model of informed choice, midwives in Canada seek to empower pregnant people as the primary decision-makers in their pregnancies and birth experiences, actively encouraging them to make informed decisions "by providing complete, relevant, and objective information in a non-authoritarian manner."[259] Health researchers Wendy Pringle et al describes:

> Although comparable narratives of patient empowerment and shared decision-making have since evolved in mainstream biomedicine, informed choice is an inherently politicized notion intended to go beyond informed consent's focus on the right to be informed about treatment options and potential consequences—notions historically bound with liability and ethics. The informed choice approach demonstrates an 'applied form of relational autonomy' in which the possibility of choice is contingent on, and inextricable from, an ethic of care.[260]

The informed choice care model may be described as a strategy that seeks to address the shortcomings of the doctrine of informed consent, described above, by focusing principally on patient empowerment. Anthropologist Margaret MacDonald explains that while the doctrine of informed consent was "forged out of a series of legal cases concerning patients' rights to be informed", informed choice "was never meant as an add-on to clinical [midwifery] care but part and parcel of a fundamentally different way of caring," involving non-hierarchical midwife-client relationships, longer format appointments, continuity of care, and a respect for the birthing person's "own knowledge, feelings, and past experience about her body and

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[254] Sherwin, "A Relational Approach to Autonomy", *supra* note 9 at 27.
[255] *Ibid*.
[256] Mariner, *supra* note 230 at 387.
[257] *Ibid* at 396.
[258] Wendy Pringle et al, "'Ultimately, the choice is theirs': Informed choice vaccine conversations and Canadian midwives" (2022) 00 Birth 1 at 1.
[259] *Ibid* at 2. See also: Margaret E MacDonald, "The Making of Informed Choice in Midwifery: A Feminist Experiment in Care" (2018) 42 Cult Med Psychiatry 278 at 278 [MacDonald, "The Making of Informed Choice"].
[260] Pringle, *supra* note 258 at 3.

previous pregnancies as well as her lifestyle and moral or religious orientation" as fundamentally important to care decision-making.[261]

While there have been some criticisms of this model on the basis that patients sometimes do not receive adequate guidance,[262] a review of complaints regarding the inadequacy of informed consent processes in obstetrical care delivery makes clear that there are many lessons to be drawn from this ethos of care. I further explore these issues in Chapters 3 and 4.

Dignity

Dignity is a driving concept in the Canadian rights landscape—"notions of human dignity underlie almost every right guaranteed by the *Charter*."[263] Though "dignity" itself is not a free-standing constitutional right in Canadian law,[264] it has been consistently recognized as an animating value in Canadian rights discourse.[265] In her reasons in *Egan v Canada*, for example, Justice L'Heureux-Dubé described human dignity as "the heart of individual rights in a free and democratic society."[266] In addition, the Supreme Court has described "a concern for the protection of individual autonomy and dignity" as underlying the *Charter* rights to both liberty and security of the person.[267]

What, then, does it mean to protect an individual's dignity? The concept of dignity is difficult to pin down—it is "an abstract and subjective notion."[268] Perhaps most relevant to dignity in the context of childbirth are Justice Wilson's concurring reasons in *R v Morgentaler*, regarding the impact of the legislative abortion scheme on the right to security of the person:

> She is truly being treated as a means—a means to an end which she does not desire but over which she has no control. She is the passive recipient of a decision made by others as to whether her body is to be used to nurture a new life. Can there be anything that comports less with human dignity and self-respect?[269]

Similarly, many birthing people report experiencing constrained agency, and a perception that their interests were treated as secondary to those of their fetus.[270] Consider, for example, the ways in which Justice

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[261] MacDonald, "The Making of Informed Choice", *supra* note 259 at 287.
[262] Alison Barrett & Andrew Kotaska, "Obstetricians discuss the coal mine and the canary" in Hannah G Dahlen, Bashi Kumar-Hazard & Virginia Schmied, eds, *Birthing Outside the System: the Canary in the Coal Mine"* (New York: Routledge, 2020) 411 at 423. See also: patient complaints in *LYD v SN,* 2019 CanLII 75832 (ON HPARB) [*LYD v SN*]; *LYD v MB,* 2019 CanLII 75602 (ON HPARB) [*LYD v MB*].
[263] *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44 at para 76 [*Blencoe*].
[264] *Ibid* at para 77; Aharon Barak, *Human Dignity: The Constitutional Value and the Constitutional Right* (Cambridge: Cambridge University Press, 2015) at 209-210.
[265] *WIC Radio Ltd v Simpson,* [2008] 2 SCR 420 at para 429, in which Binnie J states: "the worth and dignity of each individual … is an important value underlying the Charter."
[266] *Egan v Canada,* 1995 CanLII 98 (SCC), [1995] 2 SCR 513 at 543 (L'Heureux-Dubé J writing in dissent, though not on this point.)
[267] *Carter, supra* note 4 at para 64. See also: *R v Ndhlovu,* 2022 SCC 38 at para 51.
[268] *R v Kapp,* 2008 SCC 41 (CanLII), [2008] 2 SCR 483 at para 22.
[269] *Morgentaler* 1988, *supra* note 101 at 173.
[270] Vedam, "Patient-led decision making", *supra* note 194; Nicole Hill, "Understanding Obstetric Violence as Violence against Mothers through the Lens of Matricentric Feminism," (2019) 10:1&2 J of the Motherhood Initiative 233 at 234; Ieva Lucs, "'I felt like an afterthought': How this woman aims to change the childbirth experience in Ontario hospitals" *CBC News* (21 March 2018).

Wilson's framing maps onto feminist scholar Nicole Hill's account of her experience of giving birth in Canada:

> During my first pregnancy, some of the first people to reference me by my newly acquired motherhood status were maternity care providers who I visited for prenatal care. These providers would make such comments as "how is mama doing today?" By virtue of the nearly microscopic fetus growing in my belly, I was no longer my named self; to my providers, I was "mama." I was no longer recognized as my own individual person with her own rights and agency but as part of this dyad.[271]

Protections for human dignity clearly have a place in the delivery room. Yet, many report the experience of giving birth in Canadian hospitals as profoundly undignified.[272]

Protections for the right to dignity in the childbirth setting may be understood as the provision of health care services and "goods necessary to live dignified existence,"[273] invoking considerations of entitlement to publicly funded and provided care. At a more granular level, respecting a birthing person's right to dignity during childbirth means enabling that person to make decisions about the course of their medical treatment, if any, and facilitating that person's "control over [their] bodily integrity"[274] to the greatest extent possible. With these principles in mind, examples of the provision of dignified care during childbirth may include: speaking to the birthing person directly, rather than talking to others in the room about them;[275] allowing the birthing person to eat and drink if they want to;[276] asking permission to have a student perform or observe procedures;[277] and not shaving the birthing person's genitals as a routine practice.[278]

Importantly, as dignity is a highly subjective value, what is required to protect and promote an individual's dignity will vary greatly depending on the person. In the childbirth context, dignity may require certain protections for an individual's modesty, such as accommodating a preference for an all-women care team for a Muslim birthing person.[279] In this respect, Christa Aubrey et al note "accommodating preferences

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[271] N Hill, *supra* note 270 at 234.

[272] Kathrin Stoll et al, "I felt so much conflict instead of joy: an analysis of open-ended comments from people in British Columbia who declined care recommendations during pregnancy and childbirth" (2021) 18:79 Reproductive Health 1; Christine H Morton & Louise Marie Roth, "Bearing witness: United States and Canadian maternity support workers' observations of disrespectful care in childbirth" (2018) 45:263 Birth 263; "New mothers upset over treatment in Winnipeg hospitals," *CBC News* (8 November 2016).

[273] Michael Da Silva, "A Goal-Oriented Understanding of the Right to Health Care and its Implications for Future Health Rights Litigation" (2016) 39:2 Dal LJ 377 at 382.

[274] *Carter, supra* note 4 at para 64.

[275] J Hall, *supra* note 138 at 9.

[276] Canada, Public Health Agency of Canada, *Canadian Hospitals Maternity Policies and Practices Survey* (Ottawa: Public Health Agency of Canada 2012) [*Canadian Hospitals Maternity Policies and Practices Survey*]; Ontario, Ontario Public Health Association, "Informed Decision-Making for Labour & Birth" (2018) [Ontario Public Health Association, "Informed Decision-Making"].

[277] Rachel Reed, Rachael Sharman & Christian Inglis, "Women's descriptions of childbirth trauma relating to care provider actions and interactions" (2017) 17:21 BMC Pregnancy and Childbirth 1.

[278] *Canadian Hospitals Maternity Policies and Practices Survey, supra* note 276; Ontario Public Health Association, "Informed Decision-Making", *supra* note 274; World Health Organization, *WHO recommendations: Intrapartum care for a positive childbirth experience* (2018) at 68 online: https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf.

[279] Christa Aubrey et al, "Perspectives of Immigrant Women on the Gender of Provider During Childbirth," (2018) 40:6 J Obstet Gynaecol Can 677; Christa Aubrey et al, "Gender of Provider—Barrier to Immigrant Women's Obstetrical Care: A Narrative Review" (2017) 39:7 J Obstet Gynaecol Can 567; David I Shalowitz et al, "Clinical Opinion: Responding to patient requests for women obstetrician-gynecologists" (2022) Am J Obstetrics & Gynecology 678.

for female providers is congruent with patient autonomy and beneficence, grounded in principles of cultural sensitivity and patient-centred care."[280] Beyond issues of cultural competency and religious accommodations, similar considerations may be important to the dignity of a victim of sexual assault whose "experiences involving a perpetrator who was a man may lead her to request a woman physician."[281] In such situations, making the effort to provide a patient with an all-women care team may be necessary to the provision of dignified care.[282]

Likewise, protections for dignity in childbirth may mean making efforts to mitigate gender dysphoria for trans men experiencing childbirth, such as using correct pronouns and chosen terms, as well as sensitivity with respect to chestfeeding.[283] Legal scholar Elizabeth Kukura explains that a "commitment to informed consent as a continuing process throughout labour and delivery gives people who experience gender dysphoria, have a history of trauma, or otherwise have a fraught relationship with their bodies the opportunity to control when and how they are touched during childbirth."[284] Affording and protecting such control has direct repercussions for the quality of care experienced by the birthing person, as well as their medical outcomes.

These are only a few examples of the myriad ways dignity must be negotiated and considered in the context of childbirth, both as an essential component of the *Charter* right to medical self-determination, and as a key factor in the enhancement of patient medical outcomes.

Self-managing childbirth

Considering the right to medical self-determination and all it entails, it may reasonably be argued that birthing people in Canada have a right to self-manage their births, without the assistance of a physician, midwife, or other medical professional (variously referred to as "freebirthing," or "unassisted childbirth.") "Freebirthing" is defined as the "clandestine practice whereby women intentionally give birth without healthcare professionals […] present in countries where there are medical facilities available to assist them."[285] Freebirth advocate Laura Kaplan Shanley describes:

> In an unassisted childbirth no one acts as a midwife. Instead, the birthing woman herself determines the course of her labour. Partners or friends may participate to varying degrees, but no one instructs the woman as to how to give birth, when to push, what position to be

[280] Aubrey, "Perspectives of Immigrant Women", *supra* note 279 at 678.
[281] Shalowitz, *supra* note 279 at 679; 680.
[282] Iris Gorfinkel, Elana Perlow & Sheila Macdonald, "The trauma-informed genital and gynecologic examination" (2021) 193 CMAJ E1090.
[283] Trevor MacDonald et al, "Transmasculine individuals' experiences with lactation, chestfeeding, and gender identity: a qualitative study" (2016) 16:106 BMC Pregnancy & Childbirth 1; Trevor Kirczenow MacDonald, "Lactation Care for Transgender and Non-Binary Patients: Empowering Clients and Avoiding Aversives" (2019) 35:2 J Human Lactation 223.
[284] Elizabeth Kukura, "Reconceiving Reproductive Health Systems: Caring for Trans, Nonbinary, and Gender-Expansive People During Pregnancy and Childbirth" (2022) 50:3 J Law Med Ethics 471 at 483.
[285] Gemma McKenzie, Glenn Robert & Elsa Montgomery, "Exploring the conceptualisation and study of freebirthing as a historical and social phenomenon: a meta-narrative review of diverse research traditions" (2020) 46 Med Humanit 512 at 512.

> in, etc. Occasionally suggestions may be offered but it is assumed that **the woman giving birth is the true expert on her own body** [emphasis in original].[286]

As set out above, a pregnant person in Canada ostensibly has the right to decide the course of the medical treatment they elect (or refuse) when it comes to their plans for pregnancy and childbirth. However, people who choose to give birth outside the institutionalized system face criminal risks and significant administrative barriers, including child protection implications.[287]

Though advocates laud unassisted home birth as a safe option,[288] newborns do sometimes die in unassisted births[289] and, when they do, birthing people may be subject to criminal prosecution.[290] For example, a birthing person who declines medicalised treatment may be charged with failing to provide the necessities of life pursuant to the duty under section 215(1) of the *Code*.[291] Deaths of newborns during unassisted home births may also give rise to charges contrary to section 238(1) of the *Code* (which prohibits the killing of an unborn child during the process of birth and which carries a maximum sentence of life imprisonment)[292] and section 242, which makes it a crime for a person giving birth to fail to obtain assistance in childbirth, when that failure results in the permanent injury or death of the child and with the intention to conceal the birth of the child or to cause the death of the child.[293] Though a person seeking an unassisted childbirth may not intend to conceal the birth or to cause the death of their child, the unavailability of witnesses or records attesting to the birthing person's intentions (a by-product of the clandestine nature of unassisted childbirth) may make it difficult for a birthing person to meet the Crown's case in that respect in a criminal proceeding.

Moreover, choosing unassisted childbirth or other non-conventional childbirth care may lead to increased scrutiny by health professionals or others, resulting in involvement by child protection agencies,

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[286] Laura Shanley, "What is Unassisted Childbirth?" *Unassisted Childbirth* (website), online: https://unassistedchildbirth.com/what-is-uc/what-is-unassisted-childbirth/.

[287] See, for example: *JF v MDC,* 2018 CanLII 91181.

[288] Heather Jean Cameron, *Expert on her own Body: Contested Framings of Risk and Expertise in Discourses on Unassisted Childbirth* (MA Thesis, Lakehead University Department of Sociology, 2012) [unpublished] at 137: "Women who advocate for unassisted childbirth typically frame childbirth as something that can usually occur autonomously and safely, without the need for an outsider to monitor and/or worry about possible risks." See also: "Why some women are choosing freebirth", *supra* note 81; "The Complete Guide to Freebirth" *The Freebirth Society* (website), online: https://www.freebirthsocietycourses.com/cgtf; Nicola Bryan, "Freebirth: 'Giving birth without medical help felt safer" *BBC News* (23 January 2022); Joanna Moorhead, "Freebirthing: is giving birth without medical support safe?" *The Guardian* (14 September 2013).

[289] See, for example: Brandy Zadrozny, "'I brainwashed myself with the internet'" *NBC News* (21 February 2020). There is no available data about the safety of unassisted home births, likely due in large part to the secretive nature of the practice. The World Health Organization reports in Canada in 2017 (the most recent available data), the rate of deaths in children 0-27 days old due to "birth asphyxia and birth trauma" was 0.5 per 1000 live births. (World Health Organization, "Rate of deaths by country: Birth asphyxia and birth trauma" (27 November 2018) *Global Health Observatory data repository* (website), online: https://apps.who.int/gho/data/view.main.ghe2002015-CH11.) The data does not distinguish between mode of birth. However, a 2019 Canadian study found there is no significant difference between safety outcomes of midwife-assisted planned home births and planned hospital births for women of low obstetrical risk. (Eileen K Hutton et al, "Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses," (2019) 14 EClinicalMedicine 59.)

[290] See, for example: Gerry Dewan, "St Thomas police lay charges in death of newborn baby" *CBC News* (4 May 2022).

[291] *Criminal Code,* RSC 1985, c C-46, s 215(1).

[292] *Criminal Code,* RSC 1985, c C-46, s 238(1).

[293] *Criminal Code,* RSC 1985, c C-46, s 242.

and the risk that children will be taken into care.[294] Child protection legislation varies by province, but most provincial acts state that a child will be in need of protection when that child is deprived of necessary health care (including through failure or refusal to seek out or obtain such care).[295] Short of failure to obtain medical treatment, stigma associated with unassisted childbirth may lead to reports to child protection agencies on the basis of neglect, or potential to cause physical harm or suffering. In *Tremblay v Daigle,* the SCC rejected the notion that a fetus can be a "child in need of protection" for the purposes of provincial child welfare regimes.[296] Nonetheless, child protection agencies have historically exercised jurisdiction over pregnant people through the "birth alerts" regime, in which pregnant people are "flagged" by child welfare agencies as posing a risk of neglect or harm before a child is born.[297] In many cases, birth alerts have resulted in the seizure of newborns within days or hours of their births.[298] Reports of neglect or potential harm made in response to a pregnant person's birth plan could put a person who seeks to birth outside the system at risk of having their child removed from their care.

These risks are magnified intensely for racialized and Indigenous pregnant people, who are disproportionately the subjects of oversight by child welfare agencies, including as the subjects of birth alerts.[299] This fact is especially troubling given that Indigenous people may be more likely to seek out options to give birth outside the institutional system, due to trauma experienced in the Western medical context, as well as due to ongoing systems of oppression that constrain their choices.[300]

Beyond direct legal risks, people who choose unassisted childbirth are at risk of being deemed to fall outside the range of what is "rational," and, by extension, designated incompetent. The right to medical self-determination is protected in Canada—but only for those judged competent to exercise that right.[301]

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[294] See: *JF v MDC, supra* note 287; *JF v AR,* 2019 CanLII 2338 (ON HPARB) [in which a child was taken into care following a planned unassisted home birth]; *AR v NK,* 2019 CanLII 119783 (ON HPARB) [in which a physician notified child protection agencies of a potential risk to an unborn child in response to the pregnant person's partner asking, during a prenatal appointment, whether the pregnant person "could use marijuana during labour in order to avoid the epidural"]; and *SD v Allen,* 2023 CanLII 13763 (ON HPARB) [in which a physician contacted child protective services to report concerns that a pregnant person was refusing to take iron pills to treat her "borderline anemia" and had expressed an intention to refuse a blood transfusion, if one was indicated during childbirth].

[295] Canada, Public Health Agency of Canada, *Provincial and Territorial Child Protection Legislation and Policy 2018* (Ottawa: Public Health Agency of Canada 2018) at 18-24.

[296] *Tremblay v Daigle*, supra note 1 at 663.

[297] Following the release of the National Inquiry into Missing and Murdered Indigenous Women and Girls Final Report, which included a call for an immediate end to birth alerts, all Canadian provinces have announced a formal end to the practice of birth alerts. However, it is unclear whether governments will cease all child protection-related surveillance of pregnant people. (Canada, National Inquiry into Missing and Murdered Indigenous Women and Girls, *Reclaiming Power and Place: the Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls* (Ottawa: 2019) [MMIWG Final Report]; Priscilla Ki Sun Hwang, "Quebec sent Ottawa hospital hundreds of birth alerts despite Ontario ban" *CBC News* (15 May 2023). Regarding ongoing surveillance of pregnant people, see, for example: Ontario, Legislative Assembly, *Official Report of Debates (Hansard),* 42nd Parl, 2nd Session, vol A (6 April 2022) at 2939 (Sol Mamakwa).

[298] Brielle Morgan, "Birth alerts follow you 'for the rest of your life' says Indigenous mom who had newborn taken" *APTN News* (22 September 2021); Camille Cardin-Goyer, "Birth Alerts" *Elle Canada* (16 August 2021); University of Toronto, Fraser Mustard Institute for Human Development Policy Bench, *The Efficacy of Birth Alerts: Literature Scan* (Toronto: 2021) at 17-19 [*The Efficacy of Birth Alerts: Literature Scan*].

[299] *The Efficacy of Birth Alerts: Literature Scan, supra* note 298 at 17-19.

[300] Priscilla Ki Sun Hwang, "Their newborns were taken at birth. Years later, these women still don't know why" *CBC News* (29 September 2022); Chantelle Bellrichard, "Bringing birth back to remote Manitoba First Nation: Women from Norway House refusing to leave for delivery" *CBC News* (17 July 2014); Landry, *supra* note 235.

[301] *Starson, supra* note 154.

People who refuse "standard" care or seek out counterculture alternatives in childbirth may be seen or deemed to be irrational and, therefore, incompetent. Susan Sherwin explains:

> The competency criterion threatens to exclude people who are oppressed from the scope of autonomy provisions altogether. This is because competency is often equated with being rational, yet the rationality of women and members of other oppressed groups is frequently denied.[302]

People who choose to give birth without trained assistance are often cast as irrational in media portrayals, signifying a broader cultural perception. Health researchers Sperlich and Gabriel explain: "Giving birth without trained attendants intentionally […] can appear a provocative choice; popular media has often painted these women as incompetent and irresponsible."[303] Moreover, one study describes:

> The media frequently presents freebirth as a 'deviant' behaviour, and online newspaper reports often attract negative public comments whereby freebirthing women are considered irresponsible, selfish, stupid, and rash. Consequently, it is a decision that gives rise to stigma and condemnation.[304]

Choices and decisions deemed "irrational" are commonly those seen to depart from or contradict scientific evidence. This dichotomy of what is "scientific" (and, therefore, *right*) and what is unscientific (and, therefore, *wrong*) is at odds with many birthing people's conceptions and experiences of childbirth. As health researchers Holten and de Miranda explain: "Intuition often functions as authoritative knowledge among women who choose to birth outside the system […] Listening to, acting upon and trusting one's intuition are crucial because intuition is given the highest authority above other forms of knowledge."[305] There is limited space (if any) for intuition in either law or medicine, both of which typically presume a reasonable person making rational decisions in their own self-interest.

When birthing people make choices that are perceived by others to be irrational, they may be in danger of being subjected to medico-legal assessments of their capacity. For example, in *Children's Aid Society of Belleville and Hastings County v LT,*[306] the Ontario Provincial Court issued an order under the *Mental Health Act* for assessment of a pregnant woman's mental capacity "on the basis that her behaviour posed a danger to both herself and the 'child'"[307] because she refused obstetrical care.[308] The pregnant

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[302] Sherwin, "A Relational Approach to Autonomy", *supra* note 9 at 26.
[303] Mickey Sperlich & Cynthia Gabriel, "'I got to catch my own baby': a qualitative study of out of hospital birth" (2022) 19:43 Reproductive Health 1 at 2. See also: Amy Chasteen Miller, "On the Margins of the Periphery: Unassisted Childbirth and the Management of Layered Stigma" (2012) 32 Sociological Spectrum 406. For examples of media depictions, see: Leanne Hall, "KIDDING ME: I'm having an unassisted pregnancy, I haven't even taken a test to confirm it and I won't use a midwife either" *The Sun* (10 February 2022); Emily Lefroy, "I'm pregnant with my third 'free birth' baby: I refuse to see doctors" *New York Post* (23 February 2023); Emily Blatchford, "Opinion: Freebirthing isn't 'natural'. It's dangerous" *Kidspot* (2 August 2018).
[304] McKenzie, Robert & Montgomery, *supra* note 285 at 512.
[305] Lianne Holten & Esteriek de Miranda, "Women's motivations for having unassisted childbirth or high-risk homebirth: An exploration of the literature on 'birthing outside the system'" (2016) 38 Midwifery 55 at 59.
[306] *Re Children's Aid Society of City of Belleville, Hastings County and T et al*, 1987 CanLII 4441 (ON CJ) [*Re CAS of City of Belleville*].
[307] Nelson, *Law, Policy and Reproductive Autonomy, supra* note 165 at 188.
[308] In this case, the court also issued an order making the still unborn child a ward of the Children's Aid Society for a period of three months. The court's finding that a fetus can be a "child in need of protection" under provincial child protection legislation was later deemed incorrect by the SCC, which held in *Tremblay v Daigle* that a state cannot "extent its wardship jurisdiction to a foetus" (*Tremblay v Daigle*, *supra* note 1 at 663).

woman's "attitude" regarding her pregnancy was a "significant criterion" for the judge in coming to his decision:

> She stated in her evidence that the child will be born "wherever" and I think that summarizes her attitude towards the safe delivery of the child. She refuses to seek, maintain or accept any form of medical assistance […].[309]

This decision, though dated, reflects an ongoing societal view of pregnant people who refuse recommended treatment or otherwise depart from established norms as mentally ill or "crazy."[310]

More recently, in *C (Re),*[311] the Ontario Consent and Capacity Board heard an application in respect of "Ms. C," who was seven months pregnant and living with schizophrenia. At issue was Ms. C's capacity to consent to treatment with antipsychotic medication, as well as the validity of her involuntary hospitalization.

On a detailed assessment of the evidence provided by the parties, the Consent and Capacity Board found that Ms. C showed some insight into her mental illness, as well as appreciation of the potential negative consequences of taking the medication. The Board found that Ms. C's refusal to take the antipsychotic medication was, at least in part, based on her expressed concerns about the effects the medication would have on her unborn child. As a result, the Board declined to uphold the finding of incapacity.[312]

The medical team sought to continue Ms. C's involuntary hospitalization on two primary bases. First, Ms. C had missed "several" prenatal appointments. Although no issues had arisen in Ms. C's pregnancy, the medical team explained there are "inherent risks" associated with pregnancy and birth "that can be minimized with pre-natal care." [313] Second, the medical team sought continuation of Ms. C's involuntary hospitalization based on her stated desire to have a vaginal birth. The medical team observed Ms. C had a scar indicating she had had at least one prior C-section and raised concerns about the risk of uterine rupture during an attempted vaginal delivery. On cross-examination, the physician conceded that Ms. C's pregnancy had been "uneventful" to date.[314] He also "conceded that, <u>but for the pregnancy, he did not think he had grounds to keep her as an involuntary patient</u> [emphasis added]."[315] In the result, the Ontario Consent and Capacity Board found the relevant legislative requirements for involuntary hospitalization were not met. It directed that if Ms. C wanted a vaginal delivery on the day of birth, "potential risk and her capacity can be assessed at that time, if need be."[316]

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[309] *Re CAS of City of Belleville, supra* note 306.
[310] Chasteen Miller, *supra* note 303 at 411.
[311] *C (Re),* 2009 CanLII 21431 (ON CCB) [*C (Re)*].
[312] *Ibid.*
[313] *Ibid.*
[314] *Ibid.*
[315] *Ibid.*
[316] *Ibid*.

The facts of *C (Re)* provide an example of the kind of scrutiny pregnant people may be subjected to when they refuse recommended medical care and the ways they may be required to defend their choices—as well as their capacity to choose.[317]

The characterization of people who depart from mainstream childbirth practices as being irrational or "mentally disturbed" endures in both popular and legal discourse. For example, "mental disturbance" is linked directly to childbirth in Canadian criminal law. Section 233 of the *Criminal Code* sets out the offence of infanticide as follows:

> A female person commits infanticide when by a wilful act or omission she causes the death of her newly-born child, if at the time of the act or omission she is not fully recovered from the effects of giving birth to the child and by reason thereof or of the effect of lactation consequent on the birth of the child her mind is then disturbed.[318]

Infanticide is one the three forms of culpable homicide in the *Criminal Code*. It carries a maximum sentence of a five-year term of imprisonment, indicating that Parliament intended infanticide by reason of "mental disturbance" to attract a lower degree of blameworthiness than other forms of homicide.[319]

The offence is unique for several reasons. First, it is one of only two offences in the *Code* that can exclusively be committed by "a female person."[320] Second, it requires "a mother-child relationship between the perpetrator and the victim."[321] Third, it sets an unusually low threshold for a finding of mental disturbance in the criminal law context—one that does not require a finding of a diagnosed mental disorder.[322] A person who causes the death of their child while suffering from a mental disorder that has rendered them incapable of appreciating the nature of the act or omission, or knowing it was wrong, would be deemed not criminally responsible pursuant to section 16 of the *Criminal Code*.[323] In contrast, infanticide addresses mental disturbance *caused by* the event of childbirth. It is, thus, codified in Canadian law that childbirth can be a deeply distressing event—distressing enough to provide a partial defence to the very serious charge of homicide.[324]

The charge of infanticide was considered most recently—and for the first time[325]—by the Supreme Court of Canada in 2016 in *R v Borowiec*, in which a woman was found not guilty of murder at trial, but guilty of the lesser charge of infanticide. The trial judge concluded, considering the evidence of an expert

[317] See also: *Baby R, Re, supra* note 172 at para 4.
[318] *Criminal Code,* RSC 1985, c C-46, s 233.
[319] *R v Borowiec,* 2015 ABCA 232 at para 144 [*Borowiec* ABCA].
[320] H Archibald Kaiser, "*Borowiec*: Exploring Infanticide, a Particularly Dark Corner and Providing Another Reminder of the Need for Reforming Homicide Sentencing" (2017) 65:1-2 Crim LQ 242 at 245.
[321] *R v LB,* 2011 ONCA 153 at para 59.
[322] *R v Borowiec,* 2016 SCC 11 at para 34 [*Borowiec* SCC]. See also: *R v Pemberton,* 2019 ONSC 4206 at para 53.
[323] *Borowiec* ABCA, *supra* note 319 at para 143.
[324] Infanticide "operates both as a stand-alone offence and as a partial defence […] to a charge of murder." (*Borowiec* SCC, *supra* note 322 at para 15.) Legal scholar Sanjeev Anand explains: "[A]lthough the Crown can charge a woman with the offence of infanticide, from a practical perspective it is often utilized as a defence by counsel for accused charged with murder in relation to their newborns" (Sanjeev Anand, "Rationalizing Infanticide: a Medico-Legal Assessment of the *Criminal Code*'s Child Homicide Offence" (2010) 47:3 Alberta L R 705 at 707).
[325] Kaiser, *supra* note 320 at 243.

witness and the accused's "bizarre actions,"[326] that the accused's mind was disturbed within the meaning of the *Code*. The Supreme Court of Canada upheld the trial judge's finding in a unanimous decision, in which it focused on the legal meaning of the phrase "her mind is then disturbed."[327] It determined such disturbance "need not constitute a defined mental or psychological condition or a mental illness" nor "amount to a significant impairment of the accused's reasoning faculties." Moreover, legal scholar Archibald Kaiser explains: "While her mental agitation, instability or discomposure must relate to her not being 'fully recovered' from the birth, the disturbance need only be temporally associated with the death."[328]

The offence of infanticide provides a window into lawmakers' (and, by extension, Canadian society's) perception of women's abilities to make "rational" decisions in the context of childbirth. In his commentary on *Borowiec,* Kaiser questions: "In terms of women's autonomy, does the offence suggest women are powerless victims of their physiology and does it thereby strengthen patriarchal values?"[329] In at least some cases, the answer appears to be "yes." Consider, for example, *R v Smith,* an infanticide case in which the Newfoundland Supreme Court found it was "almost self evident" that a young woman who gave birth unassisted "would immediately after that have a disturbed state of mind."[330] As a result of this disturbed state of mind, the trial judge found the accused acted "irrational[ly]," and "without consideration of the consequences."[331]

In many cases, infanticide provides a vehicle through which women faced with incredibly difficult circumstances may be shown compassion in the form of a finding of diminished culpability. Many commentators have argued the offence of infanticide is anachronistic, minimizes the victims, and fails to reflect Canadian society's current values and criminal justice priorities[332] (in addition to its failure to reflect current scientific evidence regarding the effect of the onset of lactation).[333] Nevertheless, the offence remains on the books, demonstrating a historic and ongoing conceptual link in Canadian law between the experience of childbirth and the inducement of mental disturbance, sometimes resulting in "irrational" or "bizarre" actions or choices.

In the context of tort law, the concept of the "reasonable" person (or "reasonable patient") also functions to delineate the range of choices that a birthing person is expected to make. American legal scholar Jamie Abrams argues the fact that most pregnant people choose to give birth within the mainstream medical system contributes to the legal construction of the "reasonable patient" as one who sacrifices their own

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[326] *Borowiec* SCC, *supra* note 322 at para 8.
[327] *Ibid* at para 1.
[328] Kaiser, *supra* note 320 at 252.
[329] *Ibid* at 245-246.
[330] *R v Smith,* 1976 CanLII 2542 (NLSC).
[331] *Ibid.*
[332] Kaiser, *supra* note 320 at 243; Rebecca S Zaretsky, "Parents Who Kill Their Babies: Why the Discrepancy and Leniency in Sentencing is Not Justified" (2012) 59 CLQ 416.
[333] Lisa Silver, "*Regina v Borowiec* On Infanticide: Does the Crime Fit the Times?" (10 August 2015), *ABlawg* (blog), online: https://canliiconnects.org/en/commentaries/37829.

interests for the benefit of their fetus, to the detriment of those who diverge from this model.[334] Abrams explains:

> The "reasonable patient" matters greatly to tort law from the perspective of juror perception, comparative negligence claims, and informed consent models. Thus, the idea that all women are normalized toward a particular decision-making framework marginalizes those who adopt a different framework.[335]

In this way, Abrams argues, the "reasonable patient" becomes the "good mother," who does not question the physician and always follows their advice regarding what is best for the fetus. The deviant patient is, by extension, cast as a "bad mother."[336] Abrams points out that in any other health care context, patients "have complete autonomy to refuse treatment against medical advice, elect high-risk courses of action, and prioritize their own interests above any other decision-making metric," but childbirth is an anomaly—due, Abrams argues, to the duty of care owed by the physician to the fetus upon its birth.[337] As discussed above, this duty (and associated tort liability implications) sometimes pushes clinical care providers to recommend courses of treatment that minimize *all* fetal harms, even to the detriment of the birthing person. Abrams explains:

> The minimization of all fetal harms decision-making model is problematic because its replication by "most women" in childbirth risks distorting the standard of care governing childbirth for all women. It suggests that the standard of care in childbirth requires complete compliance with medical advice and the minimization of all fetal risks. The actual standards of care, however, would require patient autonomy and only the minimization of unreasonable risks.[338]

Though Abrams writes specifically in the context of tort law, the ideal of the reasonable, compliant birthing person has impacts in other areas of law, and bears significantly on the question of whether there is a legal "right" to self-manage birth.

There is limited statistical data available regarding intentionally planned unassisted childbirth, both in terms of how many people elect to freebirth annually, and with respect to the safety of planned unattended births, due, in large part, to the secretive nature of the practice.[339] However, there are plentiful first-hand

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[334] Jamie R Abrams, "The Illusion of Autonomy in Women's Medical Decision-Making" (2017) 42 Fla St U L Rev 17 at 19.
[335] *Ibid* at 48.
[336] *Ibid* at 49.
[337] *Ibid* at 18; 30.
[338] *Ibid* at 47.
[339] Sperlich & Gabriel, *supra* note 303 at 2; McKenzie, Robert & Montgomery, *supra* note 285 at 512.

accounts of freebirth available online[340] and in print,[341] as well as a number of recent published scientific studies aimed at identifying the reasons behind pregnant people's choices to pursue unassisted childbirth.[342]

A review of the available literature reveals consistent and overlapping themes. First, advocates for unassisted birth often describe a desire to opt out of the traditional maternity system due to perceived shortcomings of the medicalised model of childbirth, including the midwifery model. Journalist Rebecca Grant explains some unassisted birth advocates "view licensed midwifery as an extension of the same medical model they want to avoid, referring to them as 'medwives.'"[343] The medical model, advocates argue, causes harm to birthing people and fetuses through overzealous intervention and treatment. Unassisted birth advocate Kaplan Shanley describes:

> Often a woman will say, 'Thank God I was in the hospital when I gave birth. There were complications, but the doctor saved by baby's life.' What she may not understand is that the interference by the doctor and the nursing staff, from the moment she entered the hospital, may have actually caused the 'complications' in the first place.[344]

In addition, people who choose unassisted birth often describe the experience of childbirth as an intimate, natural, spiritual, and even religious experience—qualities which may be lost in conventional childbirth care.[345]

Second, advocates commonly describe a desire to "take control" of their birthing experiences. Unassisted birth is premised on the belief that birth is an instinctive, natural process, which every pregnant person can achieve on their own. Grant describes that a "tenet of free birthing is that doctors, nurses, and midwives don't have more expertise or authority about what's needed during birth than a mother."[346] Many unassisted birth advocates argue "true informed consent is not possible in the hospital" due to the limits on choices available to them in childbirth—choice in hospital settings, advocates contend, is "choiceless

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[340] See, for example: "Birthing in Freedom and Power – Lyra's Freebirth Story" (28 August 2022), *Free Birth Society* (blog), online: https://www.freebirthsociety.com/blog/blogs%2Fbirthing-truth-a-collection-of-freebirth-stories%2Fbirthing-in-freedom-and-power-lyras-freebirth-story; "Kaylee's Freebirth Story" (30 June 2018), *Free Birth Society* (blog), online: https://www.freebirthsociety.com/blogs/birthing-truth-a-collection-of-freebirth-stories/kaylees-freebirth-story; "Freebirth Story—Planned Unassisted Homebirth" (19 January 2022), *Hopewell Heights* (blog), online: https://hopewellheightsblog.com/my-planned-unassisted-homebirth-ernies-freebirth-story/; "Hilary's Unassisted HBA2C Birth Story" (22 September 2020), *International Cesarean Awareness Network* (blog), online: https://www.ican-online.org/blog/2020/09/hilarys-unassisted-hba2c-birth-story/.

[341] Laura Kaplan Shanley, *Unassisted Childbirth,* 3rd ed (self-published, 2016); Heather Baker, *Home Birth on Your Own Terms: A How To Guide for Birthing Unassisted,* 2nd ed (self-published, 2019); Anita Evensen, *The Unassisted Baby: A Do-It-Yourself Guide to Pregnancy and Childbirth*, 3rd ed (Snow Drop Press, LLC: 2021); Lynn M Griesemer, *Unassisted Homebirth: An Act of Love* (Terra Publishing, 1998); Adrienne Carmack, *Reclaiming My Birth Rights: A Mother's Wisdom Triumphs Over the Harmful Practices of Her Medical Profession* (self-published, 2014).

[342] Holten & de Miranda, *supra* note 305; Martine Hollander et al, "Women's motivations for choosing a high risk birth setting against medical advice in the Netherlands: a qualitative analysis" (2017) 17:423 BMC Pregnancy and Childbirth 1; Claire Feeley, "Freebirthing: a case for using interpretive hermeneutic phenomenology in midwifery research for knowledge generation, dissemination and impact" (2019) 24:1-2 J of Research in Nursing 9; Claire Feeley et al, "Why do some women choose to freebirth? A meta-thematic synthesis, part one" (2015) 13:1 Evidence Based Midwifery 4; Claire Feeley & Gill Thomson, "Tensions and conflicts in 'choice': Womens' experiences of freebirthing in the UK" (2016) 41 Midwifery 16; Jasan Dannaway and Hans Peter Dietz, "Unassisted childbirth: why mothers are leaving the system" (2014) 40:12 J of Medical Ethics 817; McKenzie, Robert & Montgomery, *supra* note 283.

[343] Rebecca Grant, "Won't Call the Midwife" *Marie Claire* (20 October 2021).

[344] Kaplan Shanley, *supra* note 341 at 13.

[345] Holten & de Miranda, *supra* note 303 at 57; Kaplan Shanley, *supra* note 341 at 83-89; 125-134; Baker, *supra* note 341 at 314; 322.

[346] R Grant, *supra* note 343.

choice."[347] Consider, for example, the following account describing a home birth without medical assistance following a hospital delivery via C-section:

> I knew this time around I wanted to be in control of my pregnancy and birth. I had a heartbreaking turn with my first birth. My water broke and we found out my little girl was breech and due to hospital policies, that meant an automatic cesarean. I didn't want anyone telling me what tests I had to take or giving me some percentage chance of having a VBAC. I knew in my heart that a home birth was the only way to go.[348]

In this respect, the unassisted birth movement is, in part, a response to obstetric violence and mistreatment within the conventional medical model.[349]

In conclusion, if a right to medical self-determination exists in Canada (and the Supreme Court of Canada assures Canadians it does[350]), there must be people who validly choose to give birth on their own terms, outside of hospitals or in ways that do not fit within the scope of medical services funded by the government and available where they live. Currently, those people's choices are significantly constrained by stigma (a regulatory force that should not be underestimated[351]), assessments of their mental capacity, criminal and professional risks, and child protection implications.

Against the backdrop of a strained and chronically underfunded public health care system, governments clearly cannot guarantee every person's vision for childbirth care. However, the narrow set of choices offered by the public system for birthing people in childbirth will inevitably lead people to seek options outside the system. If the government's objective is ensuring safe outcomes in childbirth, it must expand the safe options available to people, and account for the factors motivating people to seek out alternatives—rather than pushing childbirth further into the shadows.

Because Canada has a publicly funded health care model, some may argue that the state has an interest in limiting "risky" childbirth options in the interest of reducing injuries (to either the child or the birthing person) that would result in long-term costs due to serious injury or disability. This argument leads down a dangerous path of "perfecting" pregnancy and childbirth.[352] There are many scenarios during pregnancy in which a selected course of action would increase costs for the state. For example, an individual's choice to continue a pregnancy in which the fetus has a genetic condition diagnosed through prenatal screening, or an anomaly discovered on ultrasound, may result in the birth of a child with health needs requiring additional state spending. By law, the state cannot (and, indeed, must not) infringe on a pregnant person's autonomy by requiring that that person terminate a pregnancy when it is discovered

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[347] Holten & de Miranda, *supra* note 305 at 59.
[348] Baker, *supra* note 341 at 343.
[349] R Grant, *supra* note 343.
[350] *Carter, supra* note 4 at para 67.
[351] Kirsten Bell et al, "Smoking, stigma and tobacco 'denormalization': Further reflections on the use of stigma as a public health tool. A commentary on *Social Science & Medicine's* Stigma, Prejudice, Discrimination and Health Special Issue (67:3)" (2010) 70 Social Science & Medicine 795.
[352] Isabel Karpin & Kristin Savell, *Perfecting Pregnancy: Law, Disability, and the Future of Reproduction* (New York: Cambridge University Press, 2012).

through screening that the child will (or *might*) be born with significant medical needs.[353] Equally, the state cannot constrain other lawful choices a pregnant or birthing person may make during their medical treatment in the interests of reducing public health care spending costs.

Reducing the incidence of injury and death by creating and making available safe options for childbirth is, of course, a legitimate and important state objective. However, limiting choices to the existing standards of so-called medicalised childbirth risk furthering unsafe conditions by pushing people seeking alternatives to give birth entirely outside the system,[354] in the "shadow of the law."[355] To meaningfully increase safety and reduce the risk of injury (thereby reducing long-term public health care spending) in a manner that enables pregnant and birthing people to realize their right to medical self-determination, the state must invest in alternative options for childbirth, such as increasing access to the option of midwife-attended home birth[356] and reimagining the child welfare system in a manner that is supportive and collaborative, rather than punitive.[357] Constraining choice within the existing framework in the interest of increasing safety will have the opposite effect.

Conclusion

In conclusion, this chapter provides an overview of the legal rights and entitlements of birthing people during childbirth, as a means of "setting the scene" in which birthing people's rights are navigated and given meaning in intrapartum care settings throughout Canada. However, I argue, legal rights and entitlements are not strictly prescribed by law "on the books," but, rather, developed through the ways those laws work in the lives of their subjects, and how they are interpreted and applied by state actors. Accordingly, the following chapter is a close examination of the ways these legal rights and entitlements play out "in action" in the day-to-day experiences of people giving birth in Canada today.

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[353] In making this argument, I acknowledge that the choice and autonomy of a pregnant person receiving such a diagnosis is already significantly constrained by many factors, including public attitudes toward people with disabilities. For a detailed analysis, see: *ibid* at 40-58.

[354] "'Do it yourself' births prompt alarm" (2011) 183:6 CMAJ 648 at 648-650 ["'Do it yourself' births"]; Hall, "Minimizing Risk While Maximizing Integrity," *supra* note 7 at 578; HG Dahlen, M Jackson, J Stevens, "Homebirth, freebirth and doulas: Casualty and consequences of a broken maternity system" (2011) 24 Women and Birth 47; Bryan, *supra* note 288; R Grant, *supra* note 343; Imani Bashir, "Pregnant Black Women Are Dying at Terrifying Rates—That's Why I Chose an Unassisted Home Birth," *Glamour* (1 March 2019).

[355] Robert H Mnookin & Lewis Kornhauser, "Bargaining in the Shadow of the Law: The Case of Divorce" (1979) 88:5 Yale LJ 950.

[356] Dahlen, Jackson & Stevens, *supra* note 354; Van Wagner, *supra* note 77.

[357] See, for example, *NP v Alberta (Director, Child, Youth and Family Enhancement Act),* 2012 ABCA 44, in which a woman gave birth at home unattended "to avoid the attention of the Director of Child and Family Services […], who had intervened to take the mother's previous three children from her" (para 1).

CHAPTER 3:
Law in Action

This chapter provides an in-depth analysis of the ways the rights and entitlements set out in the previous chapter play out in the lived experiences of people giving birth in Canada. I take a "law in action" approach, drawing from first person narratives of childbirth to take a closer look at how laws and policies related to childbirth are experienced.[358] This chapter is structured in parallel to the previous chapter: I examine the experience of legal entitlement to publicly funded childbirth care through two case studies, followed by a narrative synthesis of first-hand accounts regarding medical self-determination in childbirth.

3.1 Legal entitlement to publicly funded childbirth care

In childbirth, the question of entitlement to (and availability of) publicly funded care is relevant to a vast range of choices, such as place of birth, choice of birth attendant, mode of birth, method of induction of labour, and pain management. A full examination of access to all such care choices is beyond the scope of this thesis. Thus, the following analysis is comprised of two case studies.

In selecting which aspects of entitlement to childbirth care to examine in detail, I am mindful of the danger of assessing health care systems based on the needs or interests of the "typical" birthing person. In a public health care system such as Canada's, it is impossible to fund all conceivable care options, and the question of what should be funded is a challenging one. In seeking to answer it, legal scholar Dianne Pothier argues it is not enough to simply identify "the typical needs of those accessing the health care system."[359] Rather, she argues, the "starting point should be a widely diverse population seeking to access health care."[360] I adopt this approach, applying a relational lens to my examination of experiences of access to publicly funded childbirth care, in order to gain a greater understanding of "how the collective responds to claims that are not personally relevant to most of its members."[361]

As stated above, my analysis of entitlement to publicly funded care "in action" is comprised of two case studies. My first case study examines the issue of *mode of birth* through an exploration of legal entitlement to Caesarean section on patient request and, conversely, the issue of routine use of Caesarean section for birthing people with intellectual and developmental disabilities. My second case study focuses on *place of birth* and takes a broad view of the right to publicly funded "home birth" care, examining the

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[358] Pound, *supra* note 10; Sandefur, *supra* note 10 at 59.
[359] Dianne Pothier, "Relational Theory and Resource Allocation in Health Care: Accounting for Difference" in Downie & Llewellyn, *supra* note 9, 185 at 185 [Pothier, "Relational Theory and Resource Allocation"].
[360] *Ibid*.
[361] *Ibid* at 187.

impact of birth evacuation[362] policies on pregnant and birthing Indigenous people living in remote regions of Canada.

Mode of Birth

Caesarean Section on Maternal Request ("CDMR")

"Caesarean section" or "C-section" refers to delivery of a baby via surgical incision to the pregnant person's abdomen and uterus, most often performed when there is a risk to the health of the birthing person or fetus that may be mitigated through operative delivery.[363] C-sections "are considered major but safe surgery in high income countries"[364] including Canada, where they are the most common hospital-based surgery.[365] The rate of Caesarean deliveries has increased in Canada over the past decades, accounting for 18.7% of births in 1997, and 29.1% of all births between 2016 and 2017[366]—a significantly higher proportion than the World Health Organization (WHO)'s "ideal rate" of 10-15%.[367] In response, widespread efforts are underway to reduce the rate of C-sections both within obstetrical settings[368] and through the expansion of midwifery.[369]

Against this backdrop, there is a small but vocal countermovement gaining ground: pregnant people who seek the option of giving birth via Caesarean section for non-medical reasons, claiming it "as an alternative equally legitimate to vaginal delivery."[370] This practice is commonly referred to as "Caesarean delivery on maternal request" or "CDMR."[371] It is difficult to identify what proportion of C-sections occur

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[362] The term "birth evacuation" refers to policies (both explicit and implicit) that result in pregnant people living in remote communities being urged or required by providers to leave their home communities and travel significant distances in order to give birth in major urban centres (Karen M Lawford, Ivy L Bourgeault & Audrey R Giles, "'This policy sucks and it's stupid:' Mapping maternity care for First Nations women on reserves in Manitoba, Canada" (2019) 40:12 Health Care Women Int 1302 at 1302.

[363] "Caesarean Section," *Mount Sinai Hospital* (website), online: https://www.mountsinai.on.ca/care/cs.

[364] Ida Emilie Steinmark, "Caesareans or vaginal births: should mothers or medics have the final say?" *The Guardian* (13 February 2022).

[365] "Hospital stays in Canada" (23 February 2023), *Canadian Institute for Health Information* (website), https://www.cihi.ca/en/hospital-stays-in-canada; Yanfang Guo et al, "Birth outcomes following cesarean delivery on maternal request: a population-based cohort study" (2021) 193: 18 CMAJ E634 at E634.

[366] Jing Gu et al, "Examining Cesarean Section Rates in Canada Using the Modified Robson Classification" (2020) JOGC 757 at 758; 761. The numbers used in coming to this statistic include all provinces and territories except for Quebec.

[367] World Health Organization, *WHO recommendations: non-clinical interventions to reduce unnecessary caesarean sections* (October 2018).

[368] Margaret Morris & George Carson, "It's time to curb rising C-section rates in Canada" *Ottawa Citizen* (18 January 2021); Gu, *supra* note 366; Kim Smith, "Why is the C-section rate still climbing in Canada?" *Global News* (3 June 2019); "Ontario hospitals strive to cut C-section rates" *CBC News* (20 April 2015); Michel Rossignol et al, "Preventable Obstetrical Interventions: How Many Caesarean Sections Can Be Prevented in Canada?" (2013) 35:5 JOGC 434.

[369] See, for example: Anna Chapman et al, "Maternity service organisational interventions that aim to reduce caesarean section: a systematic review and meta-analyses" (2019) 19:206 BMC Pregnancy and Childbirth 1; André Picard, "Midwives: Underused and misused assets in Canada" *The Globe and Mail* (10 July 2013).

[370] Nelson, *Law, Policy and Reproductive Autonomy, supra* note 165 at 191-192. See also: Magnus Murphy & Pauline McDonagh Hull, *Choosing Cesarean: A Natural Birth Plan* (Amherst, NY: Prometheus Books, 2012).

[371] Terminology used to refer to elective Caesarean sections varies widely both across jurisdictions and within Canada. In this section, I adopt the nomenclature used by the Society of Obstetricians and Gynecologists of Canada ("SOGC") of "Caesarean Delivery on Maternal Request" or "CDMR." SOGC defines CDMR as: "a planned primary [Caesarean section] in the absence of a clear obstetrical or medical indication to avoid a vaginal delivery" ("SOGC Committee Opinion No 361", *supra* note 148). In this context, "primary" means the birthing person has not previously given birth via Caesarean section. With respect to the issue of medical indication, it is also important to note that "what constitutes 'clinical need' for caesarean is a matter of clinical discretion" (Elizabeth Chloe Romanis & Anna Nelson, "Maternal request caesareans and COVID-19: the virus does not diminish the importance of choice in childbirth" (2020) 46 J Med Ethics 726 at 726-727). The billing code used for Caesarean sections is the same, regardless of whether the procedure is "medically indicated." See, for example, the Ontario Ministry of Health Schedule of Billing Codes and Fees (Obstetrics) at K6 (General, RRO 1990, Reg 552, "Schedule of Benefits: Physician Services").

via CDMR in Canada, because "reports of prevalence vary widely."[372] National statistics are not available in Canada,[373] but there is consensus that CDMR represents only "a small minority" of births.[374]

Although Canadians do not have an explicit right to Caesarean birth, current clinical guidance lays the groundwork for an enforceable entitlement to publicly funded CDMR. The Society of Obstetricians and Gynecologists of Canada's (SOGC) most recent Committee Opinion on the topic states:

> [W]hen a person requests a Caesarean delivery, reasons for their request should be thoroughly explored. The process of counselling and decision making may take several sessions. The discussion should highlight the person's values, fears, or concerns central to their request. […]. Reaching a mutual decision on mode of delivery should be done without bias or coercion. […] If after such counselling and clear recommendation for a vaginal delivery the patient maintains a request for delivery by CS, an obstetrician may then choose one of the following paths:
>
> 1. Agree to perform the CS, after 39 + 0 weeks' gestation, providing that the person is able to demonstrate an understanding of the risks and benefits of the mode of delivery that they have requested
> 2. Decline to perform the CS, particularly in circumstances where:
>   a. The obstetrician believes there are significant health concerns for the pregnant person or baby if a planned CS is undertaken; or
>   b. The person does not appear to have sufficient understanding to provide informed consent for the procedure
>
> If an obstetrician declines to perform a CDMR, the obstetrician has a responsibility to refer the patient for a second opinion or transfer care and document the details of their discussion with the patient in the chart.[375]

Thus, while pregnant people in Canada cannot compel their obstetricians to perform C-sections, the Opinion makes explicit a professional obligation on the part of obstetricians to listen to their patients' reasons for requesting Caesarean delivery, provide them in-depth counselling "without bias or coercion" and, if necessary, refer to another provider.[376] The referral requirement means doctors cannot coerce patients into attempting vaginal delivery by abandoning (or threatening to abandon) them as patients if they do not agree.

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[372] Eileen K Hutton & Jude Kornelsen, "Patient-Initiated Elective Cesarean Section of Nulliparous Women in British Columbia, Canada" (2012) 39:3 Birth 175 at 176.
[373] Janet Bryanton, Cheryl Tatano Beck & Stephanie Morrison, "When Fear Surrounding Childbirth Leads Women to Request a Planned Cesarean Birth" (2022) 44:7 Western J of Nursing Research 643 at 644.
[374] Hutton & Kornelsen, *supra* note 372 at 181. See also: Guo, *supra* note 365 at E634; E641. While the proportion of people electing CDMR in Canada is presently small, critics rates raise concerns regarding costs to the public system associated with the rise in Caesarean deliveries (see, for example: Karen Born, Joshua Tepper & Nan Okun, "Pulling back the curtain on Canada's rising C-section rate" *Healthy Debate* (29 May 2014)). Elaraby et al note that in two recent studies conducted in China and Brazil, where CDMR is a popular option, "providers claimed that [Caesarean section] is expected by service users and families, posing substantial pressure on providers" (Sarah Elaraby et al, "Behavioural factors associated with fear of litigation as a driver for the increased use of caesarean sections: a scoping review" (2023) 13:3070454 BMJ Open 1 at 7). However, advocates for CDMR emphasize that planned Caesareans are associated with lower costs than emergency Caesareans, in part because they "allow for more efficient use of operating rooms and [reduce] the need for extra staffing and overtime," and, therefore, must be considered separately from existing, general data on Caesarean deliveries. In addition, advocates point out public cost-savings associated with reduction in pelvic floor repair costs, emergency interventions in vaginal deliveries, postpartum rehospitalization, and cost to future pregnancies associated with birth injuries sustained in vaginal deliveries (Murphy & Hull, *supra* note 370 at 224-228). More research is needed in the Canadian context regarding cost effectiveness of CDMR in order to draw conclusions regarding cost to the public system.
[375] "SOGC Committee Opinion No 361", *supra* note 148 at 970-971.
[376] *Ibid*.

The Opinion, while not law, sets standards for professional oversight and discipline and informs the standard of care for civil claims, resulting, in effect, in an enforceable entitlement to publicly funded CDMR for many Canadians.

The current SOGC guidance is a radical change from its previous position, reflected in its now-retired 2008 Joint Policy Statement on Normal Childbirth, which unequivocally directed that a C-section "should not be offered to a pregnant woman when there is no obstetrical indication."[377] The updated guidance conveys a tacit recognition that "[t]he state of the science is such that it is not possible to point to either vaginal or surgical delivery as clearly best."[378] Moreover, this shift in stance reflects a broader and evolving recognition of the right to medical self-determination,[379] including choices others may deem "foolish."[380]

People seek elective Caesarean delivery for many reasons, including a desire to avoid complications in labour,[381] perceptions that people who give birth via planned C-section receive a higher quality of care,[382] concerns regarding the impact of childbirth on pelvic floor health,[383] history of sexual assault,[384] a desire to maintain dignity,[385] a desire to emulate celebrities,[386] and a desire to plan the date of birth, whether for "convenience"[387] or based on cultural beliefs regarding auspicious birth days.[388] Research also commonly identifies fear of childbirth as a major contributing factor to requests for CDMR, including fear of pain, fear of "losing control," or fear of mistreatment by care providers.[389]

Patient-initiated requests for Caesarean delivery are undeniably a product of the complex network of social relationships and cultural influences in which pregnant people are embedded. In this broader context, some relational theorists argue patient requests for interventions such as CDMR cannot be truly

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[377] "Joint Policy Statement on Normal Childbirth" (2008) 30:12 JOGC 1163 at 1164 [SOGC "Joint Policy Statement on Normal Childbirth"].
[378] Nelson, *Law, Policy and Reproductive Autonomy, supra* note 165 at 192.
[379] "SOGC Committee Opinion No 361", *supra* note 148 at 967-968; Jill Buchner, "Want a C-section? Your doctor should offer information, not judgment" *Today's Parent* (26 June 2018).
[380] *Starson, supra* note 154 at 76.
[381] Candace Johnson, "Reproducing Inequality and Identity: An Intersectional Analysis of Maternal Health Preferences" in Stephanie Paterson, Francesca Scala, and Marlene K Solomon, eds, *Fertile Ground: Exploring Reproduction in Canada* (Montreal & Kingston: McGill-Queen's University Press, 2014) 94 at 105; Romanis & Nelson, *supra* note 371 at 727.
[382] Guo, *supra* note 365 at E634.
[383] *Ibid*.
[384] Romanis & Nelson, *supra* note 371 at 727.
[385] Kelly Grant, "Cesarean delivery associated with higher risk of severe complications for mothers aged 35 and older, study shows" *The Globe and Mail* (1 April 2019); "Childbirth: Is Plannning a C-Section a Good Choice?" (23 February 2022), *MyHealth.Alberta.ca* (website), online: https://myhealth.alberta.ca/Health/Pages/conditions.aspx?hwid=abp8154.
[386] Frances Gallagher et al, "Requesting Cesareans without Medical Indications: An Option Being Considered by Young Canadian Women" (2012) 39:1 Birth 39 at 40; Rohan D'Souza & Sabaratnam Arulkumaran, "To 'C' or not to 'C'?" (2013) 41 J Perinat Med 5 at 6. While celebrities continue to publicly discuss their experiences with CDMR (see, for example: Sarah Bunton, "21 Celebrities Who Had C-Sections & Are Willing To Talk About It, *Romper* (19 July 2016)), I note existing research does not critically assess the extent to which such reports increase awareness of CDMR as a care option, such that people ask their care providers about CDMR not out of a desire to be like celebrities, but because they would not otherwise have known about it.
[387] Guo, *supra* note 365 at E634.
[388] Candace Johnson, "Reproducing Inequality and Identity: An Intersectional Analysis of Maternal Health Preferences" in Paterson, Scala & Solomon, *supra* note 381, 94 at 105.
[389] Guo, *supra* note 365 at E634; Bryanton, Tatano Beck & Morrison, *supra* note 373; Kathrin Stoll & Wendy Hall, "Vicarious Birth Experiences and Childbirth Fear: Does It Matter How Young Canadian Women Learn About Birth?" (2013) 22:4 J Perinat Educ 225.

autonomous, because "the conditions of choice are restricted and oppressive."[390] For example, bioethics scholar Sylvia Burrow argues that offering birthing people the option of CDMR does little to increase their autonomy, because the exercise of autonomy requires "having enough information to make relevant decisions," as well as "the ability to critically reflect on desires that may unknowingly reflect social preferences."[391] In light of these "preconditions," Burrow concludes: "I doubt the choice for CDMR reflects women's increased autonomy.[392]

In particular, Burrow argues that social pressures to opt-in to the use of technology[393] during childbirth constrain the patient choice, such that requests for CDMR cannot be viewed as truly autonomous.[394] Legal scholar Erin Nelson challenges Burrow's reasoning, arguing that, on Burrow's "understanding, it seems that the only time women's reproductive choices can be autonomous is when they conform to the intuitions of some feminists as to the kinds of decisions that can be conceived of as autonomous."[395] As Nelson identifies, part of the danger of Burrow's line of reasoning is that it characterizes a choice that departs from the "norm" of idealized motherhood as non-autonomous (and, by extension, non-feminist). Indeed, as Pothier argues, a relational approach must also "factor in the perspective of members of groups who are thought to be oppressed."[396]

How, then, do people who give birth via CDMR feel about their choice? First-hand accounts of childbirth via CDMR in Canada include descriptions of the experience as "organized,"[397] "relaxed,"[398] "calm,"[399] and even "joyful."[400] One account describes the experience of giving birth via CDMR as "wonderful," explaining it "[gave] me back a sense of power over my own body […]."[401] Others describe the choice to deliver via CDMR as deeply personal: "I will definitely be opting for another elective caesarean, and will let no one tell me how to bring my baby into this world, as it's no one else's body, and no one else's experience."[402] It is clear, then, that for some people who choose CDMR, the experience is an empowering one. To deny such people the choice of CDMR on the basis that broader oppressive conditions shape the context in which the choice is made therefore appears counter to the goal of facilitating autonomy in childbirth. As Pothier argues: "There needs to be an assessment of the effects of denying choice because it is judged by the state/society not to be autonomous."[403]

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[390] Sherwin, "A Relational Approach to Autonomy", *supra* note 9 at 41.
[391] Sylvia Burrow, "On the Cutting Edge: Ethical Responsiveness to Cesarean Rates" (2012) 12:7 Am J Bioethics 44 at 45.
[392] *Ibid*.
[393] In this context, the term "technology" refers to medical technologies employed to reduce risks to the fetus in labour and childbirth, such as continuous electronic fetal monitoring and surgical interventions.
[394] Burrow, *supra* note 391 at 49.
[395] Nelson, *Law, Policy and Reproductive Autonomy, supra* note 165 at 30.
[396] Pothier, "Relational Theory and Resource Allocation", *supra* note 359 at 192.
[397] Victoria Diplacido, "I Gave Birth in Toronto During the COVID-19 Pandemic" *Elle* (8 May 2020).
[398] Murphy & Hull, *supra* note 370 at 37.
[399] Diplacido, *supra* note 397.
[400] *Ibid*.
[401] Murphy & Hull, *supra* note 368 at 327.
[402] McDonagh Hull & Lashewicz, *supra* note 149.
[403] Pothier, "Relational Theory and Resource Allocation", *supra* note 359 at 192.

Childbirth is a socially constructed phenomenon.[404] As a result, *all* choices regarding mode of birth—including vaginal delivery—are profoundly shaped by cultural influences.[405] For example, my own ardent hope for a vaginal delivery was undeniably shaped by a desire to experience the empowering process of unmedicated birth I had heard about in my friends' birth stories, as well as in the media I consumed, such as Ina May Gaskin's books on "natural" childbirth.[406] Equipped with the information I'd gleaned from these sources, I developed a plan to give birth in the way I believed to be "right" and "best"—and I am not alone in that experience. Author Leslie Jamison describes the ways in which C-sections are socially constructed as inferior to vaginal birth:

> The dismissive, often unspoken critique of the C-section understands it as birth without labor, birth without pain, birth without sacrifice. If a mother is supposed to do anything, she is supposed to sacrifice herself for her children, and pain in childbirth is the earliest barometer of that sacrifice […]. A cesarean often involves pain, but it's unnatural pain, and it's typically medicated away. Even when a C-section isn't elective, it still means a woman doesn't undergo that supreme, heroic effort of pushing a baby through the birth canal.[407]

Thus, vaginal birth is constructed as "natural" and "good," and the pregnant person who seeks out CDMR is irrational[408] or "too posh to push."[409] In this way, the social pressure to have a "natural" birth is an oppressive force, constraining and limiting freedom of choice in childbirth by promulgating an image of the "right" way to give birth.[410] Consider, for example, the experience of Andie Perris, a Toronto woman who endured a prolonged labour and a vacuum-assisted birth, and suffered a postpartum hemorrhage. Perris recounted her experience to the BBC:

> Looking back, she says, she probably should have had a C-section. But she had been set against it. "Feeling like there was one 'right' way to have a baby, it made me laser focused on that right way," she says. "And of course, there's not one right way. But I was so wrapped up in this vision of how nature 'intended' you to have a baby.[411]

Stories such as Perris's demonstrate that Burrow's discussion of technology touches on only part of the story. Social pressure to submit to technology does not, alone, deprive an individual of autonomy in

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[404] Wendy Mitchinson, *Giving Birth in Canada, 1900-1950* (Toronto: University of Toronto Press, 2002) at 158. See also: Raymond G De Vries, "Birth and Death: Social Construction at the Poles of Existence" (1981) 59:4 Social Forces 1074 at 1076-1077; Barbara Katz Rothman, "The Social Construction of Birth" (1977) 22:2 Journal of Nurse-Midwifery 9.
[405] MacDonald, "Gender Expectations", *supra* note 72 at 239-240.
[406] See, for example: Ina May Gaskin, *Ina May's Guide to Chidbirth* (New York: Bantam Books, 2003).
[407] Leslie Jamison, "A Personal History of the C-Section" *The New York Times Magazine* (24 August 2021).
[408] Romanis & Nelson, *supra* note 371 at 726. See also: McDonagh Hull & Lashewicz, *supra* note 149.
[409] Jane Waver & Julia Magill-Cuerden, "'Too Posh to Push': The Rise and Rise of a Catchphrase" (2013) 40:4 Birth 264. See also: Sharon Kirkey, "Too precious to push—shame, fear and the spike in C-sections: 'It's not safer, but it's believed to be safer'" *The National Post* (5 April 2016); "Hollywood comes north with 'Too Posh to Push'" *CTV News* (20 October 2008).
[410] See, for example: Amanda Ruggeri, "The pressure on women to have the 'perfect' birth" *BBC* (22 January 2023); Amy Tuteur, "The pressures of natural childbirth" *Chicago Tribune* (9 May 2016); Sirin Kale, "'I was told they didn't offer C-sections'—the dangerous obsession with 'natural births'" *The Guardian* (14 April 2022); Purshaiyna Thirukumar, Amanda Henry & Dominiek Coates, "Women's Experiences and Involvement in Decision-Making in Relation to Planned Cesarean Birth: An Interview Study" (2021) 30:4 Journal of Perinatal Education 213 at 215-216.
[411] Ruggeri, *supra* note 410.

childbirth—other social pressures, such as the pressure to achieve the ideal "natural birth," can be just as harmful.

While reducing unwanted technological intervention in childbirth is an important imperative, so, too, is targeting the oppressive influence of rhetoric that positions "natural" childbirth as supreme. Nelson and Burrow agree that "a longer menu of choices does not straightforwardly translate into increased autonomy for the women making such decisions."[412] However, Nelson urges:

> [W]e must endeavour to ameliorate the conditions that lead to oppressive socialisation in the first place, by educating and counselling individuals making healthcare decisions, as well as by supporting them in their deliberative processes.[413]

In order to achieve such processes, it is necessary to "develop and pursue policies and programs that will make available (and attractive) options that help agents [….] to identify options that are compatible with their deepest values and needs."[414] As Nedelsky explains, "we are always confronted with choices that are shaped by forces outside our control […] All we can do is make a judgment about which choice, in the face of all the multiple constraints, influences, and pressures, is most truly our own."[415] In this respect, the updated SOGC Opinion holds promise as a legal framework to enable patient autonomy—both in the way it requires collaborative conversation between patients and care providers, and in the policy's potential expressive effect of recharacterizing CDMR as a legitimate mode of birth. Law, broadly defined, is "a major force in shaping the environment in which women […] access health care and […] make decisions about health."[416] Policies such as the SOGC Guideline communicate social norms and values, "and, in doing so, […] [shape] individual preferences and behaviours."[417]

Through the 2008 Policy Statement, the SOGC sought to address higher-than-optimal rates of Caesarean delivery, positioning vaginal birth as an ideal we should "protect," [418] with the goal of incentivizing doctors and patients to avoid C-sections. However, the implicit values communicated through that policy may have had the effect of contributing to the stigmatization of Caesarean delivery in a manner that has constrained patient autonomy. In contrast, the SOGC's 2018 Opinion, which strongly emphasizes

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[412] Nelson, *Law, Policy and Reproductive Autonomy, supra* note 165 at 193; Burrow, *supra* note 391 at 45.
[413] Nelson, *Law, Policy and Reproductive Autonomy, supra* note 165 at 31.
[414] Susan Sherwin, "Relational Autonomy and Global Threats" in Downie & Llewellyn, *supra* note 9, 13 at 19.
[415] Jennifer Nedelsky, "The Reciprocal Relation of Judgment and Autonomy: Walking in Another's Shoes and Which Shoes to Walk In" in Downie & Llewellyn, *supra* note 9, 35 at 48.
[416] Catherine Frazee, Joan Gilmour & Roxanne Mykitiuk, "Now You See Her, Now You Don't: How Law Shapes Disabled Women's Experience of Exposure, Surveillance, and Assessment in the Clinical Encounter" in Dianne Pothier & Richard F Devlin, eds, *Critical Disability Theory: Essays in Philosophy, Politics, Policy, and Law* (Vancouver: UBC Press, 2006) 223 at 224.
[417] Susan Yeh, "Laws and Social Norms: Unintended Consequences of Obesity Laws" (2012) 81:1 U Cin L Rev 173 at 178.
[418] SOGC "Joint Policy Statement on Normal Childbirth, *supra* note 377 at 1164. For a further illustration of the evolution in dialogue regarding CDMR, see the 2004 Canadian Association of Midwives "Position Statement on Elective Cesarean Section," which states: "The Canadian Association of Midwives (CAM) allies with the Society of Obstetricians and Gynecologists of Canada (SOGC) by stating that vaginal birth is clearly the safest birth for most women and babies, and that caesarean surgery on demand will have disastrous social and financial consequences for health [emphasis added]" (Canadian Association of Midwives, "Position Statement on Elective Cesarean Section" (2004)).

non-judgmental respect for patient choice, may have the effect of positioning CDMR as an option morally equivalent to vaginal delivery, such that birthing people enjoy enhanced autonomy regarding mode of birth.

As the Opinion is taught in medical education settings, interpreted by care providers, and communicated to patients, perhaps the SOGC's formal re-branding of CDMR as a valid care option may have the effect of lessening some of the stigma associated with CDMR, thereby meaningfully expanding patient choice regarding mode of birth. However, it is important not to overstate the Opinion's influence; at present, advocates for CDMR raise concerns that the content of the Opinion is not always translating to clinic rooms.[419]

To "cash in" on the entitlements set out in the SOGC Committee Opinion, a birthing person must have knowledge of the opinion, as well as the ability to satisfy their obstetrician that they have "sufficient understanding"[420] of the risks involved in their decision. Moreover, it cannot be ignored that the likelihood of a person realizing the right to determine their mode of birth depends in large part on their own bargaining power as a patient, which is derived from factors such race, class, and education.[421] Just as gender "may exacerbate the asymmetry of the doctor-patient relationship, so too may being a part of another traditionally marginalised group—such as being poor or disabled or a member of a minority race."[422]

As a result, the question of entitlement to determine one's mode of birth is, for many in Canada, much more complex than simply pointing to a published guideline. A full examination of the issue requires an intersectional lens, which serves to expound the compounded effect of discriminatory treatment based on multiple, intersecting grounds.[423] While mistreatment in obstetrical care is unquestionably a matter of gender discrimination,[424] intersecting grounds of discrimination—including, for example, gender and disability—render the experience distinct, therefore necessitating unique and responsive policy solutions. Against this context, I turn to an analysis of the ability to choose one's mode of birth *beyond* Caesarean delivery, through an examination of the lived experiences of pregnant and birthing people with intellectual and developmental disabilities (IDD).[425]

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[419] McDonagh Hull & Lashewicz, *supra* note 149.
[420] "SOGC Committee Opinion No 361", *supra* note 148 at 970.
[421] For example, in Ontario, people who give birth via CDMR are more likely to be White and to have "higher" levels of education. (Guo, *supra* note 365 at E641). See also: Darine El-Chaar et al, "CAESAREAN DELIVERY ON MATERNAL REQUEST IN ONTARIO: TRENDS AND DETERMINANTS" (2019) 41:5 JOGC 716 at 716, in which researchers found that CDMR was more common among birthing people in Ontario who were older, had higher levels of education, and were White, among other factors.
[422] Ronli Sifris, "The Involuntary Sterilisation of Marginalised Women: Power, Discrimination, and Intersectionality" (2016) 25:1 Griffith L Rev 45 at 46.
[423] Kimberlé Williams Crenshaw, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics" (1989) 1 University of Chicago Legal Forum 139; Silfris, *supra* note 422 at 46.
[424] N Hill, *supra* note 270 at 236.
[425] Though a thorough examination of this issue is beyond the scope of this case study, I acknowledge that the "bargaining power" of people with intellectual and developmental disabilities is often further attenuated by virtue of the intersecting nature of additional characteristics, such as race. See, for example: Ilhom Akobirshoev et al, "Racial and Ethnic Disparities in Birth Outcomes and Labor and Delivery Charges Among Massachusetts Women With Intellectual and Developmental Disabilities" (2020) 58:2 Intellect Dev Disabil 126.

Routine Use of Caesarean Section for people with IDD

Consistent with the health sciences literature I rely upon in this case study, I use the term "intellectual and developmental disability" or "IDD" to refer to "conditions that cause impairment in cognitive and adaptive functioning before the age of 18 years old," which may include conditions such as autism spectrum disorder, cerebral palsy, Down syndrome, fetal alcohol spectrum disorder, and fragile X syndrome.[426] In doing so, I recognize that people falling within this definition of IDD have "a wide range of abilities, expectations and experiences."[427] I also recognize that disability "has no essential nature."[428] Rather: "depending on what is valued (perhaps overvalued) at certain socio-political conjunctures, specific personal characteristics are understood as defects and, as a result, persons are *manufactured* as disabled."[429]

The reproductive autonomy of people with IDD is safeguarded in Canada through a network of international law, constitutional law, legislation, case law, and policy.[430] The United Nations *Convention on the Rights of Persons with Disabilities,* ratified by Canada in 2010,[431] explicitly affirms the reproductive rights of people with IDD, including the rights to have and raise children.[432] Canadians are guaranteed the right to be free from discrimination on the basis of disability in the provision of services, pursuant to section 15 of the *Charter,* as well as through the operation of federal and provincial human rights codes. Courts have "stressed the importance of the role of accommodation in advancing the inclusion of people with disabilities in society"[433] including with respect to the provision of health-related services,[434] and the Supreme Court of Canada has affirmed the rights and capabilities of people with IDD to have and raise children.[435] Moreover, Canadian physicians,[436] nurses,[437] and midwives[438] have professional and ethical obligations to provide health services to persons with disabilities without discrimination.

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[426] Jade I Ransohoff et al, "Reproductive and pregnancy health care for women with intellectual and developmental disabilities: A scoping review" (2022) 35 J Appl Res Intellect Disabil 655 at 655; Lesley A Tarasoff, "Maternal disability and risk for pregnancy, delivery, and postpartum complications: A systemic review and meta-analysis" (2020) 222:1 Am J Obstet Gynecol 1 at 2 [Tarasoff, "Maternal disability and risk"].

[427] Reem Malouf et al, "'We both just wanted to be normal parents': a qualitative study of the experience of maternity care for women with learning disability" (2017) 7:e015526 BMJ Open 1 at 9.

[428] Richard Devlin & Dianne Pothier, "Introduction: Toward a Critical Theory of Dis-Citizenship" in Pothier & Devlin, *supra* note 416, 1 at 5. The contextual nature of disability is aptly demonstrated by the fact that some people with IDD may "'fly under the radar' of public service surveillance until they become parents at which time their cognitive ability (and hence their parental competence) is questioned" (Gwynnyth Llewellyn & Gabrielle Hindmarsh, "Parents with Intellectual Disability in a Population Context" (2015) 2 Curr Dev Disord Rep 119 at 119).

[429] Devlin & Pothier, *supra* note 428 at 5.

[430] Roxanne Mykitiuk & Ena Chadha, "Sites of Exclusion: Disabled Women's Sexual and Reproductive Rights" in Marcia H Rioux, Lee Ann Basser Marks & Melinda Jones, eds, *Critical Perspectives on Human Rights and Disability Law* (Leiden, NL: Martinus Nijhoff Publishers, 2011) 157 at 159.

[431] "Promoting the rights of persons with disabilities" (14 September 2022), *Government of Canada* (website), online: https://www.international.gc.ca/world-monde/issues_development-enjeux_developpement/human_rights-droits_homme/rights_disabilities-droits_handicapees.aspx?lang=eng.

[432] *Convention on the Rights of Persons with Disabilities,* 24 January 2007, A/RES/61/106 art 23 (entered into force 24 January 2007, ratified by Canada 11 March 2010).

[433] Mykitiuk & Chadha, *supra* note 430 at 173.

[434] *Eldridge v British Columbia (Attorney General),* 1997 CanLII 327 (SCC), [1997] 3 SCR 624 [*Eldridge*].

[435] *E (Mrs) v Eve,* 1986 CanLII 36 (SCC), [1986] 2 SCR 388 at paras 80; 84.

[436] See, for example: Canadian Medical Association, *CMA Code of Ethics and Professionalism,* Ottawa: CMA, 2018 [*CMA Code of Ethics*]; "CPSO Human Rights Policy", *supra* note 128.

[437] Canadian Nurses Association, *Code of Ethics for Registered Nurses,* Ottawa: CNA, 2017 at 4 [CNA *Code of Ethics*].

[438] See, for example: "Clients with Disabilities," *Association of Ontario Midwives* (website), online: https://www.ontariomidwives.ca/clients-disabilities; British Columbia College of Nurses & Midwives, *Code of Ethics,* Vancouver: BCN&M, 2021.

However, despite the existence of such protections, first-hand accounts of pregnant and birthing people with IDD in Canada describe experiences of mistreatment and "negative reactions," including "feeling stereotyped as being unfit to parent [...] and feeling judged by professionals (such as maternity staff) during pregnancy and childbirth."[439] These reactions are the product of lingering prejudicial beliefs regarding the sexual and reproductive capacities of people with disabilities, which directly impact upon the quality of reproductive health care people with IDD receive.[440]

During the 20th century, many Canadians with IDD were prevented from becoming parents due to the widespread influence of eugenic theories, which disseminated the belief that people with IDD should not have children, because their "unchecked reproduction [...] would reduce overall intelligence in the population."[441] Such views were operationalized through legislation in Alberta[442] and British Columbia,[443] where now-repealed statutes authorized the sterilization of Canadians deemed "mentally defective."[444] While eugenic theories have long been thoroughly discredited, societal attitudes regarding the sexuality of people with IDD lag,[445] complicating access to reproductive care for many.[446] Still today, reproductive health care for people with IDD typically "focuses on contraception, rather than health promotion and reproductive life planning,"[447] driven by a tendency to infantilise people with IDD as needing protection from their own bodies.[448] The effect of such health care strategies is the proliferation of prejudicial views of people with IDD as asexual and/or unfit to parent, which "often manifests as a lack of opportunity and support in starting families."[449]

In the context of pregnancy and childbirth, people with IDD "have high rates of adverse perinatal outcomes, including preeclampsia, caesarean section, preterm birth, and perinatal mortality, suggesting that

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[439] Lynn A Potvin et al, "'I Didn't Need People's Negative Thoughts': Women With Intellectual and Developmental Disabilities Reporting Attitudes Toward Their Pregnancy" (2019) 51:3 Canadian Journal of Nursing Research 154 at 155 [Potvin, "I Didn't Need People's Negative Thoughts"].

[440] Barbara E Gibson & Roxanne Mykitiuk, "Health Care Access and Support for Disabled Women in Canada: Falling Short of the UN Convention on the Rights of Persons with Disabilities: A Qualitative Study" (2012) 22:1 Women's Health Issues e 111 at e116.

[441] Sam Rowlands & Jean-Jacques Amy, "Sterilization of those with intellectual disability: Evolution from non-consensual interventions to strict safeguards" (2019) 23:3 Journal of Intellectual Disabilities 233 at 234.

[442] *The Sexual Sterilization Act,* RSA 1970, c 341, repealed by SA 1972, c 87.

[443] *Sexual Sterilization Act,* RSBC 1960, c 353, s 5(1), repealed by SBC 1973, c 79.

[444] Canada, Standing Senate Committee on Human Rights, *Forced and Coerced Sterilization of Persons in Canada* (Ottawa: Senate, 2021) at 17. The authors additionally note: "Saskatchewan, Manitoba and Ontario had introduced similar sexual sterilization bills but they were defeated in the 1930s and did not become law" (17).

[445] Ana Belén Correa, Ángel Castro & Juan Ramón Barrada, "Attitudes Towards the Sexuality of Adults with Intellectual Disabilities: A Systematic Review" (2022) 40 Sexuality and Disability 261 at 261-262; Amanda Saxe & Tara Flanagan, "Factors That Impact Support Workers' Perceptions of the Sexuality of Adults with Developmental Disabilities: A Quantitative Analysis" (2014) 32 Sex Disabil 45 at 45-50.

[446] Mykitiuk & Chadha, *supra* note 430 at 185.

[447] Caroline Kassee et al, "Impact of social-, health-, and disability-related factors on pregnancy outcomes in women with intellectual and developmental disabilities: A population-based latent class analysis" (2023) 16:101426 Disability and Health Journal 1 at 5.

[448] "[I]nfantilization of young people with intellectual disability is still much alive, even though the myth of the person with intellectual disability as an eternal child was debunked a long time ago. Compounding this issue is the continuous over-medicalization of sexuality and reproductive health issues for this population, evident for example in the literature on menstrual suppression and apparent forced contraception of girls and women with intellectual disability—human rights issues that were shrouded in a medico-legal discourse of 'best interests'" (Allison Carter et al, "The Sexual and Reproductive Health and Rights of Young People with Intellectual Disability: A Scoping Review" (2021) 19 Sexuality Research and Social Policy 372 at 384.) See also: Laura Retznik et al, "'It Gives Me, as her Caregiver, a Sense of Security.' Young People with Intellectual Disability and Their Experiences with Sexuality, Menstruation, Gynecological Treatment and Contraception: A Follow-up Analysis of Parents' and Caregivers' Perspectives" (2023) 41 Sexuality and Disability 97 at 98-99; 102-103; 107-108.

[449] Ransohoff, *supra* note 426 at 655. See also: Mykitiuk & Chadha, *supra* note 430 at 157.

they are a high-risk maternity population whose individual needs should be supported."[450] Research suggests Canadians with IDD are "less likely to receive adequate sexual education, […] less likely to receive prenatal care and accessed it later into their pregnancy than women without [IDD]."[451] Moreover, Canadians with IDD experience "high rates of poverty, chronic physical and mental health conditions, and systemic barriers accessing health care," which are "well-known risk factors for maternal and neonatal complications."[452] In addition, pregnant Canadians with IDD report experiencing "considerable anxiety and fear [of] losing custody of their children," which sometimes causes people to delay seeking prenatal health care[453] or to choose not to disclose their disability status,[454] perhaps detrimentally affecting the quality of care they receive. Anxiety regarding child protection implications is not unfounded; children of parents with IDD are overrepresented in the Canadian child welfare system[455] and newborns of parents with IDD are significantly more likely to be apprehended by child welfare agencies at birth.[456]

Pursuant to provincial legislation, judges and administrative decision makers may order the involuntary treatment of persons deemed incapable of consenting to medical care, including scheduled C-sections.[457] However, "direct forcible intervention is far from the only form of coercion."[458] Research demonstrates people with IDD are more likely to have their labours induced and to give birth via C-section than their peers without IDD.[459] While some of the variance is explained by elements such as comorbid conditions or social factors, researchers in both Canada and the United States note an increased prevalence of labour intervention that is not attributable to any therapeutic reason.[460] Rather, researchers suggest the increased prevalence of C-sections among people with IDD may be influenced by "a preference to control the timing of labour in women with IDD" on the part of physicians, based on a perception that "women with IDD may have difficulties understanding the phases of labour or communicating their needs" or because, due to gaps in training and education, physicians "assume that labour and delivery will be difficult

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[450] Lynne A Potvin, Hilary K Brown & Virginie Cobigo, "Social support received by women with intellectual and developmental disabilities during pregnancy and childbirth: An exploratory qualitative study" (2016) 37 Midwifery 57 at 58. See also: Lesley A Tarasoff et al, "Unmet needs, limited access: A qualitative study of postpartum health care experiences of people with disabilities" (2023) 00 J Adv Nurs 1 at 2; Hilary K Brown et al, "Association of Preexisting Disability With Severe Maternal Morbidity or Mortality in Ontario, Canada" (2021) JAMA Network Open 1 at 1.
[451] Ransohoff, *supra* note 426 at 661.
[452] Kassee, *supra* note 445 at 1-2. See also: Fareha Nishat et al, "Prenatal care adequacy among women with disabilities: A population-based study" (2022) 62:1 Am J Prev Med 39 at 43.
[453] Potvin, "I Didn't Need People's Negative Thoughts", *supra* note 439 at 155.
[454] Gul Saeed et al, "Barriers to and facilitators of effective communication in perinatal care: a qualitative study of the experiences of birthing people with sensory, intellectual, and/or developmental disabilities" (2022) 22:364 BMC Pregnancy and Childbirth 1 at 8.
[455] David McConnell et al, "Child Maltreatment Investigations in Canada: Main and Moderating Effects of Primary Caregiver Cognitive Impairment" (2021) 26:1 Child Maltreatment 115 at 115.
[456] Hilary K Brown, "Maternal Intellectual or Developmental Disability and Newborn Discharge to Protective Services" (2018) 142:6 Pediatrics 1 at 4-5. See also: Wency Leung, "Study finds newborns of Ontario women with developmental disabilities are more likely to be taken into protective custody" *The Globe and Mail* (5 November 2018).
[457] See, for example: *BB (Re),* 2020 CanLII 64488 (ON CCB); *C (Re), supra* note 311.
[458] Nelson, *Law, Policy and Reproductive Autonomy, supra* note 165 at 111.
[459] Ransohoff, *supra* note 426 at 656; Blair G Darney et al, "Primary cesarean delivery patterns among women with physical, sensory, or intellectual disabilities" (2017) 27:3 Womens Health Issues 336 at 367; Hilary K Brown et al, "Labour and delivery interventions in women with intellectual and developmental disabilities: a population-based cohort study" (2016) 70 J Epidemiol Community Health 238.
[460] Brown, *supra* note 459 at 240; Frances Biel et al, "Medical indications for primary cesarean delivery in women with and without disabilities" (2020) 33:20 Journal of Maternal-Fetal & Neonatal Medicine 3391 at 3396.

because of the disability."[461] As a result, researchers theorise that in "many cases," disability alone is used as an indication for Caesarean delivery.[462]

For example, while one UK-based study of the qualitative childbirth experiences of women with IDD includes accounts of women successfully choosing their mode of birth,[463] the same study also includes the story of a woman who recounts being "told" she would be giving birth via C-section and being excluded from conversations about her care.[464] The woman recounted: "[they] think you're stupid … treat you as though you don't exist."[465] Another woman in the same study described being asked to sign consent forms without adequate counselling or explanation, which led to her experiencing significant fear during her C-section, because she did not understand what was happening.[466] Although, like the updated SOGC Opinion, the UK guidelines regarding Caesarean section emphasize the importance of ascertaining patient values and respecting patient choice,[467] participants in the study experienced significant barriers in accessing the right to make informed decisions about mode of birth. While no similar qualitative studies have yet been undertaken in the Canadian context, the unexplained increase in Caesarean births for non-therapeutic reasons among people with IDD suggest similar dynamics may be at play in Canada.

Routine use of C-section in people with IDD is problematic for two key reasons. First, C-sections are major, invasive surgeries, which have the potential to impact an individual's future capacities to conceive and to give birth.[468] Respect for the rights of people with IDD to build families, therefore, requires careful attention to the long-term risks involved in non-therapeutic C-sections. Second, respect for the right to medical self-determination requires that people with IDD "be permitted to make their own reproductive decisions in so far as their capacity permits."[469] Instead of routinely recommending C-section for patients with IDD on the basis of their "best interest," care providers must take steps to ascertain unique patient needs, capabilities, preferences, and desires, and craft care plans that are specific to each patient,[470] consistent with the right of all persons to make decisions about their own health care.

The issue of routine use of C-section for birthing people with IDD is likely exacerbated by the fact that the SOGC has no published guidance specific to the needs of pregnant and birthing people with IDD, despite ample evidence demonstrating people with IDD experience unique challenges in pregnancy and childbirth, and despite the fact that increasing numbers of Canadians with IDD are becoming pregnant and

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[461] Brown, *supra* note 459 at 242. See also: Tarasoff, "Maternal disability and risk", *supra* note 426 at 2; Biel, *supra* note 460 at 3396. See also: Malouf, *supra* note 427 at 4-5.
[462] Biel, *supra* note 460 at 3396.
[463] Malouf, *supra* note 427 at 3, 8.
[464] *Ibid* at 4.
[465] *Ibid.*
[466] *Ibid* at 5.
[467] Maryam Gholitabar et al, "Caesarean section: summary of updated NICE guidance" (2011) 343:d7108 BMJ 1 at 1-2.
[468] Biel, *supra* note 460 at 3397.
[469] Nelson, *Law, Policy and Reproductive Autonomy, supra* note 165 at 111.
[470] For further discussion of the issue of medical intervention in a patient's "best interests" on the basis of disability alone, see: Mykitiuk & Chadha, *supra* note 430 at 186.

giving birth.[471] In June 2021, the SOGC published its first guideline regarding care needs and standards for pregnant and birthing people with physical disabilities.[472] The guideline explicitly does not apply to people with IDD, whose needs the authors acknowledge are "beyond the scope" of the document.[473]

If there is an expressive effect to SOGC's CDMR policy, so, too, is there an expressive effect to the absence of a policy addressing the obstetrical care needs of people with IDD.[474] The explicit exclusion of people with IDD tacitly communicates that the pregnancy and childbirth needs of people with IDD are less of a priority–whether because people with IDD do not get pregnant, or because their needs are not unique. By failing to publish guidance specific to the needs of people with IDD, organizations such as the SOGC perpetuate harmful outcomes by failing to adequately educate care providers on the needs of their patients. The lack of policies specific to the needs of people with IDD also serve to illustrate how "ableism and disability erasure" have become "embedded within postpartum care and obstetric care more broadly."[475]

Researchers recommend several reforms within childbirth care to better meet the needs of people with IDD. First, people with IDD may require "adapted informational support," such as pictographic materials, to assist in making informed care choices.[476] Research also supports the adoption of a collaborative, rather than "directive" care and counselling support model[477] involving multidisciplinary care teams and the use of patient advocates,[478] as well as a need for longer or more frequent prenatal care appointments for people with IDD.[479] Researchers also recommend health care providers receive training and education specific to the needs of pregnant and birthing people with IDD, including regarding their legal and ethical duties to accommodate.[480] People with IDD are entitled to such accommodations pursuant to section 15 of the Canadian *Charter*[481] and through the operation of provincial and federal human rights codes, as well as according to the requirements of the *Canada Health Act*, which directs provinces and territories must provide health care services in an "accessible" manner.[482] Inclusion of people with IDD in professional guidelines and policies regarding obstetrical care is essential to ensure the provision of consistent disability-informed care, as well as to the continued advancement of societal understanding regarding the rights and capabilities of people with IDD to reproduce and raise families.

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[471] Potvin, "I Didn't Need People's Negative Thoughts", *supra* note 439 at 155; Tarasoff, "Maternal disability and risk", *supra* note 426 at 2; Potvin, Brown & Cobigo, *supra* note 450 at 57; Elaine Xie & Meg Gemmill, "Exploring the prenatal experience of women with intellectual and developmental disabilities" (2018) 64 Canadian Family Physician S70 at S72.
[472] Anne Berndl et al, "Guideline No. 416: Labour, Delivery, and Postpartum Care for People with Physical Disabilities" (2021) 43:6 J Obstet Gynaecol Can 769.
[473] Berndl, *supra* note 472 at 770.
[474] Mykitiuk & Chadha, *supra* note 430 at 187.
[475] Tarasoff, "Unmet needs, limited access", *supra* note 450 at 10.
[476] Potvin, Brown & Cobigo, *supra* note 450 at 58; Lynne A Potvin et al, "Preparing for Motherhood: Women with Intellectual Disabilities on Informational Support Received During Pregnancy and Knowledge about Childbearing" (2020) 25:1 Journal on Developmental Disabilities 1.
[477] Potvin, Brown & Cobigo, *supra* note 450 at 63.
[478] Darney, *supra* note 459 at 9-10.
[479] Xie & Gemmill, *supra* note 471 at S73.
[480] Saeed, *supra* note 454 at 11.
[481] Pothier, "Relational Theory and Resource Allocation", *supra* note 359 at 185.
[482] *Canada Health Act,* RSC 1985, c C-6, s 7; Jackman, *supra* note 50.

In conclusion, while the SOGC's updated Committee Opinion lays the groundwork for an enforceable entitlement to CDMR for many Canadians, a closer analysis of the lived experiences of pregnancy and childbirth reveals that for others, such as birthing people with IDD, the ability to give birth in the mode of one's choosing remains further from reach.

Place of Birth

The ability to choose one's place of birth is widely identified in the literature as a key element of autonomy in childbirth.[483] Advocates have made significant strides over the past several decades in expanding access to home birth options, primarily through regulation and expansion of midwifery.[484] In regions of Canada where midwives are regulated and practising, pregnant people experiencing low-risk pregnancies may plan to give birth in their homes, with the assistance of a midwife.[485] Though the number of people who give birth at home is small,[486] people who choose home birth often report feeling safe, comfortable, and supported during childbirth.[487] The safety of home birth in regions where midwifery is integrated into health care systems is well-established.[488]

However, while medically assisted home birth is publicly funded and nominally provided in all provinces and territories other than PEI,[489] realizing the option of a home birth is, for many Canadians, closer to fantasy than reality. Publicly funded medical assistance during home birth is available only through the care of midwives; physicians "deliver exclusively in hospitals."[490] In practice, this means entitlement to publicly funded home birth assistance is limited to people who live in geographical regions where midwifery is regulated, funded, and available. There are significant geographical inequalities in

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[483] See, for example: Beth Murray-Davis et al, "Deciding on home or hospital birth: Results of the Ontario choice of birthplace study" (2014) 30 Midwifery 869; Vedam, "Patient-led decision making", *supra* note 194; Kirstie Coxon, Jane Sandall & Naomi J Fulop, "To what extent are women free to choose where to give birth? How discourses of risk, blame and responsibility influence birth place decisions" (2014) 16:1 Health, Risk & Society 51.
[484] Stephanie Paterson, "Deinstitutionalizing Pregnancy and Birth: Alternative Childbirth and the New Scalar Politics of Reproduction" in Paterson, Scala & Solomon, *supra* note 381, 178 at 179; 192-197; Van Wagner, *supra* note 77 at 71-87.
[485] Saraswathi Vedam et al, "The Canadian birth place study: examining maternity care provider attitudes and interprofessional conflict around planned home birth" (2014) 14:353 BMC Pregnancy and Childbirth 1 at 1 [Vedam, "The Canadian birth place study"]. Vedam et al additionally note: "Some provinces and institutions have instituted regulatory sanctions which prohibit physicians from attending home births" (2).
[486] Though national statistics on midwife-attended home birth are not available, the Association of Ontario Midwives states that midwives in Ontario attend approximately 4000 home births each year. Therefore, out of a total of 145,771 live births in Ontario in 2022, approximately 1 in 5000 were planned home births. ("Birthplace Options," *Association of Ontario Midwives* (website), online: https://www.ontariomidwives.ca/home-birth; "Ontario Demographic Quarterly: highlights of fourth quarter," (5 April 2023), *Government of Ontario* (website), online: https://www.ontario.ca/page/ontario-demographic-quarterly-highlights-fourth-quarter).
[487] Murray-Davis, *supra* note 483 at 870.
[488] Kathrin Stoll et al, "Perinatal outcomes of midwife-led care, stratified by medical risk: a retrospective cohort study from British Columbia (2008-2018)" (2023) 195:8 CMAJ E292; Elizabeth Nethery et al, "Birth Outcomes for Planned Home and Licensed Freestanding Birth Center Births in Washington State" (2021) 138:5 Obstetrics & Gynecology 693.
[489] "Midwifery in Canada: Legal Status" *supra* note 78; "Midwifery care expanded to Yukoners", *supra* note 88. Midwifery regulation is an ongoing project in Prince Edward Island ("'HealthPEI' Midwifery Services," *supra* note 81; "Midwifery program making progress on PEI" *CBC News* (9 June 2022).
[490] Vedam, "The Canadian birth place study", *supra* note 485 at 2.

access to midwifery services in Canada,[491] as described in the previous chapter, thus limiting the ability to give birth at home with publicly funded medical assistance to a subset of Canadians.

Even in regions where home birth is purportedly available, access may be significantly restricted by factors such as availability of midwives,[492] lack of knowledge regarding the option of midwifery care,[493] or local policy. For example, Nova Scotia suspended the option of home birth for six weeks during the first wave of the pandemic.[494] It was the only jurisdiction within Canada to do so for a prolonged period.[495] Although the stated rationale of the suspension was to prevent the spread of infection, the policy decision additionally signals government prioritization of care it considers "elective" versus "essential." During this time, pregnant people who planned home births had to choose between giving birth in hospital, or giving birth at home without licensed medical assistance.[496] Reported accounts include stories of women in Nova Scotia giving birth at home with only their partners, or with the assistance of lay (unlicensed) midwives.[497] Such accounts indicate worrying shortcomings in government delivery of childbirth-related services—when insured health care services such as home birth care are delivered in a manner that "breeds conditions for unsafe access,"[498] the *Charter* right to security of the person may be infringed.[499]

Rural birthing considerations and birth evacuations

Taking a broader view of the question of entitlement to give birth "at home," such entitlement is, perhaps, most illusory for pregnant and birthing people living in remote areas of Canada. Pursuant to Health Canada policy,[500] pregnant people living in remote communities without ready access to surgical care (most

[491] Hanson, Mpofu & Hopkins, *supra* note 95; Elizabeth K Darling et al, "Access to Ontario Midwifery Care by Neighbourhood-Level Material Deprivation Quintile, 2006-2017: A Retrospective Cohort Study" (2020) 19:8 Can J of Midwifery Research and Practice 8; "The Landscape of Midwifery Care for Aboriginal Communities in Canada" (2016) National Aboriginal Council of Midwives, Discussion Paper.
[492] Shannon Charlebois, "Integration of midwifery care in Canada" (2023) 195:8 CMAJ E306 at E306; Elena Neiterman, "Causes of the causes: Exploring Retention Among Canadian Midwives Utilizing Ecological Systems Theory" (2021) 1:100025 Qualitative Research in Health 1 at 1; Michelle Gomez, "Expecting parents have to relocate to give birth due to midwife shortage on Salt Spring Island" *CBC News* (11 July 2022); Emily Senger, "Midwifery is in demand, but increasing school program capacity isn't easy" *MacLean's* (8 October 2020).
[493] Elizabeth K Darling et al, "Access to midwifery care for people of low socio-economic status: a qualitative descriptive study" (2019) 19:416 BMC Pregnancy & Childbirth 1 at 9.
[494] Taryn Grant, "Nova Scotia suspends home births during COVID-19 pandemic" *CBC News* (30 March 2020).
[495] "COVID-19 or not, families have the right to choose home birth!" *Nova Scotia Doula Association* (website), online: https://www.novascotiadoulas.org/advocacy-families-want-home-births; Claire Sibonney, "Nova Scotia has cancelled all home births—could it happen in other provinces?" *Today's Parent* (1 April 2020).
[496] Sibonney, *supra* note 495.
[497] Connolly, *supra* note 86.
[498] Erdman, "Constitutionalizing Abortion Rights", *supra* note 30 at 260.
[499] Such infringement is, as always, subject to section 1 of the *Charter*. In the context of urgent pandemic restrictions, it is likely that significant judicial deference would be granted to government decision-making regarding infection prevention.
[500] Though the policy is not formally documented, it is widely recognized and implemented. As the authors of a 2019 study describe: "Physicians, health administrators in both sending and receiving communities, and nurses working with First Nations peoples on reserves are very familiar with the evacuation policy; however, the details of Health Canada's evacuation policy remain elusive and undocumented" (Lawford, Bourgeault & Giles, *supra* note 362 at 1306). See also: Karen Lawford, "Locating Invisible Policies: Health Canada's Evacuation Policy as a Case Study" (2016) 37.2:2 Atlantic 147.) Health care for Indigenous people in Canada is typically administered by the federal government, hence this section's focus on federal policy. Constance MacIntosh explains: "Although general jurisdiction over health matters is provincial […] Section 91(24) of the Canadian Constitution assigns jurisdiction over 'Indians and lands reserved to the Indians' to the federal government, which has been taken to mean that the health of 'Indians' is a federal matter" (Constance MacIntosh, "Relational Theory and Indigenous Health: Insights for Law Reform and Policy Development" in Downie & Llewellyn, *supra* note 9, 230 at 239).

commonly, Indigenous women in Northern Canada)[501] are routinely required to leave their communities during the third trimester of their pregnancies and travel alone to give birth in major urban centres.[502] Medical anthropologists Leslie Dawson and Terri Suntjens explain:

> Originating between the 1960s and 1980s, and still in policy today, Indigenous women in rural and remote communities in Canada are evacuated at thirty-six to thirty-eight weeks gestational age—according to regional policy, or sooner if a high-risk pregnancy—to a hospital where they must give birth.[503]

Birth evacuation policies are the result of major gaps in access to childbirth care options in rural and remote communities throughout Northern Canada. Such gaps are not accidental. Rather, as health researcher Janet Smylie explains:

> These inequities have well-documented roots in colonial policies that favoured non-Indigenous settlements over First Nations, Inuit and Métis communities with respect to location of and access to quality health care facilities. When facilities did exist for First Nations, Inuit and Métis, they were commonly segregated and second class.[504]

As a result, pregnant people "can spend almost a month—or more—outside of their communities so as to avail themselves of maternity care services,"[505] away from their jobs and families, including young children and elders in need of care. In this context, the right to choose one's place of birth has a broader meaning, encompassing access to publicly funded medical care in one's home *community*.

The *Canada Health Act*'s accessibility criteria require that all Canadians have "reasonable access" to insured hospital and physician services "without financial <u>or other barriers</u> [emphasis added]."[506] Though the term "reasonable access" is undefined, health researchers Helen Cergio and Amélie Quesnel-Valée argue "the high costs and uncertain benefits associated with the birth evacuation policy suggest that although women in remote areas have access to this necessary care, access may not be 'reasonable.'"[507] Indeed, drawing from first-person accounts of "birth evacuees,"[508] it is clear there are significant and overlapping barriers involved in accessing publicly insured childbirth care, including financial costs, psychological and physical health risks, and loss of connection to one's culture and community.

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[501] Health care access for Indigenous peoples in Canada varies widely, and "Indigenous peoples represent a diversity of cultures and languages and, presumably with these differences, different aspirations, understandings, and expectations about health and what counts as good care" (MacIntosh, *supra* note 500 at 230). Therefore, while this section focuses on the views of some birthing people, I do not purport to capture the views or experiences of all Indigenous birthing people in Canada.

[502] Hilah Silver et al, "Childbirth evacuation among rural and remote Indigenous communities in Canada: A scoping review" (2022) 35 Women and Birth 11 at 14.

[503] Dawson & Suntjens, *supra* note 17 at 233.

[504] Janet Smylie, "Long-distance travel for birthing among Indigenous and non-Indigenous pregnant people in Canada" (2021) 21:193 CMAJ E948 at E954.

[505] Lawford, Bourgeault & Giles, *supra* note 362 at 1306.

[506] Canada, Library of Parliament, "The *Canada Health Act*: An Overview" by Marlisa Tiedemann, Background Paper, (2019) at 4.

[507] Helen Cergio & Amélie Quesnel-Vallée, "A Failure of Access?: The Birth Evacuation Policy in Canada's North" (2019) 10 Health Science Inquiry 70.

[508] Jaime Cidro, Rachel Bach & Susan Frohlick, "Canada's forced birth travel: towards feminist indigenous reproductive mobilities" (2020) Mobilities 1 at 6; Zoua M Vang et al, "Interactions Between Indigenous Women Awaiting Childbirth Away From Home and Their Southern, Non-Indigenous Health Care Providers" (2018) 28:12 Qualitative Health Research 1859.

With respect to financial barriers of birth evacuation, government funding is typically provided to cover travel and accommodation costs for the birthing person and one support person, but travel expenses, accommodations, and meal costs for additional support people are not covered.[509] As a result, families are required to plan for the care of children or elders for indeterminate periods of time, and birthing people must frequently take advanced leave from their employment,[510] which may impact the duration of their entitlement to leave following birth.[511] In addition, to be eligible for government medical travel assistance, an individual must meet certain medical criteria, and "must have used up all other third-party and employer insurance options or have no insurance plan."[512] Health researchers Erika Lee et al explain that funding allowances provided are often "insufficient for adequate accommodation and nutrition" for pregnant people while they await giving birth. As a result, "birthing parents often spend weeks isolated in inner city temporary motel or boarding house accommodations with a single escort as support and limited access to country food."[513]

During this waiting period, some birth evacuees report "feeling 'lonely, bored, isolated, overwhelmed, and fearful for their health and safety.'"[514] Some researchers raise additional concerns regarding gang involvement in areas where birth evacuees routinely stay awaiting childbirth, including the "recruitment" of evacuated pregnant women into forced sex work.[515] Additionally, during the COVID-19 pandemic, enforced travel for pregnant women meant increased risk of virus transmission and associated serious illness or death, and at least one woman died after contracting COVID-19 as a result of travelling to give birth.[516]

Birthing people interviewed about their experiences with birth evacuation report a strong desire to be home while awaiting birth,[517] among their families and communities. Although the stated rationale of the policy is to reduce maternal and infant mortality by ensuring access to surgery in the event of an emergency,[518] it practically results in removal of pregnant people from their communities, families, friends, and systems of support during a sacred period of their lives.[519] Separation from older children is commonly

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[509] Lee, Gundmunson & Lavoie, *supra* note 58 at 6.
[510] *Ibid*.
[511] "EI maternity and parental benefits: What these benefits offer" *Government of Canada* (website), online: https://www.canada.ca/en/services/benefits/ei/ei-maternity-parental.html.
[512] Lee, Gundmunson & Lavoie, *supra* note 58 at 6.
[513] *Ibid*.
[514] Lawford, Bourgeault & Giles, *supra* note 362 at 1321.
[515] *Ibid.*
[516] Karen Lawford, "COVID-19 death highlights dangers of birth evacuation policy in Indigenous communities" *Healthy Debate* (25 February 2021); Beth Brown, "Nunavut woman dies weeks after contracting COVID-19 following childbirth in Winnipeg hospital" *CBC News* (4 January 2021).
[517] Jude Kornelsen et al, "Alienation and Resilience: The Dynamics of Birth Outside Their Community for Rural First Nations Women" (2011) Journal of Aboriginal Health 55 at 60 [Kornelsen, "Alienation and Resilience"].
[518] *Ibid* at 56.
[519] Dawson & Suntjens, *supra* note 17 at 235; British Columbia, First Nations Health Authority, *Sacred and Strong: Upholding Our Matriarchal Roles* (Victoria: British Columbia Office of the Provincial Health Officer, 2021).

identified as a principal concern for people required to leave their communities to give birth.[520] For example, a pregnant First Nations woman explained to the authors of one study:

> I know it [being sent to the south for childbirth] is for our safety. [But] it's hard to have to leave. . . my mom's working at a camp [away from home] . . . and there's no one to take care of my kids. So the kids are up north with my spouse's family and I feel so distressed over it even though I'm only here 2 weeks. I can't imagine some of them [other pregnant women] that have to wait longer.[521]

Understandably, birthing people are eager to return home following childbirth, even if that means travelling while still experiencing physical discomfort or pain following childbirth or continued need for medical assistance.[522]

Following birth, evacuees are sometimes required to drive home with their newborns for up to 14 hours.[523] In one case, a midwife described being asked by a woman who "sustained a small perineal tear that did not require surgical repair" during childbirth to repair the tear with a stitch, to enable her to access funding for a flight home. Lawford et al describe: "In this example, the care provider, family, and the woman understood the flight approval requirements enough to request and consent to a procedure that was not medically necessary."[524] Similarly, stress and difficulty associated with being separated from other children "has been linked to increased rates of induction of labor for social reasons."[525] In other words, birth evacuees sometimes choose to have their labours induced to avoid prolonged periods of separation. Both examples describe situations in which birthing people requested and consented to unnecessary medical interventions (involving potential risk of infection or injury) to mitigate the harms of the policy. Thus, the operation of the policy—while intended to *reduce* risk of harm to birthing people and newborns—sometimes results, in the lived experiences of its subjects, in increased risk to health, safety, and wellbeing.

Another example of health risks inadvertently increased by the operation of birth evacuation policies are the risks associated with avoidance of evacuation. Pregnant people may lie or conceal their pregnancies to avoid leaving their communities, in the interest of giving birth at home. Health researchers Helen Cergio and Amélie Quesnel-Vallée describe:

> Reported instances of women hiding their pregnancies, lying about due dates, refusing to leave the community and deciding to give birth on their own, demonstrate a preference for delivering within the community.[526]

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[520] "'It's 2021': Nunavut mothers say it's high time the territory gets more birthing services" *CBC News* (26 September 2021).
[521] Vang, *supra* note 508 at 1863.
[522] Kornelsen, "Alienation and Resilience", *supra* note 517 at 60.
[523] Lawford, Bourgeault & Giles, *supra* note 362 at 1324.
[524] *Ibid*, discussing an account included in Rachel Olsen, "*Relocating childbirth: the politics of birth place and Aboriginal midwifery in Manitoba, Canada"* (DPhil Thesis, University of Sussex Faculty of Social Anthropology, 2013) at 155.
[525] Kornelsen, "Alienation and Resilience", *supra* note 517 at 56.
[526] Cergio & Quesnel-Vallée, *supra* note 507. See also: Vang, *supra* note 508 at 1860.

Pregnant people who resist evacuation may be coerced by medical providers through various means, "including scaring women with stories of negative birth outcomes, and threatening involvement of local law enforcement, loss of access to medical care, or monetary fines."[527] Additionally, as described in the previous chapter, Indigenous people are subject to significantly increased child protection scrutiny, including birth alerts,[528] meaning decisions regarding planned place of birth care may put Indigenous people at risk of having their newborns apprehended at birth.

Through birth evacuation policies, Indigenous people are cast as unable to give birth without the assistance and intervention of settlers—birth is constructed as risky and unsafe in rural communities. In this way, the biomedical model of childbirth is privileged as superior to Indigenous ways of knowing.[529] This biomedical framing of childbirth is inadequate in meeting the needs of Indigenous birthing people in rural and remote Canadian communities. At present, most Indigenous women access prenatal and childbirth care through the mainstream medical system, which is premised on a model of mitigating risk through medical intervention. However, the mainstream medical system abysmally fails Indigenous women:

> While the western medicalization of birth is typically justified as a measure to improve maternal and infant health outcomes, Indigenous women and birthing people in Canada continue to experience higher rates of adverse birth outcomes than non-Indigenous women, as well as two times the risk of maternal mortality compared to the overall Canadian population.[530]

In response, many advocates call for "return" of birth to Indigenous communities,[531] which involves "reclaiming women's central position and knowledge around pregnancy, birth, and mothering."[532]

In contrast to the prevailing biomedical framing of childbirth, this proposed approach is a relational one, which accounts for the "relational identity, autonomy, and judgment"[533] of birthing people. In Indigenous traditions, childbirth is "embedded in relationships and spirituality."[534] Legal scholar Constance MacIntosh explains that "Indigenous ideologies of health [are] […] grounded in the 'interrelated-ness' of 'physical, spiritual, emotional and mental dimensions' and reflective of a 'collectivist' approach to perceiving and addressing health."[535] Thus, in contrast to the predominant biomedical approach focused primarily on prevention of obstetrical risk during childbirth, a relational conception of childbirth may address holistically the broader needs, interests, goals, and traditions of birth for Indigenous people. For example, by repatriating childbirth to rural communities, Indigenous people may experience childbirth as

[527] H Silver, *supra* note 502 at 16.
[528] MMIWG Final Report, *supra* note 297 at 364.
[529] Dawson & Suntjens, *supra* note 17 at 228.
[530] Caroline Fidan Tyler Doenmez et al, "Heart work: Indigenous doulas responding to challenges of western systems and revitalizing Indigenous birthing care in Canada" (2022) 22:41 BMC Pregnancy & Childbirth 1 at 3.
[531] Lee, Gundmunson & Lavoie, *supra* note 58; National Aboriginal Council of Midwives, "Guided by Our Ancestors: Indigenous Midwives and Advocacy" (2019); National Aboriginal Council of Midwives, "Diverse Pathways: Bringing Indigenous midwifery home" (2019).
[532] Dawson & Suntjens, *supra* note 17 at 237.
[533] Pothier, "Relational Theory and Resource Allocation", *supra* note 359 at 190.
[534] Dawson & Suntjens, *supra* note 17 at 235.
[535] MacIntosh, *supra* note 500 at 234.

a sacred ceremony, rather than simply a medical event.[536] Anthropologists Ashley Hayward and Jaime Cidro explain: "recognizing the importance of birthplace (geographical location) and honoring the sacredness of birth is a significant way to recognize and implement Indigenous rights."[537] In addition, the act of returning childbirth to Indigenous communities involves reclaiming traditional knowledge and expertise that was "severed" with "the transfer of birth from the home to hospitals."[538]

In imagining a "return" of childbirth to Indigenous communities, however, it is important to resist "focus[ing] on romanticized versions of 'traditional culture' without critically evaluating" the effects of such a shift.[539] Though birthing people are technically free to choose to remain in their remote communities to give birth, the risks of maternal and infant mortality are considerably increased without access to surgical care options,[540] thus significantly constraining birthing peoples' choices regarding place of birth. In addition, in this respect, choice of place of birth intersects with issues of mode of birth explored earlier in this chapter; through the expansion of Indigenous-led midwifery, birthing people may enjoy expanded access to vaginal birth in their home communities but would still be required to travel to access obstetrical care options in the event of medical complications, a desire for epidural pain relief, or a desire for CDMR. Thus, while Indigenous-led midwifery is a critical element of childbirth care reform, equitable care delivery also requires expansion of obstetrical care options throughout rural regions.

While there are many ongoing initiatives to revitalize and expand Indigenous led childbirth care,[541] the project of improving of childbirth care throughout Northern Canada requires *significant* and *long-term* government investment, both for the widespread training of Indigenous midwives and doulas, who employ Indigenous Knowledge and cultural traditions,[542] as well as to facilitate the establishment of new, Indigenous-led medical centres in both urban and rural communities.[543] Without substantial funding, there is a risk that disproportionate burdens will fall on individual advocates or community organizations, resulting in provider burnout, inadequate time and resources,[544] inability to keep services affordable and accessible to people who need them and, ultimately, program failure.[545]

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[536] Dawson & Suntjens, *supra* note 17 at 235; Hayward & Cidro, *supra* note 58; Laura Beaulne-Stuebing, "Why Indigenous women are bringing 'the first ceremony'—birth—back to their communities" *CBC News* (18 December 2022).
[537] Hayward & Cidro, *supra* note 58 at 221.
[538] Doenmez, *supra* note 530 at 3.
[539] Hadley Friedland, "Navigating Through Narratives of Despair: Making Space for the Cree Reasonable Person in the Canadian Justice System" (2016) 67 UNBLJ 269 at 300; Rauna Kuokkanen, *Restructuring Relations: Indigenous Self-Determination, Governance, and Gender* (New York: Oxford University Press 2019) at 228.
[540] Barrett & Kotaska, *supra* note 262 at 425.
[541] Doenmez, *supra* note 530 at 4.
[542] National Aboriginal Council of Midwives, "Bringing Birth Back: Aboriginal Midwifery Toolkit" (2014); Doenmez, *supra* note 528; Jaime Cidro et al, "Putting them on a strong spiritual path: Indigenous doulas responding to the needs of Indigenous mothers and communities" (2021) 20:189 Intl J for Equity in Health 1.
[543] MMIWG Final Report, *supra* note 297 at 16.7.
[544] Larissa Wodtke et al, "The need for sustainable funding for Indigenous doula services in Canada" (2021) 18 Women's Health 1 at 1.
[545] Feleshia Chandler, "Nova Scotia ends use of controversial birth alerts but calls for change persist" *CBC News* (30 November 2021); Emma Tranter, "Inuit midwives say they reluctantly quit after experiencing years of mistreatment" *The Canadian Press* (28 February 2021).

Canada has an obligation to fund initiatives to expand both midwifery and physician-managed childbirth care for Indigenous people in Northern communities based on the current government's commitment to implementing the TRC Calls to Action,[546] as well as the findings of the National Inquiry into Missing and Murdered Indigenous Women and Girls' (MMIWG) Final Report.[547] Both the TRC and the MMIWG Inquiry recommended significant reforms to delivery of health care to Indigenous populations,[548] with the MMIWG Inquiry's Calls for Justice including specific recommendations regarding the "availability of effective, culturally appropriate, and accessible health and wellness services within each Inuit community."[549] Moreover, Canada has a duty to facilitate Indigenous self-governance over health care both pursuant to section 35 of the *Constitution Act*,[550] and as codified the United Nations Declaration on the Rights of Indigenous Peoples[551] and its implementation into Canadian law.[552]

Expanded access to obstetrical and midwifery care may also be advanced in rural and remote regions of Canada through *Charter* claims. Although Canadians are not legally prohibited from giving birth at home—whether in their bedrooms or in their home communities—significant restrictions on their ability to do so with medical assistance result in birthing people seeking childbirth options outside the system, in manners that increase risk of bodily harm or death, thereby potentially engaging section 7 of the *Charter*. In addition, unequal provision of childbirth-related health care services to Indigenous people in Northern Canada may ground a claim of discrimination based on Indigeneity pursuant to section 15 of the *Charter*.[553] Although publicly funded health care is not a constitutional right in Canada, "given that the state has chosen to provide medicare, there are some constitutional dictates about how it is implemented in order to conform to the *Charter*"[554]—including ensuring health care is not administered in a manner that amounts to discrimination on the basis of a protected ground.[555] Therefore, while there are numerous legal bases upon which to ground an entitlement to publicly funded "home" birth for Indigenous birthing people in remote

[546] "Truth and Reconciliation Commission of Canada" (29 September 2022), Government of Canada (website), online: https://www.rcaanc-cirnac.gc.ca/eng/1450124405592/1529106060525.
[547] Government of Canada, "Federal Pathway to Address Missing and Murdered Indigenous Women, Girls and 2SLGBTQQIA+ People" (3 June 2021), online: https://www.rcaanc-cirnac.gc.ca/eng/1622233286270/1622233321912.
[548] Canada, Truth and Reconciliation Commission of Canada, *Truth and Reconciliation Commission of Canada: Calls to Action* (Winnipeg: Truth and Reconciliation Commission of Canada, 2012) at 22-24.
[549] MMIWG Final Report, *supra* note 297 at 16.7.
[550] *The Constitution Act, supra* note 32, s 35.
[551] *United Nations Declaration on the Rights of Indigenous Peoples,* GA Res 61/295, UNGAOR, 61st Sess, Sup No 53, UN Doc A/61/295 (2007) 1 at arts 4; 21; 23-24. There is precedent for basing a right to "home birth" in international human rights law. In *Ternovszky v Hungary,* No 67545/09, [2010] ECHR 1 a pregnant woman who sought to give birth at home brought a claim before the European Court of Human Rights on the basis that a Hungarian law precluded her from having a safe home birth, because it imposed liability on health professionals who assisted in home births with the threat of conviction or fine. The European Court of Human Rights found that the right to "respect for private life" under Article 8 of the European Convention on Human Rights ("the Convention") encompassed protections for individual autonomy, including the right to decide whether to become a parent, and, by extension, "the right of choosing the circumstances of becoming a parent." The Court determined the Hungarian law effectively precluded health care provider assistance at home births and, therefore, was a violation of the Convention. In response, the Hungarian government established a legal framework to facilitate professional-assisted home birth (M Eggermont, "The Choice of Child Delivery Is a European Human Right" (2012) 19:3 Eur J Health L 257 at 259).
[552] *United Nations Declaration on the Rights of Indigenous Peoples Act,* SC 2021, c 14.
[553] I am not aware of any existing *Charter* claims challenging birth evacuation policies, nor inequitable access to birth care in Northern Canada.
[554] Pothier, "Relational Theory and Resource Allocation", *supra* note 359 at 185.
[555] *Eldridge, supra* note 434.

regions of Canada, a close examination of the lived experiences of birthing people's abilities to choose their place of birth paints a starkly different picture.

In conclusion, the question of whether Canadians are entitled to publicly funded childbirth "home birth" care depends in significant part on where in the country a person lives. While the *Canada Health Act* requires provinces and territories provide coverage for health services that is comprehensive, universal, and accessible,[556] a case study of the accessibility of "home birth" care for people throughout Canada reveals the gaps between the state of the law on the books and the reality of law in action are wide.

3.2 The right to medical self-determination

Next, I turn to examine the right to medical self-determination "in action," as it plays out in Canadian childbirth settings. The following is a narrative synthesis of first-person accounts of childbirth drawn from reported disciplinary decisions by health professional regulatory bodies, through which I seek to understand Canadian birthing people's lived experiences of their right to self-determination during childbirth. I take a deductive approach, grouping accounts according to the elements of medical self-determination identified in the previous chapter: (1) the right to make decisions about one's own treatment; (2) the right to informed consent; and (3) the right to dignity.

My methodology has some limitations. First, using disciplinary decisions will have the effect of overrepresenting negative experiences of childbirth, as such decisions typically come to be because something went "wrong." I acknowledge survey results indicate most people in Canada have generally positive experiences of childbirth.[557] In addition, the events described in the decisions represent the subjective views of each party; the accounts have not been proven in court or otherwise verified beyond the analyses conducted by the investigatory committees and review boards. However, I note that none of the included decisions reference any indication of bad faith on the part of a complainant. I also recognize that without access to the original complaints and hearing transcripts, I may be missing information relevant to my analysis. In particular, the decisions do not include demographic information about the birthing people making the complaints. This is a significant gap, because rates of reported mistreatment by care providers during labour and childbirth are increased based on factors such as race,[558] socioeconomic status,[559] and disability.[560] Finally, I acknowledge that using reported disciplinary decisions likely results in the

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[556] *Canada Health Act,* RSC 1985, c C-6, s 7; Jackman, *supra* note 50.
[557] Andrei Smarandache, Theresa H M Kim, Yvonne Bohr & Hala Tamim, "Predictors of a negative labour and birth experience based on a national survey of Canadian women" (2016) 16:114 BMC Pregnancy and Childbirth 1 at 1.
[558] Brandi Morin, "Abuse at Canadian Hospitals Is Putting Indigenous Moms & Their Babies At Risk" *Refinery29* (11 November 2020); Rochelle Maurice, "We bawl so we are heard: the stories we must tell about obstetric racism" (2023 31:1 Sexual and Reproductive Health Matters 1 at 1-5; Camille Kroll et al, "Cultivating the ideal obstetrical patient: How physicians-in-training describe pain associated with childbirth" (2022) 312:115365 Social Science & Medicine 1 at 3; 5; Vedam, "Patient-led decision making", *supra* note 194 at 591.
[559] Kroll, *supra* note 558 at 6-7; N Hill, *supra* note 270 at 240-241.
[560] Potvin, "I Didn't Need People's Negative Thoughts", *supra* note 439 at 155; Malouf, *supra* note 427 at 3.

overrepresentation of views of people who have the financial resources, education, and ability to pursue complaints processes.[561]

Nevertheless, although imperfect, disciplinary decisions provide a unique window into how birthing people experience and understand their rights during childbirth. Disciplinary decisions often include detailed quotations from complaints against care providers, which shed light upon the expectations, hopes, and values of birthing people during childbirth—and, by extension, assist in identifying the areas in which legal rights and protections "on the books" fail to translate into practice. Moreover, disciplinary decisions offer fertile soil for a relational approach to understanding autonomy in childbirth, as they focus centrally on the relationships between patients and their care providers. Through this analysis, I aim to illustrate the ways in which experiences of self-determination in childbirth are realized through connection and collaboration with others.

Search strategy and inclusion criteria

I conducted a search of disciplinary decisions on CanLII using the keywords "birth" and "labour."[562] I limited the results to decisions reported between January 1, 2018 and August 31, 2023. I included all health disciplinary decisions that described experiences of childbirth. Complaints related to events that occurred before 2013, complaints focused solely on prenatal or post-partum care, complaints related to the care of newborns following birth, and complaints focused solely on system-level issues at hospitals or practices were excluded. A total of 33 disciplinary decisions met the inclusion criteria: 28 from Ontario, 4 from British Columbia, and 1 from Alberta. Of the included decisions, 15 involved complaints against physicians, 11 involved complaints against midwives, six involved complaints against nurses, and one decision involved a complaint against a Respiratory Therapist. A full table of the cases included is attached as Appendix B.

The right to make decisions about one's own treatment

The Supreme Court of Canada has repeatedly endorsed the right of competent individuals to make decisions about their own medical care.[563] In Canadian jurisprudential discourse, self-determination is typically presented in a manner consistent with the "liberal individualist vision of the self."[564] Self-determination is often framed as the right to control one's own body, and to police its "boundaries."[565] Canadian law

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[561] I seek to mitigate some of this imbalance in the first part of this chapter, which focuses on lived experiences of childbirth among Canadians with intellectual and developmental disabilities, as well as Indigenous birthing people living in remote regions of Canada.
[562] This analysis does not capture all disciplinary decisions made regarding childbirth in Canada in the past five years; only those reported and published on CanLII.
[563] *Carter, supra* note 4 at para 67, citing *AC v Manitoba*, *supra* note 151 at para 39.
[564] Jennifer Llewellyn, "Restorative Justice: Thinking Relationally about Justice" in Downie & Llewellyn, *supra* note 9, 89 at 90 [Llewellyn, "Thinking Relationally"].
[565] See: "Law, Boundaries, and the Bounded Self" in Nedelsky, *Law's Relations*, *supra* note 9 at 91-117.

recognizes as a fundamental principle the "inviolability of the human body,"[566] a characterization rooted in historical conceptions of the body as "sacred" in the sense that "'no one has a right to meddle with' another's body 'in any the slightest manner.'"[567] However, a review of recent disciplinary decisions demonstrates that the right to make decisions about one's health care during childbirth depends in large part on the birthing person's relationships and interactions with others. The decisions provide support for a central premise of relational theory: that "autonomy is not to be equated with independence" but, rather, is "made possible by constructive relationships."[568]

The centrality of relationships to the experience of autonomy is perhaps most evident in complaints regarding who was present, or permitted to be present, during labour and childbirth. Two of the decisions involved complaints regarding denials of patient requests to have family members in the room during labour.[569] One decision involved a complaint that the midwife failed to "follow through on her commitment," made during the patient's labour, to be present for the birth, resulting in the birthing person being cared for by a midwife she did not know personally.[570] Finally, one of the complaints dealt with the ability of a birthing person to decline care from certain providers—in that case, a resident physician, whom the birthing person perceived, based on a prior negative experience, to be unqualified.[571] In each of these cases, the presence (or exclusion) of specific individuals was a key component of their experience of making decisions about their care.

The decisions also illustrate how autonomy in childbirth may be "undermine[d] or enhanced"[572] through relations with others, as birthing people often depend on others to realize their goals in childbirth. For example, several complaints included experiences of providers failing to respect birth plans, particularly in the context of pain management. In *TC v NP,* for example, a birthing person who originally planned to have a homebirth with the assistance of a midwife complained that when she changed her mind and requested an epidural to assist with the pain of labour, her midwife "failed to respect [her] choice to have an epidural and her requests to go to the hospital."[573] In *KM v COG,* a birthing person complained that her nurse "failed to respect [her] birthing plan when she kept telling [the patient] to get an epidural" despite the patient having "made it clear when she arrived that she had no interest in receiving this form of pain relief."[574] In addition, the birthing person complained her nurse inappropriately denied her requests to take

566 *Engel v Salyn,* [1993] 1 SCR 306 at 315.
567 Kristin Louise Savell, "Sex and the Sacred: Sterilization and Bodily Integrity in English and Canadian Law" (2004) 49:4 McGill LJ 1093 at 1105, citing William Blackstone, *Commentaries on the Laws of England: A Facsimile of the First Edition of 1765-1769,* vol 3 (Chicago: University of Chicago Press, 1979) at 120.
568 Nedelsky, *Law's Relations*, *supra* note 9 at 118.
569 *Borg v Ross,* 2022 CanLII 93723 at para 8 [*Borg*]; *TC v NP,* 2018 CanLII 54696 at para 6 [*TC v NP*].
570 *EO-P v CO,* 2018 CanLII 4101 (HPARB) at para 9; 29-32 [*EO-P v CO*].
571 *RS v ASMA,* 2020 CanLII 26170 (ON HPARB) at paras 61-73.
572 Nedelsky, *Law's Relations*, *supra* note 9 at 119.
573 *TC v NP, supra* note 569 at para 6. See also: *Complainant v British Columbia College of Nurses and Midwives,* 2021 BCHPRB 140 at paras 4-9 [*Complainant v BCCNM*].
574 *KM v COG,* 2019 CanLII 92207 (ON HPARB) at para 5 [*KM v COG*].

a shower for pain management, ignored her request not to move the bed, and denied her request for a portable heart rate monitor, which would have allowed her to move around freely during labour.[575] In *Lance v Pelletier,* the birthing person complained her midwife "discouraged pain management techniques and attempted to influence the location and method of birth irrespective of [the birthing person's] responses when she said no on multiple occasions," and failed to "respect [her] decision to decline a mirror during pushing."[576] In each of these cases, the people giving birth had clear visions of how they wanted their birth experiences to look, and were profoundly disappointed when their planned treatment choices were not respected or realized.

In some cases, patients felt their care providers disregarded their birth plans to make the births "easier" for health care staff to manage. In *KM v COG,* for example, the birthing person explained to the Committee her belief that "many of the [nurse's] actions (or inactions) that day were a result of her apparently not wishing to be inconvenienced during the delivery, noting that a delivery in which the mother is strapped to a non-mobile monitoring device, with an epidural, would be a delivery not requiring much attention from the nurse."[577] Similarly, another complainant described: "I think […] [the doctor] intentionally poked hard enough and did things to speed the delivery along in his selfish interest and not in the best interest for me or my baby."[578] These first-hand accounts are clearly inconsistent with the right to make decisions about one's own health care, signalling that, for at least some birthing people, such rights fail to translate into the delivery room.

Some cases demonstrate the ways in which broader institutional factors within hospitals or other care settings can undermine a birthing person's ability to realize their goals in childbirth. In *EV v JM,* for example, a woman gave birth vaginally to twins in a hospital. Because she was carrying twins, the pregnancy and delivery were designated "high risk" and it was recommended that a respiratory therapist be present, in case either baby needed to be resuscitated. Neither baby required resuscitation. However, according to "standard protocols,"[579] a respiratory therapist assessed both babies following birth. The birthing person objected to what she considered to be unnecessary assessment of the babies by the respiratory therapist. She explained she had told her midwife in advance that she did not want a respiratory therapist in the labour and delivery room, and "her midwife knew that she did not want […] the babies taken from her or for the babies to be touched."[580] In particular, the birthing person objected on the basis

[575] *Ibid* at para 5.
[576] *Lance v Pelletier,* 2023 CanLII 55218 (ON HPARB) at para 10 [*Lance*].
[577] *KM v COG*, *supra* note 574 at para 16.
[578] *Complainant v. College of Physicians and Surgeons of British Columbia (No. 1)*, 2022 BCHPRB 18 (CanLII) at para 19 [*Complainant v CPSBC* 2022].
[579] *EV v JM,* 2018 CanLII 4731 (ON HPARB) at para 11 [*EV v JM*].
[580] *Ibid* at paras 6; 31.

that the respiratory therapist's assessments resulted in unnecessary separation,[581] which caused harm to both babies and herself:

> The [respiratory therapist's] time with both babies represented an unnecessary and invasive form of medical intervention that should not have happened. The separation of children and Mother caused incredible distress to the Applicant and the twins. The Applicant stated that, as a result Twin A was forced to "cry-it-out" in the overbed warmer.[582]

The Committee, "while recognizing that the Applicant's wishes may not have been as delicately handled as they could have, and that standard protocols did not allow her to have the birthing experience she desired […] concluded that no actual harm was done to the babies"[583] and, accordingly, took no disciplinary action. The Review Board confirmed the Committee's decision.[584] This case provides an example of situations in which a birthing person's stated plans and goals of care are considered secondary to institutional policy—in this case, the hospital's "standard protocol" took precedence over the patient's desired "birthing experience," precluding her from making decisions about her care.

Finally, some decisions reveal the complexity for care providers in balancing their duties to provide adequate guidance, while also respecting patients' rights to make care decisions. In *LYD v SN*, for example, a midwife explained that she broached the topic of medical induction of labour in hospital over the phone with her client during the early stages of her labour, to which she claimed the client "quickly said no, no, no, no, no."[585] In response, the midwife explains she ended the discussion of induction. The birthing person complained that she was not provided adequate information or guidance regarding methods to induce labour.[586] The Committee expressed concern that the midwife ended the discussion regarding induction of labour as soon as the birthing person said "no," explaining that "it is incumbent on a midwife to ensure a client understands the decision they are making, even when a client declines an intervention right away."[587] As this decision demonstrates, facilitating autonomy in childbirth requires more than simply leaving a birthing person alone. However, the balance is delicate. In *KM v COG,* described above, for example, the birthing person complained her nurse failed to respect her birth plan by suggesting she get an epidural, despite her stated intention not to have one.[588] The Committee in that case found the nurse's offer of an epidural was reasonable, given that one "cannot receive an epidural past a certain point in the labour

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[581] Although the birthing person's rationale is not described in the decision, her stated desire not to be separated from her babies except in the event resuscitation was required may have been driven by a desire to ensure immediate and uninterrupted skin-to-skin contact following birth, an evidence-based practice recommended by the Public Health Agency of Canada (Canada, Public Health Agency of Canada, *Family-centred maternity and newborn care: National guidelines* (Ottawa: Public Health Agency of Canada, 2019) at 6-14).
[582] *EV v JM, supra* note 579 at para 6.
[583] *Ibid* at para 11.
[584] *Ibid* at para 35.
[585] *LYD v SN, supra* note 262 at para 10.
[586] *Ibid* at para 6.
[587] *Ibid* at para 44.
[588] *KM v COG*, *supra* note 574 at para 5.

process."[589] Such interactions illustrate the difficulty of balancing respect for patient autonomy and decision-making with care providers' duties to ensure patients understand their options.

A review of recent disciplinary decisions provides a window into some of the barriers faced by birthing people in accessing their right to make decisions about their health care in practice. It also makes clear that the right to make decisions about one's health care depends, in large part, on a birthing person's relationships with those around them, as well as "the forces that structure those relations,"[590] such as hospital policies, medical school curricula, or staffing resources.[591]

The right to informed consent

The right to informed consent imposes upon Canadian health care providers[592] a positive obligation to disclose the information necessary to enable a patient to make informed health care decisions.[593] Information provided must be responsive to a patient's unique circumstances and goals of care.[594] Although research consistently demonstrates birthing people experience informed consent as enhancing their sense of autonomy, as well as their trust in care providers,[595] the right to informed consent does not always translate meaningfully into patient experience. A review of recent health disciplinary decisions reveals inadequacies in current consent processes, which, for some, have the effect of significantly impeding the exercise of autonomy in childbirth.

Many of the included disciplinary decisions describe care providers' failure to explain procedures, options, risks, or possible outcomes.[596] In some cases, complainants expressed frustration and distress at not being updated or kept apprised of the status of their labour or the health of their babies, and felt their providers' failures to adequately communicate prevented them the opportunity to make informed care decisions.[597] Some patients felt they were deceived or misled regarding the qualifications of their care providers, thus negating their consent. In *KH v HL,* for example, a birthing person complained her doctor failed to inform her he was a family physician practicing obstetrics, and not an obstetrician.[598] In *TC v NP,* the birthing person complained her midwife "neglected to inform the [patient] and her husband that she had taken a lengthy break from her practice and that the [birthing person] was one of the [midwife's] first

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[589] *Ibid* at para 30.
[590] Nedelsky, *Law's Relations*, *supra* note 9 at 119.
[591] *Ibid*.
[592] Hall, Prochazka & Fink, *supra* note 231 at 533.
[593] Mariner, *supra* note 230 at 400.
[594] *Reibl, supra* note 5. See also: *Hopp, supra* note 232.
[595] Denise O'Brien, Michelle M Butler & Mary Casey, "The importance of nurturing trusting relationships to embed shared decision-making during pregnancy and childbirth" (2021) 98:102987 Midwifery 1 at 1.
[596] *Borg, supra* note 569 at para 8; *Mckendry v Margel*, 2021 CanLII 12968 (ON HPARB) at para 23 [*Mckendry*]; *FMY v CG*, 2020 CanLII 64727 (ON HPARB) at para 5 [*FMY v CG*]; *Chiodo v Carter*, 2022 CanLII 94804 (ON HPARB) at para 8; *EO-P v CO, supra* note 568 at para 9; *LN v NB*, 2020 CanLII 63853 (ON HPARB) at para 5 [*LN v NB*]; *MD v DSC*, 2019 CanLII 52291 (ON HPARB) at para 21 [*MD v DSC*]; *MD v KMG*, 2019 CanLII 52295 (ON HPARB) at para 24 [*MD v KMG*].
[597] *LN v NB, supra* note 596 at para 5; *MD v DSC, supra* note 596 at para 21; *MD v KMG, supra* note 596 at para 24.
[598] *KH v HL,* 2021 CanLII 13973 (ON HPARB) at para 9 [*KH v HL*].

deliveries back […].”[599] These complaints indicate some birthing people have a strong desire to be involved in decision-making about their care, beyond straightforward consent conversations regarding the risks of a proposed procedure.

Some birthing people complained that their care providers asked them to sign consent forms without adequate explanation. In one case, a birthing person complained her physician gave her a form to sign "as she was being returned into the OR following significant blood loss, without explaining what she was signing."[600] In another case, a birthing person complained her doctor gave her a form to sign consenting to a C-section, and suggested she did not need to read it before signing, despite his failure to inform her of the risks and benefits of a C-section.[601] In another, a nurse brought a birthing person a consent to treatment form, and told her that if she did not sign it, the hospital would not treat her.[602] The birthing person alleged when she refused to sign the form because no doctor had explained to her what she was consenting to, the nurse "got upset and raised her voice, and took the form away."[603] These interactions demonstrate that the legal doctrine of informed consent may be reduced in clinical practice to a formality—a matter of "compliance" with administrative obligations[604]—rather than the robust conversations Canadian case law and professional health guidance require.

Some complaints dealt with failure to obtain consent prior to performing a procedure or other medical intervention. The non-consensual interferences described in the decisions range in seriousness. In one case, for example, a birthing person complained that when she "asked a doctor to stop trying to remove tape from her leg because the tape was pulling on her skin and leg hair," her nurse "proceeded to tear the tape off the [patient's] leg without warning or permission."[605] In the same case, the birthing person complained her nurse "poked at" her hand when attempting to insert an IV, without explaining what she was doing.[606]

Other situations involve more significant infringements of bodily autonomy. In one decision, for example, the complaint alleges a nurse provided a birthing person with nitrous oxide to assist with pain management, without explaining what the drug was or how it was to be used. Following use of the nitrous oxide, the patient experienced numbness in the back of her head, which the nurse explained was "most likely due to overdosing on the gas."[607] The birthing person and her husband raised concerns that she had been provided the nitrous oxide without education "about the medication, its expected action, precautions

[599] *TC v NP, supra* note 569 at para 6.
[600] *CCML v RV,* 2019 CanLII 110800 (ON HPARB) at para 8 [*CCML v RV*].
[601] *FMY v CG, supra* note 596 at para 5.
[602] *Complainant v BCCNM*, *supra* note 573 at para 10.
[603] *Ibid.*
[604] Hall, Prochazka & Fink, *supra* note 231 at 534.
[605] *KM v COG*, *supra* note 574 at para 5.
[606] *Ibid.*
[607] *Complainant v BCCNM*, *supra* note 573 at para 7.

or instructions, potential side effects, adverse effects, or recommended follow-up."[608] In another case, a birthing person complained her physician failed to inform her of the risks and benefits of rotating her baby during labour prior to attempting it, and also failed to inform her of the risks and benefits of a C-section.[609] In another, the complainant alleged a physician "did not explain the risks associated with forceps assisted delivery, did not explain the alternative option of delivery by caesarean section, and did not obtain informed consent from [the birthing person] before proceeding with the forceps delivery."[610] The Complainant stated she "assumed there were no risks involved in the forceps assisted delivery because none were explained."[611] In this case, the baby "sustained a permanent injury to his left eye, as well as cuts to his head and neck, and a facial nerve palsy"[612] that were attributed to the use of forceps during the delivery. While the disciplinary decisions do not draw conclusions regarding whether the birthing people in these cases would have consented to treatment had they been properly informed, these accounts nonetheless signal serious failings in the way the legal doctrine of informed consent is translated into clinical practice.

Three of the complaints addressed non-consensual procedures carried out to induce or accelerate labour. In *Mckendry v Margel,* the birthing person complained her physician "never discussed or explained in detail what he was doing prior to doing it, particularly when he broke her water."[613] The complainant further described: "At no point during any of her cervix checks did the [physician] ask her if she was okay with these examinations and she understood that she had no choice [emphasis added]."[614] In *FMY v CG,* the birthing person complained her doctor failed to explain what a "stretch and sweep"[615] was, and failed to obtain her informed consent prior to performing one on her.[616] While no further information is provided regarding the context of the procedure in the reported decision, non-consensual "stretch and sweeps" have been documented to occur in Canada, typically in the context of what the pregnant person understands is a straightforward pelvic exam.[617] Similarly, in *CL v KNMB,* the complaint alleges a physician performed an artificial rupture of membranes[618] without patient consent or discussion, during what the patient believed to be a routine pelvic exam.[619] Regarding the issue of consent, the complainant alleged:

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[608] *Ibid.*
[609] *FMY v CG, supra* note 596 at para 5.
[610] *Complainant v The College of Physicians and Surgeons of British Columbia,* 2019 BCHPRB 62 at para 2 [*Complainant v CPSBC* 2019].
[611] *Ibid* at para 12.
[612] *Ibid* at para 2.
[613] *Mckendry, supra* note 596 at para 23.
[614] *Ibid* at para 26.
[615] A "stretch and sweep" or a "membrane sweep" is a procedure in which a care provider "inserts a gloved finger through the cervical canal and uses a sweeping motion to separate the membrane from the cervix" to accelerate the onset of labour (Colleen Fisher Tully, "What you need to know before your membrane sweep" *Today's Parent* (20 April 2023)).
[616] *FMY v CG, supra* note 596 at para 5.
[617] Sahar Fatima, "What is obstetric violence—and could it have happened to you?" *Today's Parent* (25 February 2020).
[618] Artificial rupture of membranes is a procedure in which a care provider intentionally breaks a pregnant person's amniotic sac to induce or accelerate labour. ("What is artificial rupture of the membranes?" (23 February 2022), *MyHealth.Alberta.ca* (website), online: https://myhealth.alberta.ca/health/AfterCareInformation/pages/conditions.aspx?HwId=abn3047).
[619] *CL v KNMB,* 2020 CanLII 59938 (ON HPARB) at para 21 [*CL v KNMB*].

> Before labour began, the Respondent performed a pelvic examination to see the state of the Applicant's cervix and then, without her consent and without any discussion of the procedure, the Respondent aggressively began to break her water.
>
> The Applicant's wife, who was present, indicated in her statement that she recalls being confused as the doctor took her hand out of her wife's vagina and grabbed the amnio hook, because it was not something they had ever discussed.[620]

In this case, the Committee commented that the doctor could have better explained the course of action, but "had no concerns with the [doctor]'s care of the Applicant and determined to take no further action with respect to this aspect of the complaint."[621] Accordingly, the Board confirmed the Committee's decision.[622]

Therefore, although the doctrine of informed consent is recognized in Canadian law as the "primary paradigm for protecting the legal rights of patients,"[623] recent disciplinary decisions indicate the doctrine fails to translate to the lived experiences of many patients giving birth. Informed consent is a fundamentally relational concept; it is realizable through relationships with care providers. Therefore, in seeking to close the gaps between the right to informed consent on the books and the experiences of birthing people in action, it is necessary to move beyond standard consent forms toward a shared decision-making model—perhaps one incorporating elements of midwifery's alternate model of informed *choice*—in which consent discussions are "informed by a patient's interpersonal relationships and broader social environment."[624] Strategies for actioning this goal are described in Chapter 4.

The right to dignity

Respect for patient dignity is a matter of professional responsibility for physicians,[625] nurses,[626] and midwives[627] in Canada. Yet, several of the decisions included in this analysis describe harms to dignity, including rude or unprofessional treatment, or experiences of being mocked, humiliated, or demoralized. An examination of recent disciplinary decisions makes clear that the experience of dignity during childbirth depends, in large part, on the provision of dignified treatment by care providers. Legal scholar Jennifer Llewellyn explains how dignity may be understood through a relational lens:

> [D]ignity conceived of relationally is different than dignity reflected in liberal justice. Dignity does not refer to the inherent value of the individual qua *rational* agent. Dignity is not something that resides in the individual alone. Rather, it marks the relationship between

[620] *Ibid* at paras 21-22.
[621] *Ibid* at para 28.
[622] *Ibid* at para 30.
[623] Hall, Prochazka & Fink, *supra* note 231 at 533.
[624] "ACOG Committee Opinion: Informed Consent and Shared Decision Making in Obstetrics and Gynecology" (2021) 137:2 Obstetrics & Gynecology e34 at e36. See also: O'Brien, Butler & Casey, *supra* note 595 at 2.
[625] *CMA Code of Ethics, supra* note 436 at 2.
[626] CNA *Code of Ethics, supra* note 437 at 12.
[627] See, for example: College of Midwives of Ontario, *Code of Ethics,* Toronto: CMO, 2015 at 1; BCCN&M *Code of Ethics, supra* note 438 at 1.

> and among parties. Dignity refers here to the way in which we are connected with others—that such connections must reflect our own value and that of others.[628]

The decisions included in this analysis clearly illustrate the key role care providers play in facilitating or frustrating the realization of dignity for birthing people during childbirth. Some complainants describe not being spoken to directly or acknowledged by care providers during labour,[629] or their care providers not taking the time to introduce themselves prior to delivery.[630] Others describe "rude and unprofessional"[631] mannerisms, negativity,[632] bullying behaviour,[633] care providers yelling or raising their voices,[634] or visible impatience or frustration in response to patient requests.[635]

While health care providers are not (and should not be) held to a standard of perfection, it is important to recall the power dynamic between care providers and labouring patients—"rude" behaviour or displays of impatience on the part of care providers can shape decisions birthing people make during childbirth, many of whom may feel compelled to comply out of a desire to be a "good patient."[636] For example, in one decision involving an unnamed complainant in British Columbia, the birthing person describes her obstetrician entering the delivery room "visibly grumpy and impatient" and recalls that he "wanted to almost immediately do an episiotomy," despite the fact that she had "only just started pushing."[637] When the birthing person asked if she could continue to try pushing on her own, she alleges the obstetrician made foreboding remarks regarding her child's safety, which had the effect of scaring her into acceding to the episiotomy.[638] She describes:

> I then promptly agreed to the episiotomy because I was in a vulnerable state and was pressured, and it was obvious that [the Registrant] would not help if something were to happen and we all did not do as he said.[639]

In this case, the birthing person directly attributes her physician's mannerisms and behaviour to her "consent" to an unwanted medical intervention.[640]

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[628] Llewellyn, "Thinking Relationally", *supra* note 564 at 94-95.
[629] *KM v COG*, *supra* note 574.
[630] *LMLN v JFRB,* 2019 CanLII 26554 (ON HPARB).
[631] *Mckendry, supra* note 599; *Borg, supra* note 569 at para 8.
[632] *LN v NB, supra* note 596 at para 5.
[633] *Mckendry, supra* note 596; *Complainant v CPSBC* 2022*, supra* note 578 at para 19.
[634] *Complainant v BCCNM*, *supra* note 573 at para 10; *WR v DKB,* 2021 CanLII 78761 (ON HPARB) at para 6 [*WR v DKB*].
[635] *LN v NB, supra* note 596 at para 5; *Complainant v CPSBC* 2022*, supra* note 578 at para 19; *Borg, supra* note 569 at para 8.
[636] N Hill, *supra* note 270 at 238; Leanne Chantrel Johnson, *Exploring Respect During Childbirth among Nurses, Women and their Families* (PhD Thesis, University of Alberta Faculty of Nursing, 2022) [unpublished] at 50; 107.
[637] *Complainant v CPSBC* 2022*, supra* note 578 at para 19.
[638] *Ibid.*
[639] *Ibid.*
[640] *Ibid.*

Birthing people also describe their concerns being "ignored,"[641] "brushed off,"[642] "dismiss[ed]" or "minimiz[ed],"[643] being belittled in response to sincere questions,[644] being "scolded,"[645] or having their pain "downplayed and mocked"[646] or "ignored."[647] In some cases, complainants describe care providers suggesting or implying they do not care about the well-being of their own babies.[648] In one case, for example, a person in early labour asked for medical pain relief, and recalls her nurse asking "if she wanted to 'kill [her] baby' because taking more drugs would do so."[649] In others, complainants describe care providers as flippant, distracted, or indifferent to their pain.[650] For example, in one decision involving an emergency C-section, the birthing person complained her obstetrician "did not give her his full attention during the C-section" and "joked and laughed with staff in the OR."[651] In another case, a midwife attending a scheduled home birth explained she was delayed in arriving at her client's home because she stopped to buy a beverage at Tim Horton's, "despite receiving an urgent plea from the patient and her partner" to arrive as soon as possible.[652] In another, a birthing person complained that her midwife "began texting during the active delivery part of [her] labour and dictated texts to another midwife while her fingers were inside the [birthing person's] vagina."[653] In each of these instances, the reviewing committees found patient care was not meaningfully affected by the conduct complained of, and, thus, discipline was not warranted.[654] However, while the care providers in these examples may not have run afoul of their professional obligations, it is clear from the effort and personal sacrifice[655] the complainants put into filing these complaints (and, in both of these cases, appealing to review boards) that harm *has* occurred—although a route to meaningfully address and remediate such harm may not presently exist.

Some complaints involve situations in which care providers are perceived to question or doubt the birthing person's judgment, thereby undermining birthing people's confidence in their bodies and abilities. Examples of such situations include scenarios in which care providers question or express doubt about the degree of pain a birthing person is experiencing,[656] or make comments regarding the progression of their labour that imply (or are perceived to the birthing person to imply) mistrust of the birthing person's judgment. In *Borg v Ross,* for example, a birthing person complained her midwife failed to appropriately

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[641] *Mckendry, supra* note 596.
[642] *Ibid.*
[643] *Borg, supra* note 569 at para 8.
[644] *LN v NB, supra* note 596 at para 5.
[645] *Lance, supra* note 576 at para 10.
[646] *Complainant v BCCNM*, *supra* note 573 at para 8.
[647] *Lance, supra* note 576 at para 17.
[648] *Complainant v CPSBC* 2022*, supra* note 578 at para 19; *Complainant v BCCNM*, *supra* note 573 at para 9.
[649] *Complainant v BCCNM*, *supra* note 573 at para 9.
[650] *CCML v RV, supra* note 600 at para 8; *Borg, supra* note 569 at para 4; *Lance, supra* note 576 at para 17.
[651] *CCML v RV, supra* note 600 at para 49.
[652] *Borg, supra* note 569 at para 4.
[653] *Lance, supra* note 576 at para 10.
[654] *Complainant v BCCNM*, *supra* note 573 at paras 33-34; *CCML v RV, supra* note 600 at para 49; *Borg, supra* note 569 at para 55.
[655] Consider, for example, the birthing person in *Lance v Pelletier,* who stated that "although she would prefer not to be named [in the published decision], she felt strongly enough about her complaint that she accepted having her name made public" (*Lance, supra* note 576 at para 5).
[656] *Complainant v BCCNM*, *supra* note 573 at para 9.

manage her care during labour by telling her "that if she could speak through her contractions, she was not in active labour," "dismissing the patient's description of her contractions," expressing "displeasure about the patient attending the hospital without notifying her first," and "dismissing or minimalizing [the patient's] concerns."[657] As a result, the birthing person explained, she was left feeling "demoralized […] to the point that she was unable to trust her own judgment."[658] Similarly, in *IS v KBO*, a birthing person complained her physician "behaved in an unprofessional manner by suggesting that [the patient's] anxiety was responsible for the failure of her cervix to continue dilating" during labour.[659] In this case, the respondent physician explained to the Committee that when she advised the birthing person to have an epidural "to help her relax," "she did not intend to imply that anxiety would result in the failure of the cervix to dilate."[660]

These interactions speak to a common tension in childbirth, where, due to prevailing social constructions of childbirth and motherhood, childbirth is entangled in issues of adequacy, and one's body being "good enough" to birth without technological intervention.[661] They also speak to the serious communication challenges involved in childbirth-related health care delivery; a true "meeting of the minds" between birthing people and care providers can be hindered by the fact that for the care provider, childbirth is an everyday event, whereas for the birthing person, it may be a rare and deeply meaningful experience.[662] This incongruity can result in serious barriers to communication. Consider, for example, the midwife who stopped for coffee on her way to attend to a patient in labour.[663] Stopping to buy coffee before work is a normal (and mundane) experience for many, and it is understandable that a midwife may feel justified, based on her experience and understanding of the typical timeline of labour, in stopping for a beverage on her way to her shift. But for the patient and her family, who were experiencing a profound life event, the midwife's actions were callous and deserving of professional sanction. These examples serve to demonstrate how the relationship between care providers and birthing people shapes their perception and experience of the right to self-determination in childbirth, well beyond the conventional liberal understanding of inherent human dignity.

Complaints regarding harms to dignity often involve a perceived lack of empathy or compassion on the part of care providers. In *Lemme v Desaulniers*, for example, in addition to complaints regarding the quality of care provided during labour, the parents of a newborn who died as the result of a uterine rupture

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[657] *Borg, supra* note 569 at para 8.
[658] *Ibid.*
[659] *IS v KBO,* 2020 CanLII 23216 (ON HPARB) [*IS v KBO*].
[660] *Ibid* at para 48.
[661] Claudia Malacrida & Tiffany Boulton, "Women's Perceptions of Childbirth 'Choices': Competing Discourses of Motherhood, Sexuality, and Selflessness" (2012) 26:5 Gender & Society 748 at 759; Jenny Splitter, "I was determined to have a VBAC, but in the end, it didn't matter" *The Washington Post* (10 October 2017).
[662] Malacrida & Boulton, *supra* note 661 at 749.
[663] *Borg, supra* note 569 at para 4.

complained that their midwife failed to follow up with them after their loss.[664] In a related decision, the Review Board confirmed the decision of the Committee to "encourage" the midwifery practice to "incorporate a bereavement course into their continuing education."[665] However, the Review Board also noted that "[w]hile the Committee encouraged the Practice to develop a framework for supporting bereaved families, a protocol related to that issue is not a requirement under the professional practice standards."[666] It is unclear from the text of either decision whether the complainants experienced any sense of justice from their participation in the disciplinary process.

Though, as discussed in the previous chapter, dignity is highly subjective, some of the cases involve more serious allegations of degrading treatment, including experiences of aggressive or assaultive behaviour. In *WR v DKB,* the birthing person described her obstetrician "yelling" at her, and "grabbing her legs and pushing them in a harsh manner in order to apply a scalp clip."[667] In *Mckendry v Margel,* the complainant alleged her obstetrician performed "vaginal examinations in a rough, painful manner" and performed a vaginal exam while she was "unaware of what was happening, leaving her feeling as though she was sexually assaulted."[668] Neither the investigatory committees nor review boards found serious fault in the actions of the physicians described in either of these cases, pointing, instead, to misunderstandings and miscommunications. In this respect, these complaints illustrate some of the ways in which "[p]rocedures that are routine for [medical] staff may be 'strange, frightening intrusions'" for the person giving birth, thus contributing to the experience of incongruity described above, and, in some cases, resulting in significant long-term harms.[669]

Other complaints focus on infringements on the right to dignity in the context of modesty or maintaining a sense of pride during childbirth. In *KM v COG,*[670] for example, a labouring woman requested a second hospital gown to cover herself. Her nurse refused, saying she would not need it because she would "just be lying down."[671] In addition, after her doctor broke her water, the same patient asked her nurse to change her soaked pads. The nurse refused, saying "No, later, you'll just get wet again."[672] In this case, the Committee found the nurse was "unsympathetic to the [Complainant's] discomfort,"[673] and issued a caution to the nurse, which the Review Board confirmed.[674] In *LYD v MB,*[675] a birthing person described being

[664] *Lemme v Desaulniers,* 2022 CanLII 62781 (ON HPARB) at para 9 [*Lemme v Desaulniers*].
[665] *Lemme v Chatelain,* 2022 CanLII 62775 (ON HPARB) at para 1 [*Lemme v Chatelain*].
[666] *Ibid* at para 21.
[667] *WR v DKB, supra* note 634 at para 6.
[668] *Mckendry, supra* note 596 at para 4.
[669] Elsa Montgomery, Catherine Pope & Jane Rogers, "The re-enactment of childhood sexual abuse in maternity care: a qualitative study" (2015) 15:194 BMC Pregnancy & Childbirth 1 at 3. See also: C Vedeler, "What women emphasise as important aspects of care in childbirth—an online survey" (2022) 129 BJOG 647 at 649-650.
[670] *KM v COG*, *supra* note 574.
[671] *Ibid* at para 5.
[672] *Ibid.*
[673] *Ibid* at para 37.
[674] *Ibid* at para 1.
[675] *LYD v MB, supra* note 262.

"humiliated" when midwives attending her home birth allegedly refused to provide her with a blanket to cover her naked body, prior to firefighters arriving to resuscitate her newborn baby.[676] In this case, as in several of the cases included in this analysis, the baby died. However, rather than focusing only on perceived failings in the provision of medical care to her newborn, the birthing person's complaint describes the humiliation she experienced because she was denied a blanket. This underscores the importance of dignity during childbirth as a matter of treating the birthing person not simply as a vessel for the baby, but as a person who is deserving of dignified care and treatment on their own merit.

Llewellyn explains that dignity, understood relationally, is "the commitment that others to whom we are connected cannot be simply a means to an end but must also be accorded value in and of themselves, and this value must be reflected in the nature of our relationship with them."[677] Llewellyn explains the concept of dignity is perhaps best understood through comparison to the notion of "indignity":

> This relational nature of dignity is reflected in the way we talk about indignity, as something we do to one another or cause through our treatment and interactions. […] As we conceive of it, indignity results from degrading, humiliating, or debasing another.[678]

Thus, in the same way we "clearly recognize the relational nature of indignity as brought about through our social interactions and arrangements,"[679] we may understand the right to dignity in childbirth as realizable through interactions with care providers.

The key to realizing dignity in childbirth depends, therefore, on the birthing person's network of relations with others involved in the experience of childbirth, including doctors, midwives, and nurses. As Nedelsky explains: "relatedness, even dependency, is not, as the Anglo-American theoretical tradition teaches, the antithesis of autonomy, but a literal precondition of autonomy and […] interdependence is a constant component of autonomy."[680]A review of recent Canadian disciplinary decisions involving experiences of childbirth reveals the central importance of dignity to birthing people. Closing the gap between the right to medical self-determination "on the books" and the experience of medical self-determination, thus, requires—perhaps counterintuitively—careful attention to the birthing person's connections to others.

Conclusions

An analysis of recent disciplinary decisions addressing perceived inadequacies in childbirth care demonstrates significant gaps between the legal right to medical self-determination on the books and the experiences of the right in practice. Birthing people describe an inability to make decisions for themselves

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[676] *Ibid* at para 18.
[677] Llewellyn, "Thinking Relationally", *supra* note 564 at 95.
[678] *Ibid.*
[679] *Ibid.*
[680] Nedelsky, *Law's Relations*, *supra* note 9 at 124-125.

during childbirth in several respects, as well as significant shortcomings in informed consent discussions, and profound injuries to personal dignity.

The harms described by birthing people in these disciplinary decisions often do not fit within conventional legal understandings of "harm," which primarily focus on tangible harms to the individual,[681] such as pecuniary loss and bodily injury. Recall *EV v JM,* for example, in which a birthing person made a complaint about the unwanted presence of a respiratory therapist when she gave birth to her twins. The investigatory Committee concluded that while "standard protocols did not allow her to have the birthing experience she desired […] no actual harm was done to the babies [emphasis added]."[682] In this case, the investigatory Committee applied a narrow, legal definition of "harm," which did not account for (or deliberately discounted) the intangible harms or losses experienced by the birthing person *as a result* of being unable to determine the course of her "birthing experience," as well as the harms perceived by the birthing person to be associated with her newborn son "crying it out."

In considering that part of the harm in *EV v JM* was in the birthing person's inability to realize her birth plan, I note the facts incorporate the additional element of provider duties to children once born alive, as the birthing person's plans included a preference for immediate skin-to-skin *following* birth. In situations where a newborn child is at risk of significant harm due to their parents' choices regarding their care, providers throughout Canada are obligated, pursuant to provincial legislation, to notify local child welfare authorities.[683] In such cases, a judge may order that the state take temporary guardianship of the child so that life-saving care may be provided, contrary to parental wishes.[684] However, such risk assessments must be conducted on a principled, case-by-case basis, rather than as a matter of blanket adherence to standard protocols. In non-urgent situations, parents have a significant degree of discretion when it comes to determining the course of medical treatment their children receive once born, both with respect to directing positive actions by care providers (for example, in the case of newborn circumcision[685]) and in declining routine, evidence-based treatment, such as vaccinations.[686] In the context of care decisions that do not involve risk of serious harm to a newborn child, risks and benefits must be considered in collaboration with parents. In the case of *EV v JM,* care providers may have been able to avoid or mitigate some of the harm

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[681] Sarah Clark Miller, "Toward a relational theory of harm: on the ethical implications of childhood psychological abuse" (2022) 18:1 J Glob Ethics 15 at 15.
[682] *EV v JM, supra* note 579 at para 11.
[683] "CPS Position Statement: Medical Neglect", *supra* note 177 at 374.
[684] *B(R) v Children's Aid Society, supra* note 153. See also: *AC v Manitoba*, *supra* note 151 at para 195; "CPS Position Statement: Medical Neglect", *supra* note 177 at 374.
[685] The health benefits of the procedure, weighed against the risks, do not favour routine newborn circumcision, and there is ongoing ethical debate about the practice. Nonetheless, newborn circumcision is performed without medical indication throughout Canada, for religious reasons or otherwise as a matter of parental preference (Canadian Paediatric Society, Position Statement, "Newborn male circumcision" (1 January 2021); Sumit Dave et al, "Canadian Urological Association guideline on the care of the normal foreskin and neonatal circumcision in Canadian infants (full version)," (2018) 12:2 Can Urol Assoc J E76 at E94; J Steven Svoboda, Peter W Adler & Robert S Van Howe, "Circumcision Is Unethical and Unlawful" (2016) 44 JL Med & Ethics 263; Anonymous, "Circumcision and the Oppression of the Medical Colonizer: A Critical Reflection" (2018) 19:2 Critical Social Work 94; Jenni Singer, "The Pros and Cons of Circumcision" *Parents* (7 January 2020)).
[686] Alison Braley-Rattai, "The Best Interest of the Child and the Limits of Parental Autonomy to Refuse Vaccination" (2022) 15:1 McGill JL & Health 65 at 101-102.

experienced by the birthing person and her family by consulting her in advance regarding her desire for immediate skin-to-skin, and making a principled decision based on the physical status of the twins at birth, rather than removing them to be examined as a matter of routine practice.

In some situations, law may not recognize harm has occurred because there is no evidence to suggest a person would have made a different choice if given the opportunity to do so, or because there is no evidence that the outcome would have been different if the birthing person had been able to choose their care themselves.[687] This understanding fails to account for harms caused by denying a birthing person the right to medical self-determination. Complainants' experiences of denial of autonomy in childbirth defy conventional understandings of how "blame" or "liability" may be attributed, focusing instead on injuries that are not easily quantifiable, such as harms to dignity or loss of self-esteem. Consider, for example, *Borg v Ross*, in which the complainant's experience of the care she received during labour left her feeling "demoralized […] to the point that she was unable to trust her own judgment."[688]

While such harms do not fall clearly into compensable legal categories, the complainants in these cases have unquestionably experienced some form of loss, the effects of which are profound and long-lasting. Consider, for example, the experiences of an unnamed complainant, who gave birth in British Columbia:

> I have tried to forget and move past what has happened but I have not been able to. It has traumatized me and my family. I think about what happened all the time and am paralyzed and numb about what happened. I feel strongly that I need to make a formal complaint so that [the Registrant] does not do this again to anyone else's baby. […] He definitely caused us years of emotional trauma. […] What he did with me was not right.[689]

In this case, the Review Board's decision was published in 2022, seven years after the events giving rise to the complaint occurred, indicating the experience has had a long-term effect.

In each of the cases discussed in this analysis, the birthing person appealed the decision of the Committee, in pursuit of closure. Complainants variously sought "assurance that nothing else could have been done,"[690] "acknowledge[ment]"[691] of the harms caused, or a desire for care providers to "take responsibility."[692] One decision alludes to broader patterns of obstetric mistreatment within care settings,[693] which are also demonstrated in media reports[694] and academic research.[695] Complainants in these cases have

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[687] See, for example: *Gerelus et al v Lim et al,* 2006 MBQB 194 (CanLII) at para 136, affirmed in *Gerelus v Lim et al,* 2008 MBCA 89 (CanLII).
[688] *Borg, supra* note 569 at para 8.
[689] *Complainant v CPSBC* 2022*, supra* note 578 at para 19.
[690] *Complainant v College of Midwives of British Columbia,* 2018 BCHPRB 117 at para 8.
[691] *AGK v CLK,* 2019 CanLII 13687 at para 24.
[692] *Chiodo v Babe,* 2022 CanLII 94805 (ON HPARB) at para 8.
[693] *KM v COG*, *supra* note 574.
[694] Fatima, *supra* note 617; Burns-Pieper, 'Stop! Stop!', *supra* note 2; Burns-Pieper, "A scene from a horror movie", *supra* note 3.
[695] Kathleen Rice, "Re-centering Relationships: Obstetric Violence, Health Care Rationalities, and Pandemic Childbirth in Canada" (2023) 37:1 Med Anthropol Q 59; Samir Shaheen-Hussain, Alisa Lombard & Suzy Basile, "Confronting medical colonialism and obstetric violence in Canada" (2023) 401:10390 *The Lancet* 1763; Natasha Procenko, *Shifting Maternity Care in Canada: A Feminist Post-Structural Study of Experiences of Disrespect and Abuse in Facility-Based Childbirth* (MHA Thesis, Dalhousie University Faculty of Health Administration, 2021).

undeniably experienced harm and, in response, seek a sense of justice. As Llewellyn describes: "[j]ustice is our response to the powerful moral intuition that something is wrong and begs response and redress."[696] While a review of recent disciplinary decisions indicates there is, indeed, something awry with the state of childbirth care delivery, there is currently no clear route to justice for those who have been wronged.

Harms associated with denial of the right to medical self-determination are not meaningfully remediable through the civil legal system, which is costly and inaccessible for most complainants, and ill-suited for addressing intangible aspects of obstetric mistreatment, such as harms to dignity or self-worth.[697] While, as evidenced above, many birthing people turn to professional disciplinary processes to seek redress, the relief that system offers complainants is limited—perhaps demonstrated most clearly through the fact that, in each of the decisions discussed in this analysis, the Complainants were dissatisfied with the investigatory committees' decisions, and appealed to review boards.

These disciplinary decisions illustrate that medical self-determination is often not simply a matter of *independence* but, rather, *interdependence*. Birthing people rely to a significant extent on cooperation, collaboration, and connection with others to facilitate the realization of their personal goals for childbirth. The conventional Canadian legal system and professional complaints processes both focus on "the individual ascription of blame and liability for past harms."[698] However, because autonomy rights in childbirth are realized constitutively, harms resulting from denial of autonomy must be understood and responded to relationally. Llewellyn explains:

> A relational view of justice is fundamentally concerned with the character and conditions of relationship. Wrongdoing (injustice) is then also understood relationally on this account. Wrongdoing is defined in terms of the harm that results to equality of relationship. Injustice, on a relational justice account, reflects the existence of inequality of relationship between and among individuals, groups, and communities.[699]

In this way, a relational lens assists in understanding "hitherto overlooked forms of harm,"[700] and offers an alternate path forward, through non-conventional legal means. With these principles in mind, in my final chapter, I turn my attention to the potential of a restorative justice approach in childbirth, both to bridge the gaps between legal rights "on the books" and in action, and to bridge the gaps between care providers and patients in a manner that fosters patient autonomy.

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[696] Llewellyn, "Thinking Relationally", *supra* note 564 at 90.
[697] *Ibid* at 91.
[698] Ami Harbin and Jennifer J Llewellyn, "Restorative justice in transitions: The problem of 'the community' and collective responsibility" in Kerry Clamp, ed, *Restorative Justice in Transitional Settings* (London: Routledge, 2016) 133 at 133.
[699] Llewellyn, "Thinking Relationally", *supra* note 564 at 95.
[700] Clark Miller, *supra* note 681 at 17.

CHAPTER 4:
Closing the Gaps

Analysis of first-hand accounts of giving birth in Canada reveals that significant gaps exist between legal rights as they are set out in law, and the way those rights are experienced in the lives of birthing people. As Sherwin explains, "the physician-patient relationship is not a dyad that exists in some abstract, eternal realm; it is found within overlapping networks of other relationship, which bind patients and physicians to their respective family members, other health professionals, neighbors, employers, health services administrators, and so on."[701] Given the complex network of relationships in which experiences of mistreatment during childbirth occur, I argue any proposed policy solutions to close these gaps must be analysed through a relational lens.

Though relational analyses of issues related to pregnancy and childbirth are not new,[702] a relational approach offers a novel alternative to current prevailing responses to obstetric violence,[703] which focus primarily on individual harms and individualized responses, and, accordingly, often fail to account for the broader contexts within which such mistreatment occurs.[704] Aside from costly and challenging civil claims, people in Canada have two main routes for voicing concerns about the treatment they experienced during childbirth: making complaints to regulatory bodies or contacting the media. In either case, the stage is set with two principal players: the victim (the birthing person) and the perpetrator (the health care provider.)

Upon receipt of a complaint, regulatory bodies, such as medical colleges, scrutinize the conduct of the registrant who is the subject of the complaint, focusing on the specific events described and prescribed standards of conduct. However, such narrow investigations often fail to account for systemic issues in the provision of medical care, or for a nuanced understanding of the experience of harms that fall short of established standards of "improper" conduct. Llewellyn explains that "[s]tandard complaint processes are not designed to deal with relational complexity."[705] Rather, such processes "reflect a prescriptive and formal

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[701] Sherwin, *No Longer Patient, supra* note 250 at 83.
[702] See, for example: *ibid* at 108-111; Sherwin, "A Relational Approach to Autonomy", *supra* note 9 at 20-21.
[703] For the purposes of this chapter, I use the term "obstetric violence" to refer to wide range of conduct, including (but not limited to): "forced/ non-consented to medical procedures (eg caesarean sections, episiotomies, inductions, forceps delivery, vaginal examinations); unnecessary, but apparently consented to, medical treatments; withholding medical treatment/pain relief; slapping, pinching, restraining of women during labour; verbal and emotional abuse (eg shouting, threats, coercion, being lied to obtain compliance/consent); neglect; and disrespectful treatment (eg putting the needs of the care provider ahead of those of the woman; ignoring the woman's embodied experience)" (Karen Brennan, "Reflections on criminalising obstetric violence: A feminist perspective" in Camilla Pickles & Jonathan Herring, eds, *Childbirth, Vulnerability and Law* (London: Routledge 2019) 226 at 229.)
[704] Sara Cohen Shabot, "We birth with others: Towards a Beauvoirian understanding of obstetric violence" (2020) 28:2 The European Journal of Women's Studies 1 at 3.
[705] Jennifer J Llewellyn, "Responding Restoratively to Student Misconduct and Professional Regulation: The Case of Dalhousie Dentistry" in Gale Burford, John Braithwaite & Valerie Braithwaite, eds, *Restorative and Responsive Human Services* (New York: Routledge, 2019) 127 at 136 [Llewellyn, "Responding Restoratively"].

approach to regulating behaviour" that is focused on enforcing individual behaviours according to proscribed standards, and "ensur[ing] accountability for transgressions."[706]

Similarly, Canadian media coverage of obstetric violence often focuses principally on individual complainants and individual care provider accountability.[707] Sociologist Nicole Hill explains that rather than considering systemic issues (such as discrimination in the provision of medical care or problems with workplace culture) in any depth, many Canadian news reports of obstetric violence construct "highly individualistic"[708] portrayals, which cast obstetric violence "as a private problem experienced by the specific individuals interviewed and discussed in the stories."[709] Moreover, Hill explains Canadian media coverage often portrays obstetric violence as a matter of individual accountability, suggesting "individual victims should address their own victimization and ultimately foster an avenue to see the issue addressed."[710] This individual accountability approach is also reflected in online advocacy groups, which often "encourage women to know their rights in childbirth, hire doulas, write detailed birth plans and disseminate them, or forgo hospital birth plans altogether."[711] Such narrow framings "focused on the immediacy of a single act, its victim and perpetrator, [risk] obscuring the structural injustices" that underly events of obstetric violence, "thereby hiding their social, political, and economic origins."[712]

In addition, though not widely discussed in Canada, criminalisation is a prominent policy response to obstetric violence internationally. Venezuela,[713] Argentina,[714] Bolivia,[715] Panama, and several states in Mexico[716] have legislatively criminalised obstetric violence in response to organized advocacy campaigns

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[706] *Ibid* at 136.
[707] Nicole Hill, "Constructing Obstetric Violence in Canadian News Media" in Castañeda, Hill & Johnson Searcy, *supra* note 17, 195 at 203 [N Hill, "Constructing Obstetric Violence"].
[708] *Ibid* at 203.
[709] *Ibid* at 196. See, for example: Alex Cooke, "NS mom says she had to 'beg' for care while giving birth at IWK hospital" *Global News* (5 November 2022); Burns-Pieper, "A scene from a horror movie", *supra* note 3; Burns-Pieper, 'Stop! Stop!', *supra* note 2.
[710] *Ibid* at 203. See, for example: Lauren Bird, "After Moncton Hospital allegations, renewed calls for patient advocate" *CBC News* (16 April 2019); Lucs, *supra* note 270.
[711] Theresa Morris et al, "'Screaming, "No! No!" It was Literally Like Being Raped': Connecting Sexual Assault Trauma and Coerced Obstetric Procedures" (2023) 70 Social Problems 55 at 67. See, for example: "Canada-Wide Complaints Directory," *The Obstetric Justice Project* (website), online: https://obstetricjustice.org/complaints, which states: "If you've experienced Obstetric Violence (mistreatment, disrespect and abuse in reproductive healthcare) speaking up about it can help break the cycle and improve care for all."
[712] Joanna N Erdman, "Bioethics, Human Rights, and Childbirth" (2015) 17:1 Health and Human Rights J 43 at 46.
[713] In Venezuela, obstetric violence is defined as: "the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women" (Pérez D'Gregorio, "Obstetric violence: A new legal term introduced in Venezuela" (2010) 111 International Journal of Gynecology and Obstetrics 201 at 201; Law 38.668, 23 April 2007, *Organic Law on the Right of Women to a Life Free of Violence,* ch III, art 15 (Venezuela)). Examples of acts of obstetric violence under the law include: "obstructing the early attachment of the child with his/her mother, performing cesareans that were not medically indicated or consented, and restricting women's choices of birth positions" (Virginia Savage & Arachu Castro, "Measuring mistreatment of women during childbirth: a review of terminology and methodological approaches" (2017) 14:138 Reproductive Health 1 at 5).
[714] The legal definitions of obstetric violence in Argentina and Panama are very similar to Venezuela's definition (Law 26.485, 11 March 2009, *Integral Protection of Women for Sanctioning, Preventing, and Eradicating Violence against Women*, B.O. 31632, article 6(e) (Argentina); Rachelle Chadwick, "Breaking the frame: Obstetric violence and epistemic rupture" (2021) 35:3 Agenda 104 at 107.)
[715] Bolivia does not explicitly define obstetric violence, "but rather develops a legislative framework around violence within health services that includes a special focus on pregnant and childbearing women." Bolivia's legal framework additionally defines "violence against reproductive rights," which includes incidents related to miscarriage and breastfeeding (CR Williams et al, "Obstetric violence: a Latin American legal response to mistreatment during childbirth" (2018) 125:10 BJOG 1208 at 1209).
[716] Obstetric violence has been classified as a crime in the Mexican states of Aguascalientes, Chiapas, Guerrero, Puebla, the State of Mexico and Veracruz. (Omar Calvo Aguilar, Marta Torres Falcón & Rosario Valdez Santiago, "Obstetric violence criminalised in Mexico: a comparative analysis of hospital complaints filed with the Medical Arbitration Commission (2020) 46 BMJ Sex Reprod Health 38 at 38; 11 April 2023,

on the part of feminist groups and public health organizations.[717] Legal scholars and advocates have called for similar legislative responses in the United Kingdom,[718] South Africa,[719] and Italy.[720]

While criminalisation arguably serves the important functions of denouncing obstetric violence[721] and bringing global attention to the issue,[722] some commentators have noted the practical impact of such legislative response has been limited.[723] For example, Venezuela became the first country to legally define and criminalize obstetric violence in 2007.[724] However, legal scholar Camilla Pickles explains the dearth of Venezuelan case law applying the legislation "suggests that the legislation is not being used to support pregnant people's rights."[725] Similarly, in Mexico, "authorities are reticent to criminally charge physicians,"[726] thus curtailing the potential impact of the law. In a comparative study of obstetric violence complaints filed in two Mexican states, one that has criminalised obstetric violence and one that has not, the authors of the study concluded "criminalising obstetric violence has not produced a substantial change in health care in Mexico."[727] The authors further identify that while many of the complaints analysed for the study pointed to structural problems in birth care delivery, "the criminalisation of obstetric violence covers only the individual behaviour of health personnel," and does not address broader systemic issues.[728] By focusing solely on individual actors as the perpetrators of obstetric violence, criminalisation is fundamentally limited as a policy response, because it fails to account for the fact that obstetric violence is "a structural phenomenon rooted in hierarchical relations of power (i.e., biomedical, racialized, gendered, and classed) and not in individual agents."[729]

Código Penal del Estado Libre y Soberano de Puebla, article 365 Bis (Puebla, Mexico)). The state of Chiapas, for example, defines obstetric violence as the "appropria[tion of] the body and reproductive processes of a woman through dehumanizing treatment, abuse in the provision of medication or the act of pathologizing natural processes, resulting in the loss of her autonomy and of her capacity to decide freely on matters related to her body and sexuality." (Decree 139, 11 April 2018, *Código Penal para el Estado de Chiapas,* article 183 (Chiapas, Mexico)). Actions punishable pursuant to this crime include: "omitting timely and effective care in an obstetric emergency, obstructing early mother–child bonding without a justifiable medical reason, altering the natural process of low-risk childbirth without informed consent and performing a caesarean section unnecessarily" (Calvo Aguilar, Torres Falcón & Valdez Santiago, *supra* note 716 at 39). In addition, state of Puebla has criminalized the photographing or filming of obstetric procedures without the birthing person's consent (11 April 2023, *Código Penal del Estado Libre y Soberano de Puebla*, article 365 Bis VII (Puebla, Mexico); "Birth Pangs: Latin America ponders how to fight 'obstetric violence'" *The Economist* (21 May 2020) ["Birth Pangs"].

[717] Calvo Aguilar, Torres Falcón & Valdez Santiago, *supra* note 716 at 43; "Birth Pangs", *supra* note 716; Vanessa Barbara, "Latin America Claims to Love Its Mothers. Why Does It Abuse Them?" *The New York Times* (11 March 2019).

[718] Brennan, *supra* note 703 at 244-247; Danielle Mitchell, "The Inadequacy of Battery as a Response to Obstetric Violence" (25 June 2021), *Durham Pro Bono Blog*, online: https://www.durhamprobonoblog.co.uk/post/the-inadequacy-of-battery-as-a-response-to-obstetric-violence.

[719] Camilla Pickles, "Eliminating abusive 'care': A criminal law response to obstetric violence in South Africa" (2015) 54 SA Crime Quarterly 5 at 5; 13.

[720] Alessandra Cicali, "How Italian women are organising against 'obstetric violence'" *openDemocracy* (4 January 2018); Alessandra Battisti, "The Need to Legislate and Regulate Obstetric Violence to Ensure Women a Real Legal Protection" (2022) 10 (Con)textos: revista d'antropologia i recerca social 133.

[721] Brennan, *supra* note 703 at 244-245; Calvo Aguilar, Torres Falcón & Valdez Santiago, *supra* note 716 at 39.

[722] Chadwick, "Breaking the frame", *supra* note 714 at 106; Maria TR Borges, "A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence" (2018) 67 Duke LJ 827 at 862.

[723] Pickles, "Eliminating abusive 'care'", *supra* note 719 at 8; Calvo Aguilar, Torres Falcón & Valdez Santiago, *supra* note 716.

[724] CR Williams, *supra* note 715 at 1208.

[725] Pickles, "Eliminating abusive 'care'", *supra* note 719 at 8.

[726] Farah Diaz-Tello, "Invisible wounds: obstetric violence in the United States" (2016) 24 Reproductive Health Matters 56 at 62.

[727] Calvo Aguilar, Torres Falcón & Valdez Santiago, *supra* note 716 at 43.

[728] *Ibid* at 44.

[729] Rachelle Chadwick, "The Dangers of Minimizing Obstetric Violence" (2023) 29:9 Violence Against Women 1899 at 1902 [Chadwick, "The Dangers of Minimizing"].

Finally, interest in unassisted birth (or "freebirth") is often driven by "previous traumatic birth experience,"[730] or other negative experiences with clinical childbirth care,[731] and may thus be categorized as a response to obstetric violence. In contrast to physician- or midwife-assisted childbirth, advocates describe unassisted birth as "unhindered" and "undisturbed."[732] Free Birth Society, a prominent advocacy organization, describes its work as "stewarding the return of matriarchy through sovereign homebirth."[733] However, the notion of a "return" to an "unhindered" or "sovereign" form of childbirth is not based in historical reality. Rather, historian Wendy Mitchison explains:

> Birthing is socially constructed and controlled in *all* societies and seldom did the parturient woman act alone in determining how her child would be born even when midwives were present […] Thus the birthing woman, unless alone, did not have control over the birthing process and the switch to doctor-"managed" birth from midwife-"managed" birth may not be as significant a change as has been suggested.[734]

As Mitchison explains, birth has never been a solo endeavour. Rather, it has historically been a collaborative enterprise, embedded in community.[735] Research consistently demonstrates the benefits of continuous support in labour and childbirth,[736] and the implementation of policies designed to slow the spread of the COVID-19 virus have illustrated the profound harms associated with isolation from family and support during pregnancy, birth, and the postpartum period.[737] Childbirth is an experience deeply rooted in our relations to others. As a result, feminist theorist Sara Cohen Shabot argues:

> [C]oping with obstetric violence, making birth humane, respected, even empowering, cannot involve denying the intersubjectivity of birth by exclusively or predominantly emphasizing the birthing woman's agency, independence, and freedom. <u>It is instead by revealing and fostering childbirth's interpersonal, shared, communal character that we might discover solutions to the urgent problem of obstetric violence</u> [emphasis added].[738]

A relational understanding of harm in childbirth assists in identifying the systemic factors giving rise to the culture of disrespect and mistreatment during labour and childbirth that many of the accounts discussed in the previous chapter describe. Such factors "structure relations, which, in turn, promote or undermine core

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[730] Melanie K Jackson, Virginia Schmied & Hannah G Dahlen, "Birthing outside the system: the motivation behind the choice to freebirth or have a homebirth with risk factors in Australia" (2020) 20:254 BMC Pregnancy and Childbirth 1 at 2.
[731] Rixa Freeze & Laura Tanner, "Freebirth in the United States" in Dahlen, Kumar-Hazard & Schmied, *supra* note 262, 27 at 27; Claire Feeley and Gill Thomson, "Understanding women's motivations to, and experiences of, freebirthing in the UK" in Dahlen, Kumar-Hazard & Schmied, *supra* note 262, 80 at 84; Mari Greenfield, Julie Komeen & Lesley Glover, "'It Can't Be Like Last Time'—Choices Made in Early Pregnancy by Women Who Have Previously Experienced a Traumatic Birth" (2019) 10 Frontiers in Psychology 1 at 1; Bryan, *supra* note 288; McKenzie, Robert & Montgomery, *supra* note 285 at 516; Baker, *supra* note 341 at 334; 336-337; 343; 354; 361; Kaplan Shanley, *supra* note 341 at 138.
[732] Baker, *supra* note 341 at 313-314; 339.
[733] "Welcome to Free Birth Society" (2023) *Free Birth Society* (website), online: https://www.freebirthsociety.com/.
[734] Mitchison, "Agency, Diversity & Constraints", *supra* note 17 at 128.
[735] For more on "childbirth's shared and communal character," see: Cohen Shabot, *supra* note 704 at 10.
[736] Bohren, *supra* note 115 at 31; Petronellah Lunda, Catharina Susanna Minnie & Petronella Benadé, "Women's experiences of continuous support during childbirth: a meta-synthesis" (2018) 18:167 BMC Pregnancy and Childbirth 1 at 9; Ylva Vladic Stjernholm et al, "Continuous Support Promotes Obstetric Labor Progress and Vaginal Delivery in Primiparous Women—A Randomized Controlled Study" (2021) 12 Frontiers in Psychology 1 at 1; AU Lokugamage & SFC Pathberiya, "Human rights in childbirth, narratives and restorative justice: a review" (2017) 14:17 Reproductive Health 1 at 4.
[737] Rice, *supra* note 695.
[738] Cohen Shabot, *supra* note 704 at 10.

values, such as autonomy."[739] In the context of childbirth, interactions between birthing people and their care providers are fundamentally shaped by patient rights, providers' legal obligations, hospital policies, cultural norms, medical education and training, standard practice, and convention.[740] By examining this broader network of factors and relationships, we may identify the crux of *why* the rights of birthing people are failing to translate into lived experience.

4.1 Preventing harm: the need for a culture shift

In the health care context, a relational lens reveals that "adverse events are emergent outcomes that arise from the relationships and interactions between people and the context they work in," including "wider system factors that influence care."[741] Considering patient rights in childbirth relationally "turns our attention to the kinds of relations that undermine or enhance autonomy, and <u>the forces that structure those relations</u>—from institutional design to gendered division of labor to beliefs about entitlement [emphasis added]."[742]

In intrapartum care, relations are fundamentally structured by the looming threat of *risk*, which informs policies and shapes both provider and patient decision-making.[743] While there are valid and serious health complications associated with giving birth, this "socially constructed risk discourse developed not in response to obstetrical emergencies but rather to scientific and technological advances, accumulated knowledge, and colonizing power."[744] Risk rhetoric pervades childbirth care delivery, such that all birthing bodies are perceived as inherently at-risk to some degree. In routine care models, risk surveillance "begins as soon as pregnancy is confirmed and continues throughout pregnancy, and the intrapartum period."[745]

Feminist theorist Angela Thachuk explains that "the development of new diagnostic procedures and technologies has led to an increasingly narrow range of what is considered normal in pregnancy and childbirth" such that "[t]he labels 'high risk' and 'low risk' dominate much of women's standard medical prenatal care."[746] As risk informs and shapes policies and practice in the obstetrical care context, certain ways of giving birth are privileged as "safest" and non-standard choices or patient refusal of recommended

[739] Nedelsky, *Law's Relations*, *supra* note 9 at 65.
[740] In this section, my proposals for policy reform focus principally on hospital-based childbirth assisted by physicians. I take this approach because, in 2021, only 2.4% of births in Canada occurred in non-hospital settings, which represents the highest proportion of non-hospital births in more than a decade ("Births, 2021" (28 September 2022), *Statistics Canada* (website), online: https://www150.statcan.gc.ca/n1/daily-quotidien/220928/dq220928d-eng.htm).
[741] New Zealand, Health Quality & Safety Commission New Zealand, *National Adverse Events Policy: Healing, learning and improving from harm* (Wellington: Heath Quality & Safety Commission, 2023) at 4 [NZ *National Adverse Events Policy*].
[742] Nedelsky, *Law's Relations*, *supra* note 9 at 119.
[743] Paula Kelly et al, "Elucidating the Ruling Relations of Nurses' Work in Labor and Delivery: An Institutional Ethnography" (2023) 10 Global Qualitative Nursing Research 1 at 14. See also: Hannah Grace Dahlen & Shea Caplice, "What do midwives fear?" (2014) 27 Women and Birth 266 at 1; Rachelle Joy Chadwick & Don Foster, "Negotiating risky bodies: childbirth and constructions of risk" (2014) 16:1 Health, Risk & Society 68 at 69; Dawson & Suntjens, *supra* note 17 at 227; Coxon, Sandall & Fulop, *supra* note 483.
[744] Dawson & Suntjens, *supra* note 17 at 234.
[745] P Kelly, *supra* note 743 at 3.
[746] Angela Thachuk, "Midwifery, Informed Choice, and Reproductive Autonomy: A Relational Approach" (2007) 17:1 Feminism & Psychology 39 at 49.

care are perceived to put birthing people and their infants at unnecessary risk.[747] Care providers "perpetuat[e] dominant biomedical and medical-legal risk discourses"[748] in the ways they talk about, view, document, and approach clinical care of birthing people. Given the hierarchical nature of many aspects of health care, this framing is passed on through on-the-job teaching, training, and role-modelling,[749] thus preserving the dominant role of biomedical risk as an organizing force.

While often associated predominantly with hospital or physician-assisted childbirth care options, risk discourse cuts across other health professions, including midwifery, in which a birthing person's risk level is determinative of their eligibility for midwife-assisted care.[750] In their relationships with patients and within health care institutions, physicians are often positioned as the final arbiters of risk; they funnel and present choices available to birthing people, based on their estimation of risk. However, the legal role of care providers is to assist, equip, and inform patients to be the final decision-makers regarding the level of risk they are willing to accept. To shift these roles and narrow the divide between patient rights "on paper" and the experience of giving birth in Canada, it is necessary to examine the broader context in which these roles are cast.

The role of the "hidden curriculum"

The importance of compassionate, patient-centered care is reflected in medical school curricula throughout Canada, which often integrate training on ethics and law into their formal educational programs.[751] In addition to individual medical school curricula, policies developed by professional organizations such as

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[747] Dawson & Suntjens, *supra* note 17 at 234.

[748] P Kelly, *supra* note 743 at 2.

[749] Kiri Hunter & Catherine Cook, "Role-modelling and the hidden curriculum: New graduate nurses' professional socialisation" (2018) 27 J Clin Nurs 3157 at 3158-3159.

[750] In Canada, midwives' legislated scope of practice sets out when a patient's care must be transferred to a physician, based on their level of risk. Transfers of care may be required, for example, where a birthing person is carrying three or more fetuses, or where a pregnant person has pre-existing insulin-treated diabetes. (British Columbia College of Nurses & Midwives, *Indications for discussion, consultation and transfer of care,* Vancouver: BCCNM, 2020 at 5-6). However, risk-based policies on the part of individual midwifery care providers may further limit eligibility. For example, people living in rural areas throughout Canada who wish to give birth at home may be ineligible for midwifery care if they live more than 30 minutes from the nearest hospital, depending on individual provider policies. Such policies are based on minimizing risk of harm in the event of an obstetric emergency requiring surgical intervention. However, health researchers Darling et al explain: "The 30-minute target is based on a presumption that being able to access a cesarean birth more quickly will result in reduced neonatal morbidity and mortality, <u>but there is little evidence to support this</u> [emphasis added]." While some birthing people choose to remain in their communities and give birth unassisted, many more feel they have no choice but to comply with provider recommendations to leave their communities, rather than giving birth at home. (Elizabeth K Darling et al, "Distance from Home Birth to Emergency Obstetric Services and Neonatal Outcomes: A Cohort Study" (2019) 64:2 Journal of Midwifery & Women's Health 170 at 171; Motluk, *supra* note 84.) See also: Simone Olivero, "What to expect if your pregnancy is deemed high risk" *Today's Parent* (21 June 2022).

[751] See, for example: "Undergraduate Medical Education: Med 1 core units," *Dalhousie University* (website), online: https://medicine.dal.ca/departments/core-units/undergraduate/program/med-1/units.html; "Department of Bioethics: Ethics in Undergraduate Medical Education" *Dalhousie University* (website), online: https://medicine.dal.ca/departments/department-sites/bioethics/Education/ethics-in-undergrad-medical-education.html; The University of British Columbia Faculty of Medicine, "UBC MDUP Exit Competencies: Role Descriptions, Key and Enabling Competencies" (8 February 2021); "University of Toronto MD Program – Competencies and Milestones," University of Toronto Undergraduate Medical Education (website), online: https://md.utoronto.ca/sites/default/files/MD%20Program%20competencies%20-%20milestones.pdf; University of Toronto Governing Council, *Standards of Professional Practice Behaviour for all Health Professional Students*, Toronto: UoT, 2015; "Competency Framework," *McGill Faculty of Medicine and Health Sciences Undergraduate Medical Education* (website), online: https://www.mcgill.ca/ugme/mdcm-curriculum-joint-programs/program-learning-outcomes/competency-framework.

the SOGC[752] and the CPSO[753] establish clear expectations for ethical clinical practice among medical students and those responsible for their education and training, including respect for patient autonomy and thorough processes for ensuring informed consent. However, as academics of medical education have long pointed out:

> [F]ormal instruction in ethics makes only a small contribution in that community, since most of the critical determinants of physicians' identities lie not within the formal curriculum but in a more subtle "hidden curriculum."[754]

The concept of the "hidden curriculum" refers to the process of "moral enculturation" health professional trainees experience, as "normative rules regarding behavior and emotions" are transmitted to students or trainees via more experienced members of their professions.[755] Though health professional students may receive formal didactic training on ethics and informed consent, the messages—whether intended or unintended—they receive during practical training rotations about how things are "actually" done may be dramatically different and, in fact, may be "antithetical to the goals and content" of the formal curriculum.[756] For example, medical anthropologists Lydia Zacher Dixon, Vania Smith-Oka and Mounia El Kotni explain: "[W]hile clinicians might *speak about* patient-centeredness as an important goal, their *actions* might emphasize measurable outcomes, cost-effectiveness, […] authority, or even attitudes of contempt for patients [emphasis in original]."[757] Health researchers Hunter and Cook describe this dynamic as a clash of "academic ideals" and "clinical realities."[758]

Through the operation of the hidden curriculum, health professional trainees internalize "values, attitudes, beliefs, and related behaviors" deemed important within their professions,[759] including those that "serve to maintain the extant culture."[760] In obstetrical care settings, the "extant culture" is one of paternalism,[761] in which patients are expected to comply readily and to defer to care providers' judgement regarding risk of harm to their fetuses.

One way in which this plays out is through the valorization of patients who are cooperative and "compliant."[762] "Physicians, nurses, and midwives […] are trained and socialized in delivering care to compliant patients"[763] who accept their recommendations and willingly submit to examinations and

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[752] Kimberly E Liu et al, "SOGC Reaffirmed Guidelines: No 246-Pelvic Examinations by Medical Students" (2017) 39:9 JOGC e322 at e324.
[753] College of Physicians and Surgeons of Ontario, *Professional Responsibilities in Medical Education,* Toronto: CPSO, 2021.
[754] Frederic W Hafferty & Ronald Franks, "The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education" (1994) 69:11 Academic Medicine 861 at 861.
[755] *Ibid* at 861.
[756] *Ibid* at 864-865.
[757] Lydia Zacher Dixon, Vania Smith-Oka & Mounia El Kotni, "Teaching about Childbirth in Mexico: Working across Birth Models" in Robbie Davis-Floyd & Melissa Cheyney, eds, *Birth in Eight Cultures: Brazil, Greece, Japan, Mexico, The Netherlands, New Zealand, Tanzania, United States* (Long Grove IL: Waveland Press, 2019) 17 at 40.
[758] Hunter & Cook, *supra* note 749 at 3158-3159.
[759] Hafferty & Franks, *supra* note 754 at 864-865.
[760] Hunter & Cook, *supra* note 749 at 3159.
[761] Sherwin, *No Longer Patient, supra* note 248 at 139; Niles, "*I fought my entire way*", *supra* note 7 at 11.
[762] Niles, "*I fought my entire way*", *supra* note 7 at 6.
[763] Morris, *supra* note 711 at 55.

interventions in the interest of minimizing risk to themselves and their babies. When confronted with the realities of clinical practice, care providers may be challenged by patients who do not fit within this compliant norm. For example, one participant in a qualitative interview-based study of birthing people's experiences of refusing maternity care services described arriving to give birth "armed with information," but found that her refusal of certain procedures was "the root cause for receiving poor quality of care, as if the refusal itself inspired retaliation." The authors explain: "Her knowledge acquisition about routine procedures was ignored and weaponized against her, making her an 'unruly' patient."[764]

The authors of a 2022 study of resident physician perspectives on the "ideal" birthing patient noted residents associated patients' "moral worth" with "stoicism and compliance within the clinical encounter."[765] The residents interviewed for the study praised patients who "remain quiet and cooperative during childbirth."[766] The authors note this characterization "may stem from residents' tasks; a person who is compliant is less time consuming."[767] Considering that in Canada, under current workplace policies, "residents can work 70 hours per week on average and up to 100 hours per week at peak periods,"[768] it is understandable—though undeniably problematic—that residents may be motivated to complete their work as expeditiously as possible, even at the expense of patient-centeredness. Contrary to their formal training, providers working within strained public health systems may find themselves exercising their clinical judgment "to ensure baseline safety rather than holistic care."[769]

The idealization of the compliant patient (and, conversely, vilification of the non-compliant patient) is clearly illustrated in the childbirth context through provider perceptions of patient-created birth plans, which are sometimes the subject of open derision by intrapartum care providers.[770] Health law scholar Nadia Sawicki describes: "there appears to be some resistance within the medical community to women's reliance on birth plans, with one article describing "the two words 'birth plan' strik[ing] terror in the hearts of many perinatal nurses."[771] Although there is no evidence indicating birthing people who prepare birth plans experience worse outcomes than those who do not, "research demonstrates that caregivers believe that they do,"[772] meaning labouring patients who present with birth plans may be perceived by providers to be at

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[764] Niles, "*I fought my entire way*", *supra* note 7 at 9.
[765] Kroll, *supra* note 558 at 2.
[766] *Ibid* at 4.
[767] *Ibid* at 4.
[768] Reena Pattani, Peter E Wu & Irfan A Dhalla, "Resident duty hours in Canada: past, present and future" (2014) 186:10 CMAJ 761 at 763. See, for example: Professional Association of Residents of Ontario, *2020-2023 PARO-OTH Agreement*, Toronto: PARO, 2020, s 16.1 "Maximum Duty Hours".
[769] Hunter & Cook, *supra* note 749 at 3158.
[770] Amy Tuteur, "Birth plans: worse than useless" (12 January 2012), *The Skeptical OB* (blog), online: https://www.skepticalob.com/2012/01/birth-plans-worse-than-useless.html; Milli Hill, *Give Birth Like a Feminist* (London: HQ, 2019) at 24-25; 28; Charlotte Edun, *What are mothers seeking to achieve when they write their birth plan?* (MA Thesis, University of York Women's Studies, 2022) at 167-169; Renece Waller-Wise, "Birth Plans: Encouraging Patient Engagement" (2016) 25:4 J Perinat Educ 215 at 217; Cristen Pascucci, "Birth Plans are Never a Joke: Trust, Betrayal, and Misogyny in Maternity Care" (20 November 2017), *Birth Monopoly* (website), online: https://birthmonopoly.com/plans/.
[771] Nadia N Sawicki, "Birth Plans as Advance Directives" (1 May 2017) *Bill of Health* (blog), online: https://blog.petrieflom.law.harvard.edu/2017/05/01/birth-plans-as-advance-directives/.
[772] Shelley White-Corey, "Birth Plans: Tickets to the OR?" (2013) 38:5 MCN: The American Journal of Maternal/Child Nursing 268 at 272.

higher risk for complications than those who do not. As White-Corey points out, this dynamic is important, because it "may influence the way they care for the patient during labour."[773] Such misconceptions are perpetuated through the operation of the hidden curriculum, through which trainees internalise cultural beliefs and values within health care institutions. Through this process, disrespect of birthing people is normalized in clinical care settings, leading to situations in which birthing people who make special requests are dismissed as "difficult."[774]

In situations where trainees recognize failures to adhere to patient rights, it may be difficult or impossible for them to raise concerns. Medical residencies and, in particular, surgical specialties such as obstetrics, are subject to systemic bullying and a "steep hierarchy"[775] of roles within their workplace. This has been shown to deter medical residents from reporting concerns about patient needs when doing so would mean speaking up against someone who is higher in the hierarchy.[776] Medical students and residents in clinical settings are continuously being evaluated by their seniors. Students and residents rely on positive evaluations to succeed in their chosen specialties, and to secure jobs following completion of training. This dynamic has been shown to contribute to low levels of reporting of mistreatment among learners, as they may be "worried that speaking up about bad behaviour will have consequences on their professional success."[777]

Mistreatment of residents and medical students is a pervasive, well-documented, and ongoing issue in medical training programs across Canada,[778] and evidence indicates that such "abuse and mistreatment within the care team leads to worse outcomes for patients."[779] The authors of a recent Canadian study explain that "the degree of hierarchy, high clinical risk, high acuity, and the litigious nature of the field [of obstetrics] all contribute to reinforcing an unforgiving culture during training,"[780] thus shaping the way residents learn to deliver clinical care. For example, American obstetrician Jesanna Cooper reflects on her experience of training as follows:

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[773] *Ibid* at 272.
[774] Consider, for example, the experience of the complainant in *KM v COG*, described in the previous chapter, who alleged her nurse denied or failed to take her requests seriously throughout her labour and delivery, including a request for a second hospital gown, a request for her soaked pads to be changed, and a request for laughing gas (*KM v COG*, *supra* note 574 at para 5).
[775] Adam B Garber et al, "Facing hierarchy: a qualitative study of residents' experiences in an obstetrical simulation scenario" (2022) 7:34 Advances in Simulation 1 at 1.
[776] Garber, *supra* note 775 at 2.
[777] "Professional Expectations in Medical Education" *eDialogue* (17 September 2020). See also: André Coleman et al, "Intimidation or harassment among family medicine residents in Saskatchewan: a cross-sectional survey" (2023) Can Med Ed 1 at 2.
[778] Laura M Mazer et al, "Assessment of Programs Aimed to Decrease or Prevent Mistreatment of Medical Trainees" (2018) 1:3 JAMA Network Open e180870 at e180870; Amanda Bell et al, "Why do few medical students report their experiences of mistreatment to administration? (2020) 55:4 Medical Education 462 at 462; Gareth Hampshire, "Dalhousie medical school taking steps to address complaints of mistreatment" *CBC News* (13 January 2023); Coleman, *supra* note 777; Karen Seidman, "Medical residents go on offensive against bullying, saying it still happens too often" *Montreal Gazette* (29 January 2016); Allison Brown, Gabrielle Bonneville & Sarah Glaze, "Nevertheless, They Persisted: How Women Experience Gender-Based Discrimination During Postgraduate Surgical Training" (2021) 87:1 Journal of Surgical Education 17; Pamela Fayerman, "Task force launched to tackle sexual harassment at UBC medical school" *Vancouver Sun* (20 February 2019); "#MeToo in medicine: Culture of silence keeps med students from reporting abuse by their mentors" *CBC Radio* (2 March 2018).
[779] Mazer, *supra* note 778 at e180870.
[780] Garber, *supra* note 775 at 1-2.

> The personal statement that I wrote at age 24 illustrated the passion, idealism, and naïveté that many medical students possess when they begin their education. Biomedical training suppresses those qualities, replacing kindness with toughness, empathy with stamina, and intellectual curiosity with rigidity. […] Intimidation, fatigue, and fear had extinguished my critical thinking abilities, joy, and love of service. […] I practiced obstetrics and gynecology just as I was taught, driven by fear and seeking safety in conformity [emphasis added].[781]

Against this backdrop, it is clear that academic training on patient rights has only a limited impact on the way providers learn to assess risk and deliver care in obstetrical contexts. In order for birthing people to be empowered to exercise their rights to medical self-determination, it is necessary to uncover the hidden curriculum, and to dismantle the culture of hierarchy and bullying in medical training programs through which the "extant culture"[782] of paternalism is perpetuated.

Fear of liability

In addition, fear of liability[783] is a significant driver of provider decision-making in the obstetric context. Obstetrics is "one of the leading medical specialties in terms of litigation risk and cost,"[784] and fear of litigation has been widely documented to have a "profound impact on maternity care, with studies across the world documenting high rates of defensive medicine, a decline in the desire to practice obstetrics or early retirement of practicing obstetricians due to litigation concerns."[785]

The term "defensive medicine" refers to "behaviour by clinicians that mainly aims to reduce their perceived legal or reputational risks, rather than to advance patient care."[786] In the childbirth context, defensive practice may involve the performance of unnecessary tests or interventions in order to avoid risk associated with ambiguity, such as the performance of C-sections "just in case," or in order to avoid a hypothetical "worst case scenario."[787] Indeed, the authors of a recent study on the impact of fear of litigation on rates of C-sections found that the "mere thought of the experience of being sued […] influenced decision making" regarding C-sections.[788] Elaraby et al explain:

> [I]n terms of decision for [mode of birth], emotional responses and primarily fear can be driven by cognitive biases including rational and irrational beliefs regarding safety and

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[781] Jesanna Cooper, "An Awakening" in Robbie Davis-Floyd & Ashish Premkumar, eds, *Obstetricians Speak: On Training, Practice, Fear, and Transformation* (New York: Berghan Books 2023) 93 at 95.
[782] Hunter & Cook, *supra* note 749 at 3159.
[783] I use the term "fear of liability" to refer to a range of unwanted consequences, including medical malpractice lawsuits, negligence claims, professional complaints, and reputational damage.
[784] Elaraby, *supra* note 374 at 1.
[785] *Ibid* at 2.
[786] Nola M Ries, Briony Johnston & Jesse Jansen, "A qualitative interview study of Australian physicians on defensive practice and low value care: 'it's easier to talk about our fear of lawyers than to talk about our fear of looking bad in front of each other'" (2022) 23:16 BMC Medical Ethics 1 at 2.
[787] Elaraby, *supra* note 374 at 4.
[788] *Ibid*.

risk. These beliefs can supersede training, guidelines or statistical evidence and are deeply entrenched in sociocultural structures [emphasis added].[789]

Similarly, in a study of the impact of risk discourse on obstetrical care delivery in rural British Columbia, where pregnant people are routinely advised to travel outside the community to give birth, health researchers Kornelsen and Grzybowski explain that "if birthing women remain in the community to deliver, rural care providers may incur stress due to the uncertainty of providing intrapartum care and the potential for community backlash if a bad clinical outcome occurs," which may lead practitioners to "cease providing intrapartum care or leave their community altogether."[790] In such cases, simply the "potential" for adverse outcomes is considered reason for providers to counsel birthing people to travel outside their communities to give birth.[791]

The performance of medically unnecessary tests and interventions driven by fear of liability negatively impacts strained public health systems and exposes birthing people and their newborns to avoidable short- and long-term health risks.[792] Against the looming threat of liability for fetal harm, care providers may be motivated to "exaggerate or misrepresent fetal risk to patients,"[793] to gain consent to treatment or induce a patient to follow a recommendation, but such "consent" is not properly informed, and, thus, represents a clear infringement on patient rights to autonomy in medical decision-making.[794]

Fear of liability as a driver of defensive practice is not limited to physicians. Midwives report fear of litigation leading them to adopt practices such as increased use of fetal monitoring technologies and an increased focus on documentation.[795] The authors of one study report midwives' concerns that increasing fear of liability among members of the profession "is hindering the normal birth process," and relationships between midwives and birthing people are "threatened" as midwives become "more focused on self-protection than actual clinical care."[796] Some midwives describe feeling they are working "under a panoptical gaze," due to pressures driven by fear of litigation, as well as oversight of hospital and regulatory authorities.[797] Similarly, nurses working in intrapartum care settings report significant "fear of professional discipline, losing their license to practice and, or, their job, and being named in civil lawsuits."[798] While nurses tend to "think of themselves as members of a caring profession and pride themselves on providing care that is holistic, compassionate, and sensitive to individual patient needs," the reality of the care they

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[789] *Ibid* at 8.
[790] Jude Kornelsen & Stefan Gryzbowski, "Cultures of risk and their influence on birth in rural British Columbia" (2012) 13:108 BMC Family Practice 1 at 5.
[791] *Ibid*.
[792] Elaraby, *supra* note 374at 1.
[793] "The Legal Infrastructure of Childbirth," *supra* note 2 at 2215. See also: Morton & Roth, *supra* note 272 at 264.
[794] Kotaska, "Informed consent and refusal", *supra* note 120 at 197; Barrett & Kotaska, *supra* note 262 at 422.
[795] Catherine R Alexander & Fiona Bogossian, "Midwives and clinical investigation: A review of the literature" (2018) 31 Women and Birth 442 at 444.
[796] Dahlen & Caplice, *supra* note 743 at 268.
[797] *Ibid*; Felicity Copeland, Hannah G Dahlen & Caroline SE Homer, "Conflicting contexts: Midwives' interpretation of childbirth through photo elicitation" (2014) 27 Women and Birth 126 at 129.
[798] P Kelly, *supra* note 743 at 4.

are able to provide within liability-motivated hospital settings is very different.[799] Kelly et al explain nurses in Canadian intrapartum settings are not able to meet the holistic care needs of their labouring patients, because "they must spend an inordinate amount of time and effort on technological interventions (continuous electronic fetal monitoring, for example) and documentation"[800] due to "constant pressure that a patient safety incident may occur and could result in legal or professional actions."[801]

The tort system is, in large part, to blame for this problem. In Canada, medical malpractice lawsuits alleging substantial birth injuries can result in damage awards worth millions of dollars.[802] Health law scholar Nadia Sawicki explains: "When compared to the limited liability risks associated with violating a birthing woman's autonomous choices, it is clear that providers wishing to minimize legal risk are acting rationally when they prioritize fetal interests over maternal interests."[803]Although tort law standards typically describe minimization of "unreasonable" risk, the significant cost awards associated with fetal harms incurred in childbirth promote a "fetal 'primacy' that directs treatment toward eliminating *all* fetal risk [emphasis in original]."[804] Because the tort law standard of care is a codification of common practices, "the fetal primacy encouraged by tort law crystallizes into a legally enforceable standard of care,"[805] which, in turn, shapes and constrains care provider discretion in clinical care delivery. In this way, "[t]ort law crystallizes and enforces a narrow standard of care, limiting birth options providers will offer and incentivizing them to compel patient compliance for fear of liability."[806]

However, fear of liability is not limited to fear of civil lawsuits. Rather, intrapartum care providers frequently report engaging in the practice of defensive medicine in order to "avoid criticism or negative interactions" from colleagues and members of allied health professions.[807] For example, in a 2012 qualitative interview-based study of risk management practices among Canadian intrapartum care providers, Hall, Tomkinson and Klein explain "[c]are providers felt that surveillance from peers created a need to plot and document every step" of labour care, and that defensive practice reduced their risk of "having their practice and professional integrity questioned" by colleagues.[808] One interviewee explained that when pregnant patients decline tests or interventions that are considered routine, the care provider becomes "vulnerable" to scrutiny or second guessing from other providers who may be involved in the

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[799] *Ibid* at 12.
[800] *Ibid*.
[801] *Ibid* at 13.
[802] See, for example: *Cheung v Samra,* 2022 ONCA 195; *Ediger v Johnston,* 2013 SCC 18; *AT-B v Mah,* 2012 ABQB 777.
[803] Sawicki, *supra* note 769.
[804] "The Legal Infrastructure of Childbirth," *supra* note 2 at 2215.
[805] *Ibid*.
[806] *Ibid* at 2214.
[807] Ries, Johnston & Jansen, *supra* note 786 at 10. See also: P Kelly, *supra* note 743 at 11; Judith H Robertson & Ann M Thomson, "An exploration of the effects of clinical negligence litigation on the practice of midwives in England: A phenomenological study" (2016) 33 Midwifery 55 at 58.
[808] Hall, "Minimizing Risk While Maximizing Integrity," *supra* note 7 at 580.

patient's care.[809] These accounts point to a broader "blame culture" in intrapartum care environments, which may impede interprofessional collaboration and negatively impact patient care.[810]

4.2 Reconceptualizing risk: from minimization to patient-centered management

To prevent rights infringements in intrapartum care settings, providers must be supported and empowered to cede the "locus of control"[811] in medical decision-making to patients. Facilitating this shift requires attention to conditions within health care professions that prevent providers from accepting and tolerating risk, including bullying and mistreatment within health care training programs, normalisation of disrespectful treatment in maternity care, and health care's pervasive "blame culture," which drives providers to practice medicine defensively, rather than with the unique goals and values of their patients in mind. Cooper explains:

> Like [our patients], obstetricians […] want birth environments that allow us to be brave. We want birth settings that allow self-control and respect, both for our patients and for ourselves. But, like our patients, we are limited by maternity care systems that impede our ability to realize our potential. […] We fear the consequences of not meeting standards set by courts, hospital governance bodies, and insurance companies. We fear not being able to support our families financially and emotionally. Alongside our patients, obstetricians suffer from flawed and dehumanizing medical training and maternity care systems.[812]

To foster "birth environments that allow [providers] to be brave,"[813] we must facilitate a "paradigm shift"[814] in the management of risk in intrapartum care. Instead of viewing birthing people as bodies "at risk," clinicians must work collaboratively with birthing people to respond to risks in a manner consistent with individual patient goals and values, and to maximize patients' abilities to make informed, autonomous decisions. In order to create conditions wherein care providers feel safe and supported to cede a degree of control in intrapartum medical decision-making to patients, a range of strategies must be employed.

i. Eliminating the hidden curriculum

Significant improvements in working conditions are required in order to support trainees and new graduates to maintain the academic and ethical ideals they were taught in school once they enter clinical practice. Importantly, disrupting toxic workplace cultures in intrapartum settings requires increasing staffing to enable doctors, midwives, and nurses to provide compassionate and holistic care to their patients, as well as to mitigate the risk of health care provider burnout. In the intrapartum context, part of this strategy should

[809] *Ibid*.
[810] P Kelly, *supra* note 743 at 11; Elaraby, *supra* note 374 at 7.
[811] Sherwin, *No Longer Patient, supra* note 250 at 137; Barrett & Kotaska, *supra* note 262 at 422.
[812] Cooper, *supra* note 781 at 100.
[813] *Ibid*.
[814] Niles, "*I fought my entire way*", *supra* note 7 at 13.

include increasing funding and availability of midwifery throughout Canada, so that those who choose to may be diverted out of hospital settings, thereby reducing hospital patient loads.

Evaluation systems for medical school and residency training programs must be restructured, such that students and residents are protected and supported in raising concerns about mistreatment and unethical conduct in intrapartum care delivery, without fear of retaliation or negative career repercussions.[815] Efforts to restructure hierarchies in medical education may include, for example, establishing new systems for evaluations, such that students and residents' clinical skills are assessed by objective third parties in scheduled practical examinations, rather than ongoing evaluation by senior staff members.

Care providers at all levels of seniority must be reminded of the impact of the hidden curriculum and required to participate in ongoing ethical training, such as interprofessional workshops involving simulated patient experiences, to maintain awareness and understanding of requirements of ethical conduct in patient care, as well as appropriate interactions with students and trainees.[816] Such sessions should include lessons on implicit biases in intrapartum care delivery, including gender and racial biases.[817] Implementation of formal mentorship programs may additionally reduce incidence of burnout among students and residents and promote professional development, particularly for members of marginalized populations.[818] Finally, there is significant potential for the use of restorative justice practices, discussed in detail later in this chapter, in addressing negative workplace cultures in clinical care settings.[819]

ii. De-normalizing disrespectful treatment of birthing people

As a necessary precondition to disrupting the existing culture of mistreatment in childbirth settings, providers must become critically aware of the way biomedical and legal risk discourse controls and shapes their work.[820] To achieve this, regulators and hospitals must design and implement behavioural programming aimed at exposing risk discourse, and de-normalizing disrespectful treatment of birthing people. Through such interventions, providers' critical thinking may be enhanced, thus enabling them to question *why* routine practices are routine and, perhaps, making them more receptive to atypical patient care requests.

Birthing people who report disrespectful care during childbirth frequently describe being treated as though they are "not regarded as whole people, but rather objects without valid feelings or concerns worthy

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[815] "Creating a safe learning environment for Black trainees" (23 February 2022) *Royal College of Physicians and Surgeons of Canada* (website), online: https://newsroom.royalcollege.ca/creating-a-safe-learning-environment-for-black-trainees ["Creating a safe learning environment"].
[816] See, for example: *CMA Code of Ethics, supra* note 436; CNA *Code of Ethics, supra* note 437; BCCN&M *Code of Ethics, supra* note 438.
[817] "Creating a safe learning environment", *supra* note 815.
[818] Helen Pethrick et al, "Peer mentoring in medical residency education: A systematic review" (2020) 11:6 Can Med Educ J e128 at e134; Onaope Egbedeyi et al, "Assessing the need for Black mentorship within residency training in Canada" (2022) 194 CMAJ E1455.
[819] Janine Carroll & Dan Reisel, "Introducing restorative practice in healthcare settings" in Theo Gavrielides, ed, *Routledge Handbook of Restorative Justice* (Oxford: Routledge 2019) 224 at 232; Mannat Kaur et al, "Restorative Just Culture: a Study of the Practical and Economic Effects of Implementing Restorative Justice in an NHS Trust" (2019) 273 MATEC Web of Conferences 1 at 3-4.
[820] P Kelly, *supra* note 743 at 14. See also: Dahlen & Caplice, *supra* note 743 at 268.

of providers' consideration."[821] Bioethicist Raymond De Vries describes this dynamic as the phenomenon of the "invisible mother," wherein "the concerns and needs of women in labour fade in the face of hospital policies and the perceived needs of their soon-to-be-born babies."[822] In order to combat this, care providers must be trained and supported in speaking directly to birthing people, including addressing birthing people by name, introducing themselves, ensuring birthing people are continually involved in decision-making about their labour and care. In addition, providers must receive ongoing training in trauma-informed care delivery, recognizing that birthing people often subjectively experience procedures and interactions considered to be "routine" by care providers as traumatic.[823]

De-normalizing disrespectful treatment in childbirth also requires confronting subtle ways we think and talk about childbirth, such as sharing childbirth "horror stories," making jokes about how undignified childbirth is, and avoiding "the ubiquitous 'the only thing that matters is a healthy baby' mantra."[824] While such discourse may appear harmless, Morris et al argue that it contributes to the normalisation of disempowerment of birthing people, thereby creating the conditions for "downstream acts of medical coercion, non-consensual procedures, and physical force."[825]

Importantly, disrupting the culture of disrespectful care in childbirth requires acknowledging and addressing gender discrimination, "fueled by longstanding stereotypes that associate femininity with irrationality, ignorance, and deviance on the one hand, and maleness with rationality and normality on the other."[826] Such stereotypes "shape medical providers' views of women patients as less rational, more emotional, and more likely to complain,"[827] thus setting the stage for the dismissal of labouring patients as "difficult" or "unruly."[828] The effects of such stereotypes are more pronounced for Black and other birthing people of colour, who are more likely than their White counterparts to be "penalized" or mistreated for declining care, or failing to "comply" with provider recommendations.[829] Thus, as noted above, providers working in intrapartum settings must be educated on an ongoing basis about the dangerous effects of implicit gender biases[830] and intersecting racial[831] and class[832] biases on their practice, and taught strategies to confront and question discrimination in care delivery settings.[833] Regulatory colleges have a role in

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[821] Priya Fielding-Singh & Amelia Dmowska, "Obstetric gaslighting and the denial of mothers' realities" (2022) 301:114938 Social Science & Medicine 1 at 2.
[822] Raymond De Vries, "Obstetric Ethics and the Invisible Mother" (2017) 7:3 Narrat Inq Bioeth 215 at 215.
[823] Reed, Sharman & Inglis, *supra* note 277 at 2; 7.
[824] Morris, *supra* note 711 at 66.
[825] *Ibid*.
[826] Fielding-Singh & Dmowska, *supra* note 821 at 2; Niles, "*I fought my entire way*", *supra* note 7 at 11.
[827] Fielding-Singh & Dmowska, *supra* note 821 at 2.
[828] Niles, "*I fought my entire way*", *supra* note 7 at 9.
[829] Laura B Attanasio & Rachel R Hardeman, "Declined care and discrimination during the childbirth hospitalization" (2019) 232 Social Science 270 at 275; Niles, "*I fought my entire way*", *supra* note 7 at 13.
[830] Fielding-Singh & Dmowska, *supra* note 821 at 2.
[831] Kroll, *supra* note 558 at 3.
[832] Vedam, "Patient-led decision making", *supra* note 194 at 591.
[833] Maggie C Runyon et al, "Exposing the Role of Labor and Delivery Nurses as Active Bystanders in Preventing or Perpetuating Obstetric Violence" (2023) Nursing for Women's Health 1.

guiding this process in practice by encouraging members to participate in ongoing education and facilitating access to training and recourses,[834] as well as in educating members on trauma-informed care in obstetrical settings. Integration of allied birth workers such as midwives and doulas may also assist in this respect, as Kroll et al explain that "[m]idwives and doulas can help to counter obstetric gaslighting and mitigate obstetrical trauma" by providing "important counternarratives to medicalized birth."[835]

iii. Countering fear of liability

While broadscale tort law reform may be an ideal route toward tackling provider fear of liability and associated blame culture,[836] there are several strategies that may be employed in the meantime to clarify provider responsibility and create the conditions wherein risk may be appropriately *managed*, rather than simply *minimized*.

First, though training alone has been shown to be insufficient in counteracting ingrained risk culture, there is agreement among commentators that care providers lack adequate training and education on legal liability, and on effectively communicating risks to patients,[837] particularly where pregnant and birthing people decline routine or recommended care options.[838] Kotaska explains that "[b]y accepting a woman's refusal, caregivers commonly believe they incur ethical and legal liability,"[839] leading to coercion, conflict, and sometimes resulting in birthing people abandoning clinical care contexts in favour of unassisted birth.[840] Intrapartum care providers "need further training in supporting informed choice, and greater knowledge about health human rights when clients make choices outside of standard care," as well as "clear guidelines for providers around situations where pregnant people decline care."[841]

Kotaska explains: "A common problem in obstetrics is the dichotomous 'black or white'; 'right or wrong'; 'safe or unsafe' thinking; none of which is usually a good approximation of the actual risk associated with medical and obstetrical conditions."[842] Rather than dichotomous "safe" and "unsafe" designations, providers must be equipped with training and resources to communicate to their patients which options carry a *significant* level of risk, which carry *some* risk, and which carry the *least* amount of

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[834] See, for example: "CPSO Human Rights Policy", *supra* note 128; "Advice to the Profession", *supra* note 128.
[835] Kroll, *supra* note 558 at 3.
[836] In discussing proposals for tort reform in malpractice claims, commentators often discuss the potential of no-fault compensation schemes for medical injuries, as have been implemented in countries such as New Zealand and Sweden (Jeremy Hunt, "Patient Safety: A Political Perspective" in Sidney Dekker, Amanda Oates & Joseph Rafferty, eds *Restorative Just Culture in Practice* (New York: Routledge, 2022) 107 at 112; Shook K Lee et al, "Canada's System of Liability Coverage in the Event of Medical Harm: Is It Time for No-Fault Reform?" (2021) 17:1 Healthcare Policy 30). While a fulsome discussion of the adoption of a no-fault malpractice scheme in Canada is beyond the scope of this thesis, I note that many complaints about rights infringements during childbirth focus not on harms provable according to existing legal standards, but on assigning responsibility with the goal of system improvement, which no-fault compensation schemes do not address. These issues are considered in Erin L Nelson, "Commentary: Some Questions about No-Fault Reform of the Medical Liability System," (2021) 17:1 Healthcare Policy 42.
[837] Laura M Glaser, Farah A Alvi & Magdy P Milad, "Trends in malpractice claims for obstetric and gynecologic procedures, 2005 through 2014" (2017) 217 Am J Obstet Gynecol 340.e1 at 340.e1; Barrett & Kotaska, *supra* note 262 at 421.
[838] Stoll, "*I felt so much conflict*", *supra* note 272 at 12.
[839] Kotaska, "Informed consent and refusal", *supra* note 120 at 195.
[840] *Ibid* at 197.
[841] Stoll, "*I felt so much conflict*", *supra* note 272 at 12.
[842] Barrett & Kotaska, *supra* note 262 at 424.

risk, and *why*. Where a patient selects an option that is deemed riskier than others (such as remaining in rural communities without surgical facilities to give birth), providers must assure their patients they will not abandon them, clearly and frankly explain their care facility's limitations, and employ proactive strategies to mitigate risk that are consistent with the birthing person's values.[843] Research indicates that when "procedures or prenatal investigations [are] presented as options rather than mandatory requirements that required compliance, participants [feel] valued and respected."[844] Moreover, researchers report that "robust discussions" regarding childbirth care options form "the basis for empowering experiences" for birthing people, even if they ultimately elect to decline a proposed procedure.[845]

iv. Collaborative "birth planning"

In the context of maternity care, "[t]he ability to exercise autonomy through choice of care options depends on many factors, from an individual's wants, needs, culture, and prior experiences to social, political, economic, and cultural attitudes and beliefs."[846] While present risk calculations may be driven primarily by concern of biomedical risk to the fetus or birthing person (and associated liability), providers must be trained and socialized to consider patients' broader relational contexts. Niles et al explain: "Clinical decision-making, when solely based on physiological indicators, rigid adherence to protocols, poor communication, and documentation, persistently fails to acknowledge persons' views, feelings, and embodied knowledge of their own health."[847] The doctrine of informed consent provides the backdrop and guiding framework for how these conversations currently take place, but, as described in Chapter 2, it is fundamentally limited. Like other aspects of conventional medical decision-making, the doctrine of informed consent is rooted in management of risk. As MacDonald explains, the doctrine of informed consent is "bound up with liability" and "the protection of both patient *and* practitioner is one of its key functions."[848]

In seeking to improve the experience of provider-patient decision-making in a manner that reaches beyond biomedical risk, it is useful to look to the midwifery concept of informed choice. While the doctrine of informed consent in conventional biomedical care requires that health professionals provide patients with the information necessary to make informed decisions about their care, the concept of informed choice goes farther, positioning the birthing person as the primary decision-maker, and accounting for their relational context, acknowledging that for many birthing people, the experience of childbirth may be a "momentous

[843] *Ibid* at 425-426.
[844] Niles, "*I fought my entire way*", *supra* note 7 at 8.
[845] *Ibid* at 9.
[846] *Ibid* at 3.
[847] *Ibid* at 11.
[848] MacDonald, "The Making of Informed Choice", *supra* note 259 at 287.

psychological, social, and spiritual" event.[849] For example, the College of Midwives of Ontario Practice Standard on Person-Centred Care requires midwives not only provide clients with the information required to make informed decisions, but, that they make efforts to "understand and appreciate what is motivating clients' choices," allow clients "adequate time" for decision-making, support "clients' rights to accept or refuse treatment" and respect "the degree to which clients want to be involved in decisions about their care."[850] To discern the individual values, priorities, and risk tolerance of each birthing person, care providers must be supported to have dedicated and ongoing discussions with birthing people regarding their preferences and desires for labour and childbirth.

However, such conversations must be specific to each person and must not necessarily be focused simply on minimizing interventions. While Canadian midwifery care focuses on "reintroduc[ing] a model of birth as a natural event,"[851] a broader philosophy of choice in childbirth-related care is essential to empowering birthing people to determine their birthing experiences. Providers must recognize that for some pregnant and birthing people, "reducing risks to physical safety and maximizing integrity" means low-intervention options such as home birth, while others feel risks are reduced and integrity maximized through the use of technology in hospital settings,[852] including interventions such as CDMR.

In order to action this, I propose the adoption of birth plans at an institutional level, created by birthing people in collaboration with their prenatal care providers and documented in patient records. At present, birth plans are often a source of conflict, as providers may perceive birth plans created by patients as a "threat to their authority or knowledge."[853] However, commentators point to the potential of co-created birth plans as a tool of communication between patients and care providers,[854] as well as the benefits of robust and proactive discussions between patients and providers regarding common labour and birth interventions.[855]

To integrate collaborative "birth planning" into routine clinical care delivery, care providers should designate one or more appointments during pregnancy specifically to discuss patient values and goals for childbirth. Researchers recommend a dedicated appointment should be scheduled "between 34-36 weeks' gestation,"[856] with additional time set aside for detailed discussion.[857] However, the concept of birth planning may be raised earlier, so that providers may "develop ongoing conversations around patient values

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[849] Thachuk, *supra* note 746 at 46.
[850] College of Midwives of Ontario, *Professional Standards for Midwives*, Toronto: CMO, 2018 at 8.
[851] MacDonald, "The Making of Informed Choice", *supra* note 259 at 282.
[852] Hall, "Minimizing Risk While Maximizing Integrity," *supra* note 7 at 578.
[853] Waller-Wise, *supra* note 770 at 217.
[854] Amy Michelle DeBaets, "From birth plan to birth partnership: enhancing communication in childbirth" (2017) Am J Obstet & Gynecol 31 at 32; Melissa Aragon et al, "Perspectives of Expectant Women and Health Care Providers on Birth Plans" (2013) 35:11 J Obstet Gynaecol Can 979 at 980; Joanne V Welsh & Andrew G Symon, "Unique and proforma birth plans: A qualitative exploration of midwives' experiences" (2014) 30 Midwifery 885 at 887; Sawicki, *supra* note 771.
[855] Stoll, "*I felt so much conflict*", *supra* note 272 at 9.
[856] DeBaets, *supra* note 854 at 32.
[857] Stoll, "*I felt so much conflict*", *supra* note 272 at 11.

and preferences."[858] Researchers recommend "ongoing discussions before and during birth [emphasis added]," to allow birthing people the opportunity to change their minds and re-evaluate their priorities as labour progresses.[859] Sherwin argues that an "important task of feminist ethics is to […] offer alternative models for medical relationships that neither replace patient authority with technical expertise nor abandon patients to their 'rights,' where that amounts to granting them the opportunity to assert their independent authority in a hostile, frightening environment."[860] This proposed model of collaborative birth planning offers such an alternative, whereby birthing people may explore and assert their rights in a safe, supported environment, in advance of labour. Even if the birthing person elects not to create a written birth plan, the appointment may provide protected time for providers to speak to patients about their birthing preferences, including answering questions about what to expect, risk management in childbirth, and plans for postnatal care.

Hospitals, midwifery practices, or individual care providers may create birth plan templates and provide them to patients in advance of discussion, to provide patients the opportunity to reflect on their values and preferences in advance. This approach has been implemented in some large care settings in Canada,[861] including Mount Sinai Hospital in Toronto, which provides a fillable birth plan template on its website for birthing people to use "to communicate [their] hopes and wishes […] regarding [their] labour, birth, and care throughout."[862] The Mount Sinai Hospital website describes patient birth plans as "a communication tool to allow for ongoing discussion" and emphasizes the importance of speaking with care providers about birth plans both during pregnancy and while in labour.[863] The template also explains that, when given to care providers, the document will become part of the birthing person's chart.[864] This is an important element of the proposed adoption of collaborative birth planning, as it would allow for care providers previously unfamiliar with a birthing person to become quickly apprised of their values, goals, and unique needs. While there are no published studies or analyses of the success or usefulness of hospital-provided birth plan templates in Canada, research indicates "that both proforma and unique birth plans [may be] useful tools to aid communication between midwives and women."[865]

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[858] DeBaets, *supra* note 854 at 32; Niles, "*I fought my entire way*", *supra* note 7 at 13.
[859] Stoll, "*I felt so much conflict*", *supra* note 272 at 11; DeBaets, *supra* note 854 at 32.
[860] Sherwin, *No Longer Patient, supra* note 250 at 140.
[861] See, for example: "Planning your Birth Experience," *Mount Sinai Hospital* (website), online: https://www.mountsinai.on.ca/patients/having-a-baby-at-mount-sinai/your-pregnancy/planning-ahead/planning-your-birth-experience-mount-sinai.pdf [Mount Sinai "Planning your Birth"]; "My Birth Plan," *Humber River Health* (website), online: http://hrccatalog.hrrh.on.ca/InmagicGenie/DocumentFolder/005072_my%20birth%20plan.pdf; "GUIDE TO COMPLETING YOUR BIRTHPLAN," *Queensway-Carleton Hospital: The Childbirth Centre* (website), online: https://www.qch.on.ca/uploads/Childbirth/Guide%20to%20Completing%20Your%20Birthplan.pdf; "Making a Labour & Birth Guide," *BC Women's Hospital & Health Centre* (website), online: http://www.bcwomens.ca/our-services/labour-birth-post-birth-care/planning-to-give-birth-at-bc-womens/make-a-labour-birth-guide; "Labour & Birth Guide For Families and Care Providers," *BC Women's Hospital & Health Centre* (website), online: http://www.bcwomens.ca/Labour-Birth-Post-Birth-Care-Site/Documents/Labour%20+%20Birth%20Guide%20for%20Families,%20Care%20Providers.v1.4.%202017.pdf.
[862] Mount Sinai "Planning your Birth", *supra* note 861.
[863] *Ibid.*
[864] *Ibid.*
[865] Welsh & Symon, *supra* note 854 at 887.

Much of the current criticism of birth plans argues planning for birth is unrealistic because conditions and options change rapidly in labour. However, by using institutional birth plan templates in provider-patient discussions to formalize collaborative birth planning, providers can learn about the beliefs, fears, and goals underlying patient preferences, and respond to emergencies or unexpected events in labour in a manner that aligns with the patient's fundamental values. For example, if a birthing person insists that they do not want an episiotomy for any reason, a provider may be inclined to explain that such a position is unrealistic. However, by discussing a patient's preferences and goals in greater depth in response to a draft plan stating "No Episiotomy," a provider may learn the patient's ultimate goal is to preserve sexual function to the greatest extent possible. Equipped with this information, a care provider may be less likely to dismiss a request as a threat to their expertise. Rather, they may talk to their patients about physiotherapy options for restoring sexual function following vaginal birth, and about elective Caesarean delivery, or CDMR, as an option for avoiding vaginal trauma.

Such collaborative birth planning may enhance the quality of patient-provider relationships, fostering greater trust and patient satisfaction, even if a negative outcome occurs in birth.[866] A similar model has been piloted with success in the Netherlands at the university hospital in Nijmegen, where a specialized clinic has been established for birthing people seeking intrapartum care that deviates from standard guidelines, such as unassisted childbirth, declining induction of labour, or declining fetal monitoring during labour.[867] The clinic is multidisciplinary in its approach, providing care by both midwives and obstetricians, and focuses significant time for birth planning conversations with patients, "spread over a minimum of three structured visits."[868] Birth planning discussions are believed to be successful "because the care providers listen to women, take them seriously, show empathy and respect their right to refuse care."[869]

In a series of interviews on the approach to care planning in the clinic, providers explained that trust between providers and patients is "built by investing time," getting to know birthing people beyond their medical questions or concerns, and seeking to understand their "vision" for childbirth.[870] Providers explain that patients feel empowered by the experience of being involved in this collaborative birth planning model, and even where the outcome of a patient's birth experience is not what they hoped for (for instance, delivery by Caesarean section), patients experience greater satisfaction as a result of feeling "involved in decision-making."[871] Importantly, the trust built between patients and providers through these interactions has made patients comfortable accepting urgent interventions during labour, as one provider explains: "*It*

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[866] Jenny Y Mei et al, "Birth Plans: What Matters for Birth Experience Satisfaction" (2016) 43:2 Birth 144 at 150; Kate Cook & Colleen Loomis, "The Impact of Choice and Control on Women's Childbirth Experiences" (2012) 21:3 The Journal of Perinatal Education 158 at 165; Vedam, "Patient-led decision making", *supra* note 194 at 587.
[867] Floor Opdam et al, "How to Make the Hospital an Option Again: Midwives' and Obstetricians' Expeirences with a Designated Clinic for Women Who Request Different Care than Recommended in the Guidelines" (2021) 18:11627 Int L Environ Res Public Health 1 at 1.
[868] *Ibid* at 2.
[869] *Ibid* at 1.
[870] *Ibid* at 6.
[871] *Ibid* at 6.

hasn't happened to me yet that I wasn't allowed to intervene while intervening was crucial. I don't know why. Maybe, like we discussed before, that I build trust from the beginning on and that people think 'She will only intervene when it is really necessary'."[872] Health researchers Opdam et al explain that the clinic is a way of maintaining patient trust in the hospital system—while some patients still choose to give birth at home after visiting the clinic, they do so because, "after weighing all the risks," they feel it is the best choice for them, not because they feel the health system has left them with no other option.[873] Providers rebuild trust with patients who may otherwise turn away from the conventional health system "by listening, conveying support and showing motivation and flexibility to explore alternative care options outside the guidelines."[874]

Finally, I note the detailed records of patient goals and values documented through extended, structured "birth planning" appointments may provide a sense of security for providers, thus mitigating the negative impacts of fear of liability.[875]

For this proposal to function on a long-term basis, changes to provincial billing codes may be required in order to appropriately compensate prenatal care providers for the longer-format appointments that will be required for in-depth discussion of patient goals and values in childbirth. While extended appointments may represent an increased short-term cost, they may also result in reduction or mitigation of long-term public health costs associated with "reduced adherence to care, psychosocial distress, and adverse maternal newborn health" induced by non-consented treatment.[876]

In conclusion, the "perception and communication of risk is an ongoing challenge in maternity care and can lead to care that is neither evidence-based nor patient-centered."[877] A relational view of childbirth helps reveal that the ways "individual practitioners come to learn their professions, the location/s they can practice in, what they can do, and how they are treated within the health care system all impact the ways that they treat women and understand birth."[878] Health researchers Walter and Ross describe the integration of a relational approach in patient decision-making settings as follows:

> The relational model sees individuals' identities, interests, ends, and beliefs as fundamentally dynamic, continually constructed and reconstructed in dialogic processes with other […]. This view of autonomy leads to a very different understanding of the sorts of discussions in which we try to persuade or influence one another. Being autonomous is not perceived to be in conflict with valuing the input of others or engaging them in important decisions. Patients […] do not abdicate their autonomy by asking trusted family members to make decisions for them or for their providers to offer their opinions. <u>An individual's interests are developed in conjunction with others. They are re-described and re-examined during challenging times. Dialogue with others about these interests and</u>

[872] *Ibid* at 5.
[873] *Ibid* at 3.
[874] *Ibid* at 10-11.
[875] *Ibid* at 1.
[876] Vedam, "Patient-led decision making", *supra* note 194 at 587.
[877] Stoll, "*I felt so much conflict*", *supra* note 272 at 2.
[878] Zacher Dixon, Smith-Oka & El Kotni, *supra* note 757 at 36-37.

choices is not an affront to an individual's autonomy in this relational account. It is, instead, the only way to allow autonomy to fully flourish [emphasis added].[879]

Therefore, in order for birthing people to meaningfully realize their rights in childbirth, it is necessary to systemically treat the underlying conditions that ail intrapartum care professions and that preclude providers from supporting patients' exercise of autonomy, and to shift to a collaborative model that accounts for patients' dynamic relations, identities, and values.

4.3 Responding to harm: a place for restorative justice

People harmed in health care settings seek legal recourse for a variety of reasons, but often do so because they are seeking a sense of justice, and to "make sure what happened to them doesn't happen to another family."[880] While complaints of mistreatment in childbirth sometimes result in care providers being ordered to complete additional training,[881] this individualized and *ad hoc* approach does not appear to be achieving success in producing broadscale improvements to patient care.[882] Investigations following complaints or adverse events in health care focus primarily "on causation and evidence gathering," and largely fail to account for or respond to human experiences like grief, anger, and trauma.[883] Against this backdrop, it is necessary to rethink what justice and, importantly, healing may look like in the wake of health care harms. Thus, the following is an examination of the potential for implementation of restorative justice practices in response to patient complaints of mistreatment in clinical childbirth settings.

What is restorative justice?

Restorative justice is a fundamentally relational way of thinking about justice, which offers an alternative "lens" for conceptualizing and addressing harm.[884] Rather than punishment or retribution, restorative justice is "fundamentally concerned with restoring the harm caused to relationships by wrongdoing."[885] It is a voluntary process in which "all those affected by an adverse event come together in a safe and supportive environment, with the help of skilled facilitators, to speak openly about what happened, to understand the human impacts and to clarify responsibility."[886]

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[879] Walter & Ross, *supra* note 13 at S19.
[880] Caroll & Reisel, *supra* note 819 at 226. See also: *Complainant v CPSBC* 2022, *supra* note 578 at para 19.
[881] *Lemme v Chatelain, supra* note 665; *Lemme v Desaulniers, supra* note 664; *MD v KMG, supra* note 596; *KH v HL, supra* note 598; *EO-P v CO, supra* note 570.
[882] The authors of a recent chapter on the implementation of restorative justice practices in healthcare settings note that while "there have been cases where legal proceedings have impacted on the way care is delivered, it is not always clear whether legal proceedings result in changes in clinical practice" (Caroll & Reisel, *supra* note 819 at 226.)
[883] Jo Wailling, Jill Wilkinson & Chris Marshall, *Healing after harm: An evaluation of a restorative approach for addressing harm from surgical mesh. Kia or ate tangata: He arotakenga i te whakahaumanu (A report for the Ministry of Health)* (Wellington: Victoria University of Wellington, 2020) at 22.
[884] Llewellyn, "Responding Restoratively", *supra* note 705 at 128.
[885] Jennifer Llewellyn, "Truth commissions and restorative justice" in Gerry Johnstone & Daniel W Van Ness, eds, *Handbook of Restorative Justice* (Oxford: Routledge 2007) 351 at 355 [Llewellyn, "Truth commissions and restorative justice"].
[886] NZ *National Adverse Events Policy, supra* note 741 at 11.

Within traditional legal frameworks, communication may be significantly stifled by fear of litigation, liability, or reputational concerns, which prevent care providers from discussing adverse experiences with patients and their networks.[887] In contrast, restorative practices are non-adversarial in nature, and are focused on providing space for reflection, with an eye to future improvement.[888] The ultimate goal of restorative processes is to establish "relationships that enable and promote the well-being and flourishing of all the parties involved"[889] and to create conditions for just relationships based on "mutual respect, care/concern, and dignity."[890] Nedelsky explains that "[o]n a relational view, the persons whose rights and well-being are at stake are constituted by their relationships such that it is only in the context of those relationships that one can understand how to foster their capacities, define and protect their rights, or promote their well-being." By focusing on how to restore and facilitate equal relationships between care providers and patients, restorative justice offers a route for meaningful protection of patient rights in childbirth care settings.

Though often most closely associated with criminal justice,[891] restorative practices have been implemented with success in a variety of health care contexts in Canada, including in addressing a culture of sexism and misogyny in Dalhousie University's dentistry program,[892] in responding to the in-custody death of Jason LeBlanc in Nova Scotia,[893] and as part of the strategy of the Motherisk Commission,[894] which investigated the use of unreliable hair testing evidence in child protection matters at the Hospital for Sick Children in Toronto, Ontario.[895]

How could restorative justice work in obstetrical care settings?

In order to paint a picture of how restorative processes might function in the childbirth care context, I draw on the facts of *EV v JM,*[896] described in the previous chapter and summarised as follows.

EV gave birth vaginally to twin boys in an Ontario hospital in 2015. Because EV was carrying twins, her birth was deemed "high risk" by her obstetrician prior to delivery.[897] EV's obstetrician advised her in advance that certain health professionals, including a respiratory therapist (RT), would be present at

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[887] Jo Wailling et al, "Humanizing harm: Using a restorative approach to heal and learn from adverse events" (2022) 25 Health Expectations 1192 at 1193; Jennifer Llewellyn, "Reimagining Our Healthcare System: a Restorative Approach" (Presentation delivered at Faculty of Nursing, UBC Okanagan, 5 October 2022) [Llewellyn, "Reimagining Our Healthcare System"].
[888] Llewellyn, "Responding Restoratively", *supra* note 705 at 129.
[889] Llewellyn, "Thinking Relationally", *supra* note 564 at 91.
[890] Llewellyn, "Responding Restoratively", *supra* note 705 at 130.
[891] Llewellyn, "Reimagining Our Healthcare System", *supra* note 887.
[892] Llewellyn, "Responding Restoratively", *supra* note 705.
[893] Michael Tutton, "Dad says NS restorative justice helped him heal after son's jail cell death" *CBC News* (1 April 2018); Jennifer Llewellyn, Jacob MacIsaac & Heather McNeil, "Facilitators' Report: A Restorative Review of the In-Custody Death of Jason LeBlanc" (2018), online: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3154715.
[894] "Our Restorative Process," *Motherrisk Commission* (website), online: http://www.archives.gov.on.ca/en/e_records/motheriskcommission/our_restorative_process.html.
[895] Llewellyn, "Reimagining Our Healthcare System", *supra* note 887.
[896] *EV v JM, supra* note 579.
[897] *Ibid* at para 4.

her delivery, in case either baby required resuscitation. JM was the RT in attendance at EV's delivery and examined the twins immediately following their birth.[898] Neither baby required resuscitation.

EV complained to the College of Respiratory Therapists of Ontario regarding JM's involvement in the delivery of her sons. She stated that she had informed her midwife in advance that she did not want an RT in the labour and delivery room, and that the "[r]espondent's presence during the deliveries and examination of the twins only caused harm" as it represented "an unnecessary and invasive form of medical intervention that should not have happened."[899] In particular, EV expressed that the separation of the twins from her immediately after birth for the purposes of examination "caused incredible distress" to both EV and the newborns, and that one of the twins was "forced to 'cry-it-out' in the overbed warmer." In addition, EV complained that she had informed her midwife that she did not want an RT present at the birth, that her midwife told her there would be no RT present, and that her midwife "did not adequately advocate on her behalf."[900] As the complaints regarding the midwife were outside the jurisdiction of the College of Respiratory Therapists, the Committee did not comment on this aspect of the complaint.[901]

The Inquiries, Complaints and Reports Committee determined "no actual harm was done to the babies" and took no further action. The Complainant appealed to the Health Professions Appeal and Review Board.[902] Following a review, the Board confirmed the decision of the Committee to take no further action. Its decision was released in February 2018, nearly two-and-a-half years after the twins were born.

Instead of proceeding via conventional complaints processes, what might it look like if the college in this case took an alternative, restorative approach? As a preliminary matter, it is necessary to consider *who* would take up the project of implementing a restorative approach. While such a project may be led by various institutional actors, including hospitals and regional health authorities,[903] it would be particularly suited to the work of regulatory bodies.

Professional regulators are legislatively mandated to ensure protection of the public by setting and enforcing standards of expected conduct in the delivery of health care.[904] However, ineffective complaints processes risk eroding public trust, and individualized approaches to harms in health care impede system-

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[898] *Ibid.*
[899] *Ibid* at para 6.
[900] *Ibid* at para 31.
[901] *Ibid.*
[902] *Ibid* at para 6.
[903] The New Zealand Health Quality & Safety Commission offers a model for implementation of restorative practices in safety investigations taken up by hospitals or regional health authorities, through its recently published "National Adverse Events Policy," which sets out detailed processes for how patients who have experienced harm "will be supported to work in partnership with health care workers, to define how they want to be involved, to share their experiences in a way that is meaningful for them and suggest improvements that address their needs" following adverse events (NZ *National Adverse Events Policy, supra* note 741 at 7). Though the national policy is newly implemented, it follows on the successful use of restorative practices as a national response in New Zealand to harms caused by the use of surgical mesh (Wailling, Wilkinson & Marshall, *supra* note 883.) In addition, restorative practices have been explored with success in the United Kingdom in at least one NHS Trust, including in the context of improving workplace culture in maternity care. While, to date, the implementation of restorative practices in NHS settings is at a preliminary stage, the organizers of a pilot restorative justice program concluded that restorative practices were found to "be uniquely suited to addressing incidents of harm within the Maternity Care setting" (Caroll & Reisel, *supra* note 819 at 232; Wailling, *supra* note 887 at 1196.)
[904] See, for example: *Regulated Health Professions Act,* 1991, SO 1991, c 18, s 3(1).

wide improvement. The implementation of restorative practices may assist regulatory bodies in gaining a greater understanding of experiences of harm and, therefore, in crafting responsive and proportionate regulatory responses. Llewellyn explains:

> Insofar as restorative justice processes and practices give central attention to relationship[s] they are better able to marshall the knowledge, authority, and relational capacity needed to ensure successful justice responses. In this way, restorative justice serves as a backdrop for the regulatory pyramid and can inform interventions at the base and all the way up.[905]

As Llewellyn alludes to, the implementation of restorative justice in regulatory settings does not preclude recourse to non-restorative responses when warranted, up to and including delicensure.[906] However, "[t]aking a relational approach to regulation would certainly prefer restorative interventions where possible," with a view to enabling and maintaining conditions that allow for just relationships between and among health care providers and patients.[907]

Applying this proposal to *EV v JM,* I suggest that first, in response to a complaint lodged with the College of Respiratory Therapists, the College would assess the suitability of the complaint for restorative justice, and the birthing person may be offered the option of proceeding by way of an alternative, restorative process. It is important that birthing people are empowered to choose restorative justice processes for themselves; even where a complaint is considered highly suitable for a restorative approach, the birthing person must retain the option to proceed via conventional processes and be afforded meaningful access to information and advice about the benefits and drawbacks of each approach.[908] This approach sets the stage for the sharing of provider perspectives with patients in a way that does not reproduce existing power imbalances in patient-provider relationships, but, rather, allows for providers to share professional expertise, knowledge and concern in a way that allows for greater understanding of what occurred for all parties. If all of the main parties to the Complaint voluntarily agree to participate, the College may contract or otherwise designate expert facilitators to guide the process, and the first stages may begin.

Phase 1: Design

At the first stage of the process, the facilitators would review the complaint, identify key issues, and design a responsive restorative process. This would involve identifying relevant stakeholders and key issues to be navigated, such as who should be included in the restorative process, how many meetings may be required, where meetings should take place, and whether legal counsel should be involved.

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[905] Llewellyn, "Responding Restoratively", *supra* note 705 at 129.
[906] *Ibid* at 130.
[907] *Ibid*.
[908] For a detailed discussion of this issue, see: Gerry Johnstone, *Restorative Justice: Ideas, values, debates,* 2nd ed (New York: Routledge, 2011) at 68-69.

In the context of *EV v JM,* the process would ideally involve EV, her partner or other affected family members, JM, the obstetrician, the midwife, any other doctors and health care personnel who were in the labour and delivery room at the time of the birth, and members of hospital administration, including management and legal personnel responsible for the development of policies relevant to the "standard protocol" followed by JM and the other care team members. Participants in restorative processes in obstetrical contexts "should not be limited to medical professionals and [should] include administrative and managerial actors in health care institute[s]" to ensure the institutional, cultural, and political nature of the issues at play are included and addressed.[909] Through such participation, managerial, administrative, and legal actors in childbirth care environments may gain new perspectives on how the policies they develop are experienced by people giving birth, which may influence direct policy change or future development. As restorative justice scholar John Braithwaite explains: "[T]he existence of a wider plurality of voices in the conference circle […] means that there are better prospects for creative problem-solving ideas to emerge."[910]

At this stage, the facilitators would also identify key issues to be navigated throughout the restorative process. In the context of *EV v JM,* these issues may include: navigating legal liability for individuals and institutions in a manner that best enables all parties to speak freely; how the restorative process may be integrated into existing or ongoing staff disciplinary review procedures, if any;[911] and whether the views and concerns of the infant twins may be properly advanced by their parents, or whether a third party should be designated to fill a *guardian ad litem*-style role.

Concerns regarding legal liability may affect the timeline of when a restorative justice process may take place. For example, some health care institutions or actors may be unwilling to engage in restorative processes until after limitation of action periods have lapsed.[912] Alternatively, however, the prospect of civil action may allow "parties to come to an agreement to address the issues and concerns through a commitment to participate fully in the restorative process."[913] In addition, in order for all parties to participate fully, birthing people may be required to waive rights to privacy in personal health information.

With respect to staff disciplinary processes, it is important that staff members are enabled to participate in the process without fear of disciplinary action. In this respect, facilitators may be required to work collaboratively with institutional management and union representatives to design processes that appropriately balance the restorative process with ongoing disciplinary processes or management strategies. Complainants also must be carefully informed of consequences of opting for a restorative process, including

[909] Lokugamage & Pathberiya, *supra* note 736 at 5.
[910] John Braithwaite, "Doing Justice Intelligently in Civil Society" (2006) 62:2 Journal of Social Issues 393 at 396.
[911] Llewellyn, MacIsaac & McNeil, *supra* note 893 at 4.
[912] Llewellyn, "Reimagining Our Healthcare System", *supra* note 887.
[913] Llewellyn, MacIsaac & McNeil, *supra* note 893 at 5.

forgoing conventional disciplinary or legal action, depending on the nature and scope of the alleged violation.[914]

Finally, restorative justice procedures must be designed with trauma-informed protection of victims at the centre of the process,[915] including considerations such as training of facilitators, preparation of parties, and questions about who will sit next to whom during meetings.[916] A proper trauma-informed approach may additionally require contracting or involvement of consultants on issues such as sexualized violence, in order to ensure the process prevents retraumatization and maximizes healing for victims.[917] At this stage, facilitators may also organize for the retention of trained counsellors to provide support to complainants or other parties before, during, and after the restorative process.

Phase 2: Investigation & Preparation of Parties

The next stage of the process is investigation of the issues and preparation of the participants. At this stage, facilitators review all relevant records, including medical records, reports, and hospital policies, in order "to gain an understanding of the facts as they were known and who was involved."[918] In some cases, the fact-finding stage may involve in-person interviews with participants conducted on-site (for example, in hospital settings), in order to gain a fulsome understanding of the institutional culture in which the incident occurred.[919]

Facilitators then contact participants and meet with them in advance to prepare them for what to expect out of the in-person encounter and restorative process generally. Describing the restorative process undertaken into the in-custody death of Nova Scotia resident Jason LeBlanc, Llewellyn explains:

> Participants were prepared to share and hear not only what happened, but what is most important about what happened, how they were affected, and to contemplate ways to move forward. This was done by meeting individually or in groups using self-reflection, building supports and thinking through how to respond to difficult questions. Some parties required multiple meetings before they were ready to participate together with others in the process.[920]

In addition, the preparation stage may include specialized teaching or training sessions for participants. For example, participants may benefit from discussion sessions with groups who were previously involved in restorative justice processes, in order to hear about their experiences and how they integrated what they

[914] *Ibid*.
[915] Melanie Randall & Lori Haskell, "Trauma-Informed Approaches to Law: Why Restorative Justice Must Understand Trauma and Psychological Coping" (2013) 36:2 Dal LJ 501 at 514.
[916] Llewellyn, MacIsaac & McNeil, *supra* note 893 at 7.
[917] See, generally: Randall & Haskell, *supra* note 915.
[918] Llewellyn, MacIsaac & McNeil, *supra* note 893 at 6.
[919] See, for example: Kaur, *supra* note 819 at 2.
[920] Llewellyn, MacIsaac & McNeil, *supra* note 893 at 6.

learned into their work and practice.[921] In *EV v JM*, for example, participants may benefit from workshops on topics such as collaboration across health professions, improved patient communication, and informed consent.

Phase 3: Encounter Stage

The next stage of the restorative process involves bringing parties together in what is sometimes referred to as the "encounter" stage.[922] Llewellyn and Howse explain: "Through this meeting parties confront and challenge one another's stories of the event. It is in such confrontation and challenge that truth is found."[923]

"Encounter" is a key element of restorative processes and may take various forms.[924] One such format is the "sharing circle," in which parties sit in a circle formation to share their experiences and perspectives on what occurred. Rather than physically positioning one side against the other, as in a court room, the parties all sit together in a circle. Depending on the number of parties, two circles may be set up—a smaller, inner circle comprised of the participants most closely affected by the events, and a larger, outer circle that includes participants who are less intimately involved, such as hospital administrators.[925] The encounter stage may occur over the course of one session, or over many sessions depending on the complexity of the issues and the number of people involved. In more complex matters, preliminary circles may be held on discrete topics, followed by a comprehensive large-format circle in which participants present what they have learned throughout the process.[926]

In *EV v JM,* a central point of difference between the Complainant and the Committee was an understanding of the *harm* that occurred to EV and her twin sons as a result of their separation following birth. The Board in this case confirmed the decision of the Committee that although "standard protocols did not allow her to have the birthing experienced she desired [...] no actual harm was done to the babies."[927] However, EV reported that she and her twins all experienced "incredible distress" as a result the separation.[928] While the distress EV and her sons experienced may not meet legal or professional standards of wrongdoing, it is clear that some harm has, indeed, occurred. Because restorative processes are not confined to legal or professional definitions of "harm,"[929] a sharing circle format may provide EV the opportunity to express and explain to the other parties the nature and extent of the harm she and her babies experienced. Through this process, other participants may gain a greater understanding of the impact of

[921] Jennifer Llewellyn, Jacob MacIsaac & Melissa MacKay, "Report from the Restorative Justice Process at the Dalhousie University Faculty of Dentistry" (2015) at 37, online: https://restorativelab.ca/wp-content/uploads/2021/05/RJ2015-Report-dentistry.pdf.)
[922] Jennifer J Llewellyn & Robert Howse, "Restorative Justice: A Conceptual Framework (Prepared for the Law Commission of Canada)" (1999) at 59.
[923] *Ibid.*
[924] *Ibid.*
[925] Llewellyn, MacIsaac & McNeil, *supra* note 893 at 7.
[926] Llewellyn, McIsaac & MacKay, *supra* note 921 at 3; 30.
[927] *EV v JM, supra* note 579 at para 11.
[928] *Ibid* at para 6.
[929] Llewellyn, "Truth commissions and restorative justice", *supra* note 885 at 356.

"standard protocols"[930] in the lives of their patients, thereby equipping them to design future policies that are responsive to the needs of their patients, as well as to deliver apologies that are responsive to patient interests and make a meaningful impact in their recoveries.[931]

Equally, through the process of sharing, patients may gain a greater understanding of the humanity of their providers, including understanding the legal and practical constraints they face in their practice, the goals and motivations underlying their actions, and the ways their lives may also have been impacted by the events underlying a patient's complaint. Consider, for example, the experience of Ernie LeBlanc, who participated in the restorative review into the in-custody death of his son, Jason. Jennifer Llewellyn, who oversaw the restorative process, explains that when Mr. LeBlanc received heavily redacted investigative reports into his son's death, it "fed his belief that they had let him die, because he didn't matter."[932] Llewellyn explains that Mr. LeBlanc began the process "distraught, upset" and "angry," and came to the encounter stage with a list of questions such as "How do you sleep at night?"[933] Through the sharing process, Mr. LeBlanc had the opportunity to hear from the prison guards and nurse who attempted to save Jason the night he died, and learned of the profound impact Jason's death had had on their lives. Mr. LeBlanc described the process in a CBC report: "It meant everything to me. I thanked them […] I accepted [their apologies] […] I could tell they meant Jason no harm. It's just a lack of knowledge."[934] Thus, participation in restorative processes may provide significant opportunity for healing, learning, and growth for victims and their family members, as well as providers. By speaking to health systems actors directly, patients such as EV may be better able to appreciate that their care providers are typically not acting with malicious intent. Where appropriate, restorative processes may enable complainants to forgive their provides, and assist them in moving beyond the experience of harm.[935]

In addition, I note that while the conventional complaint process did not allow for the Committee to address EV's concerns regarding her midwife (because the complaint was outside its jurisdiction), the encounter process provides a venue for EV to explain the experience of feeling her midwife failed to adequately advocate on her behalf. The midwife would have the opportunity to provide her own perspective in response and, perhaps, take responsibility for her role.

Finally, restorative processes are well-suited to childbirth care contexts because the participatory nature of restorative processes offers a route for victims to have their voices heard in a manner conventional legal models do not typically allow. The active role restorative processes carve out for victims is an important one, as obstetric violence victims and advocates commonly describe birthing people being treated

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[930] *EV v JM, supra* note 579 at para 11.
[931] Wailling, *supra* note 887 at 1196.
[932] Llewellyn, "Reimagining Our Healthcare System", *supra* note 887.
[933] *Ibid*.
[934] Tutton, *supra* note 893.
[935] For a detailed discussion of the potential for enhanced understanding and growth on the part of patients and patient families in restorative processes, see: Llewellyn, "Reimagining Our Healthcare System", *supra* note 887.

as passive "vessels" during childbirth, rather than being empowered to make their own care decisions.[936] Similarly, in traditional legal models, "victims are largely neglected and expected to play a passive role while professionals make all the key decisions,"[937] perhaps resulting in further victimization for individuals who felt they were not in control of their own childbirth experiences. In contrast, restorative practices afford victims "a sense of control or involvement in the resolution of their own cases."[938]

Phase 4: Follow-Up

The final phase of the restorative process is the follow-up stage. Individual participants may participate in additional meetings with facilitators to assess and support ongoing healing and systems improvement. At this stage, participants from the hospital, health authority, and college may meet together to reflect on what they learned and how they may respond to the issues raised by the complainant at an institutional level.

Several of the issues raised in *EV v JM* lend themselves to careful follow-up review. For example, EV raised concerns about lapses in communication across health professionals, when she explained she informed her midwife that she did not want an RT present during her labour and birth, but JM was not told in advance that they were not welcome. In follow-up, hospital team members may review this breakdown in communication, and identify ways to improve communication across professions in the future. For example, the hospital may consider creating an electronic record of the details of patient birth plans that may be accessed by all members of the care team, in order to ensure consistency in communication of the birthing person's treatment goals.

In addition, the health systems participants may review their process for obtaining informed consent to treatment by respiratory therapists. The Committee in *EV v JM* found "it was not the duty of the [JM] to obtain consent for the presence of, and possible treatment by a RT during the collaborative treatment plan, as consent was obtained by the obstetrician as part of the consultation process with [EV]."[939] The hospital may review its processes for explaining its collaborative health model to patients, as well as the adequacy of its informed consent processes. Participants may also consider reassessing their practices regarding separation of newborns following birth, in light of up-to-date evidence on the benefits of immediate and uninterrupted skin-to-skin contact between newborns and birthing people, including as they affect expected standards of professional conduct for respiratory therapists attending labour and childbirth.

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[936] Health scholars Perrotte, Chaudhary and Goodman explain: "The idea that the sole objective of birth is to have a healthy baby ignores women's agency, bringing them back to the status of '(now empty) vessels.'" (Violette Perrotte, Arun Chaudhary & Annekathryn Goodman, "'At Least Your Baby Is Healthy' Obstetric Violence or Disrespect and Abuse in Childbirth Occurrence Worldwide: A Literature Review" (2020) 10 Open Journal of Obstetric and Gynecology 1544 at 1555.) See also: Kathryn Gutteridge & Hannah Dahlen, "Midwifing women who make 'off-menu' choices" in Dahlen, Kumar-Hazard & Schmied, *supra* note 262, 360 at 376.

[937] Gerry Johnstone & Daniel W Van Ness, "The meaning of restorative justice" in Gerry Johnstone & Daniel W Van Ness, eds, *Handbook of Restorative Justice* (Oxford: Routledge 2007) 5 at 13.

[938] *Ibid.*

[939] *EV v JM, supra* note 579 at para 9.

Furthermore, patients participating in restorative processes may benefit from a greater understanding of health systems processes, available options, insight into their own preferences and goals, and enhanced skills in self-advocacy in health care settings, particularly for future pregnancies and births. The cathartic experience of telling their story and insights gained from hearing the accounts of others may assist birthing people and their families in processing and recovering from experiences from harm.[940]

Looking toward the future, individual health care practitioners may gain improved patient interaction skills through participation in restorative processes, thereby better enabling them to communicate with patients who have experienced harm. While the above proposal for *EV v JM* describes a relatively formal process, restorative practices can include informal interventions, such as "small impromptu conferences,"[941] which, through follow-up training, care providers may be equipped to implement in routine clinical care delivery. In addition, research indicates that providers' fear of being blamed when something goes wrong in childbirth is a significant driver of increased C-section rates, as well as a factor in low rates of vaginal birth after C-section (VBAC).[942] By conceptually shifting the way we respond to adverse events in childbirth from one of blame and retribution to one of understanding and forward-focused problem solving, providers may be empowered to offer a wider range of childbirth care options to patients.

Barriers to implementing restorative practices in childbirth settings

There are significant challenges to be navigated in the implementation of restorative processes in response to childbirth-related harms. First, I note that restorative justice processes are voluntary. Individuals cannot be subpoenaed or otherwise mandated to participate in restorative processes and may withdraw at any time. This means there may be situations where important information is missing from a discussion, or birthing people do not have the opportunity to speak directly to someone they would like to address. It also means there may be situations where one or more key parties does not wish to participate, meaning the traditional system is the only option. Thus, while the principle of voluntariness is a strength of restorative justice, because it means parties come to the metaphorical table with a willingness to learn[943] and a trust in the legitimacy of the process,[944] it also poses a potential barrier to its widespread implementation. However, I note that in previous applications of restorative justice in health care settings, healing and learning has been found to be possible even where all affected parties were not able to come together.[945]

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[940] Wailling, *supra* note 887 at 1196; Llewellyn, "Reimagining Our Healthcare System", *supra* note 887.
[941] Braithwaite, *supra* note 910 at 401.
[942] Elaraby, *supra* note 374 at 7.
[943] Gerry Johnstone, "Voluntariness, Coercion and Restorative Justice: Questioning the Orthodoxy" (2020) 3:2 Int'l J Restorative Just 157 at 158.
[944] Braithwaite, *supra* note 910 at 399.
[945] NZ *National Adverse Events Policy, supra* note 741 at 11; Llewellyn, "Reimagining Our Healthcare System", *supra* note 887.

Second, I acknowledge that many victims experience obstetric violence as sexual assault.[946] It is common for people who have experienced rights violations during childbirth to use "the language of rape, assault, and violence to describe their experiences of distress during birthing."[947] Feminists have long raised concerns that restorative justice processes are inappropriate for incidents involving sexual violence and pose a threat of revictimizing victims of sexualized violence.[948] It is, thus, critically important that all restorative processes be carried out under the direction of skilled facilitators who are trained in creating safe and supportive environments, and that participants are offered follow-up supports as needed.[949] As discussed above, there will be situations where restorative processes are inappropriate tools to address the seriousness of a situation, such as those involving patterns of deliberate assaultive behaviour.[950] In all situations, experienced leaders in restorative processes should assess the appropriateness of restorative justice as a response and recommend investigatory or disciplinary processes that are proportionate to the nature and extent of harm that has occurred.[951]

Finally, I acknowledge the potentially significant costs associated with the implementation of restorative practices in the form of upfront training, capacity-building, education, and ongoing contracting of restorative justice facilitators. Such costs would likely fall primarily on the institutional actors that take up the project of implementing restorative practices—whether government, regional health authorities, individual hospitals, or professional regulators—and may be particularly burdensome for smaller institutions or colleges. However, I note that some health colleges in Canada have existing frameworks in place for resolving complaints through alternative dispute resolution (ADR) processes, including the CPSO,[952] the College of Physicians and Surgeons of Saskatchewan,[953] the College of Midwives of Ontario,[954] and the College of Nurses of Ontario.[955] The CPSO has described its implementation of ADR as a successful approach to streamlining the complaints system, reducing delays, and facilitating "more

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[946] Morris, *supra* note 711 at 56.

[947] Chadwick, "The Dangers of Minimizing", *supra* note 729 at 1905. See, for example: *Mckendry, supra* note 596 at para 4; Sarah Yahr Tucker, "A Growing Number of Women Allege Doctors Abused Them During Childbirth" *Vice* (16 October 2019); Morris, *supra* note 711.

[948] Bruce Archibald & Jennifer Llewellyn, "The Challenges of Institutionalizing Comprehensive Restorative Justice: Theory and Practice in Nova Scotia" (2006) 29:2 Dal LJ 297 at 324-325; Clare McGlynn, Nicole Westmarland & Nikki Godden, "'I Just Wanted Him to Hear Me': Sexual Violence and the Possibilities of Restorative Justice" (2012) 39:2 JL & Soc'y 213 at 213-214; Amanda Nelund, "Policy Conflict: Women's Groups and Institutionalized Restorative Justice" (2015) 26:1 Criminal Justice Policy Review 65 at 65-68.

[949] Wailling, Wilkinson & Marshall, *supra* note 883 at 17.

[950] See, for example: Michelle McQuigge, "Doctor who induced labour without patients' consent loses right to practise in Ontario" *CBC News* (28 June 2018).

[951] For a recent example of a situation in which sexualized violence experts were consulted in the design and implementation of a restorative process, see: Llewellyn, McIsaac & MacKay, *supra* note 921 at 34.

[952] "Alternative Dispute Resolution (ADR)," *College of Physicians and Surgeons of Ontario* (website), online: https://www.cpso.on.ca/en/Public/Services/Complaints-and-Concerns/Alternative-Dispute-Resolution#:~:text=If%20the%20complaint%20is%20eligible,try%20to%20resolve%20the%20complaint.

[953] College of Physicians and Surgeons of Saskatchewan, "POLICY: Alternative Dispute Resolution", (November 2019), online: https://www.cps.sk.ca/imis/CPSS/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/Alternate_Dispute_Resolution.aspx.

[954] "Complaints and Concerns about a Midwife," *College of Midwives of Ontario* (website), online: https://cmo.on.ca/clients-and-the-public/complaints-and-concerns/#:~:text=Alternative%20Dispute%20Resolution%20(ADR)%20is,formal%20investigation%20of%20the%20complaint.

[955] College of Nurses of Ontario, "Addressing Complaints: Process Guide", (Toronto: CNO, 2023) at 2.

responsive resolution."[956] Aspects of existing ADR frameworks may be adapted to integrate a restorative justice approach, thereby mitigating some upfront implementation costs.

In addition, for each of these actors, consideration of upfront costs must be balanced against the potential cost savings associated with the avoidance or diversion of costly litigation[957] and lengthy complaints investigations, as well as the potential to reduce long term costs through increased health care provider retention, proactive problem solving, and reduced need for publicly funded mental health supports. Negative events during childbirth may have severe and lasting negative impacts on care providers, who are sometimes referred to as "secondary" or "vicarious" victims.[958] Health care providers "may experience distress as they lose their identity as healers, face 'moral injury' or are unable to express feelings of shame or remorse."[959] Care providers' experiences of negative outcomes during childbirth can play a significant role in shaping the way they manage and approach patient care in the future, and may contribute to provider burnout or decisions to leave their professions.[960] When burnout and attrition occurs on a broad scale,—as Canada is experiencing now, in the wake of the COVID-19 pandemic—health systems are critically affected, resulting in increased costs and negative impacts on patient care.[961] Restorative practices have the potential to prevent or mitigate provider burnout by emphasizing the human impacts of adverse events and focusing attention on future improvement,[962] potentially resulting in long-term cost savings for both regulators and employers.

In addition, the implementation of restorative practices may reduce public health costs associated with mental health care. Many birthing people report their worries about their traumatic deliveries being brushed aside, because they have a "healthy baby."[963] However, unaddressed and unresolved trauma in childbirth may have lasting impacts for birthing people and their partners in the form of difficulty bonding with their newborns, difficulty breastfeeding, persistent feelings of guilt, fear of giving birth in the future,

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[956] "New Process Offers Effective Resolution" *eDialogue* (11 October 2019). See also: Johanna Weidner, "Doctors' college aims to resolve minor complaints faster" *Waterloo Region Record* (24 January 2019).

[957] Art Eggleton & Raymonde Saint-Germain, "Bringing humanity back to the justice system: Why Canada needs more restorative justice programs" *CBC News* (3 November 2018); Canada, Department of Justice Canada, *The Effects of Restorative Justice Programming: A Review of the Empirical* (Ottawa: Department of Justice, 2000) at 14.

[958] Shefaly Shorey & Phyllis Zhi En Wong, "Vicarious Trauma Experienced by Health Care Providers Involved in Traumatic Childbirths: A Meta-Synthesis" (2022) 23:5 Trauma, Violence & Abuse 1585; Kathleen Kendall-Tackett & Cheryl Tatano Beck, "Secondary Traumatic Stress and Moral Injury in Maternity Care Providers: A Narrative and Exploratory Review" (2022) 3 Frontiers in Global Women's Health 1; Cheryl Tatano Beck & Robert K Gale, "A Mixed Methods Study of Secondary Traumatic Stress in Labor and Delivery Nurses" (2012) 41:6 JOGNN 747.

[959] Wailling, *supra* note 889 at 1194.

[960] Kendall-Tackett & Tatano Beck, *supra* note 958 at 11. Regarding the Canadian context, see: Kathrin Stoll & Jocelyn Gallagher, "A survey of burnout and intentions to leave the profession among Western Canadian midwives" (2019) 32 Women and Birth e441; Llewellyn, "Reimagining Our Healthcare System", *supra* note 887.

[961] Diana Duong & Lauren Vogel, "Overworked health workers are 'past the point of exhaustion'" (2023) 195:8 CMAJ E309 at E309; "Canada's health system is on life support: Health workers call for urgent mobilization to address shortages, burnout and backlog issues" *Canadian Medical Association* (10 March 2022); Mark Giunta, "Ontario hospitals continue to deal with significant staffing shortages" *Global News* (21 October 2022).

[962] Wailling, *supra* note 887 at 1194-1195.

[963] Burns-Pieper, 'Stop! Stop!', *supra* note 2; Sandra Fay Murphy, *Birthing and Being Birthed: Exploring How the Experience of Birth Trauma Impacts Birthing People in Their Postpartum Lives* (MSc Thesis, Dalhousie University Faculty of Nursing, 2020); Morris, *supra* note 711 at 57.

and increased risk of post-partum depression and post-traumatic stress disorder.[964] The implementation of restorative processes may provide a route for people affected by trauma in childbirth to process and heal, thus potentially mitigating the significant public costs associated with perinatal mental health care.[965]

[964] Jessica Leeder, "Post-traumatic (childbirth) stress disorder" *Today's Parent* (29 March 2017); Sara DuBreuil, "Why I'm opening up about the trauma of my difficult childbirth" *CBC News* (13 June 2021); Deniz Ertan et al, "Post-traumatic stress disorder following childbirth" (2021) 21:155 BMC Psychiatry 1; Cara Goodwin, "What Is Trauma, and How Common Is It?" *Psychology Today* (22 May 2023).
[965] Rachel Bergen, "How the UK model of postpartum depression care could guide Canada's treatment plan" *CBC News* (18 September 2022).

CHAPTER 5:
Conclusion

Canadian courts have repeatedly affirmed the "tenacious relevance in our legal system of the principle that competent individuals are—and should be—free to make decisions about their bodily integrity."[966] This includes protections for the right to make decisions about one's medical treatment that others might consider foolish or ill-advised, including the right to decline potentially life-saving medical treatment.[967] The principle operates in conjunction with Canadian law's rejection of fetal personhood[968] to guarantee people in Canada the right to make informed decisions about their own care during pregnancy, labour, and childbirth. However, pervasive news reports, regulatory complaints, and civil claims demonstrate that for many people in Canada, such rights fail to translate from the pages of reported decisions to their lived experiences in the delivery room.

In Canadian law, autonomy is often equated with independence, such that the freedom to make decisions about one's bodily integrity is characterized as a right to be *free from* intrusions by others. Nedelsky explains that in "the liberal tradition, part of the function of law is to contain that threat—by bounding off a sphere of individual autonomy into which no one, including the state, can intrude."[969] In modern discussions of reproductive autonomy rights, this "bounding off" is commonly articulated through the discourse of "my body, my choice."[970] However, what is often missing from such dialogue is an understanding of how—and through whom—reproductive choices are realized.

Considering childbirth through a relational lens reveals that the conventional understanding of autonomy-as-independence in Canadian law fails to account for the deeply relational nature of childbirth. As a result, current legal, policy, and public responses to rights infringements in childbirth fail to meaningfully address the harms experienced by birthing people and fail to prevent future infringements. Rather than building walls to protect birthing people from unwanted interventions (such as through the use of criminal sanctions), law and policy responses must focus on strengthening relationships between birthing people and their care providers through facilitation of meaningful and dynamic discussion around birthing peoples' preferences, values, and goals in childbirth.

At present, the most prominent threat to realization of autonomy in childbirth is the structuring force of *risk*, which permeates the conventional biomedical model of childbirth and constrains care

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[966] *Carter, supra* note 4 at para 67, citing *AC v Manitoba*, *supra* note 151 at para 39.
[967] *Fleming*, *supra* note 153; *B(R) v Children's Aid Society, supra* note 153; *Malette, supra* note 5; *Carter, supra* note 4.
[968] *Tremblay v Daigle, supra* note 1; *R v Sullivan, supra* note 1; *Dobson, supra* note 1.
[969] Nedelsky, *Law's Relations*, *supra* note 9 at 51.
[970] André Picard, "'My body, my choice'—except when it isn't," *The Globe and Mail* (18 September 2023).

providers in practice, thereby significantly narrowing the options available to birthing people. However, limiting choices in this way risks increasing dangers by pushing people seeking alternative options to give birth entirely outside the system. To improve rights-based outcomes in childbirth, law and policymakers must expand care options by shifting from a risk minimization approach to one of collaborative risk management between providers and patients. This requires investing in alternative options for childbirth, including increased access to midwife-attended home birth throughout Canada. In addition, it requires widespread patient education and advocacy campaigns regarding options for childbirth, as well as ongoing training for providers regarding the impacts of implicit biases on care delivery. Finally, upsetting the structuring force of *risk* requires system-wide efforts to destabilize the culture of blame that exists in clinical care settings, so that care providers may empower their patients to make informed choices without fear of professional repercussions.

In terms of future directions for this work, important next steps could include conducting focused interviews with birthing people in care settings throughout Canada, on the ways birthing people and care providers understand and experience their rights and obligations during intrapartum care. In addition, analysis of disciplinary complaints regarding childbirth-related care could be expanded in collaboration with regulatory colleges throughout Canada, in order to gain access to decisions that are not publicly reported and, in doing so, paint a more comprehensive picture of the types and frequency of rights violations patients are experiencing, as well as improving geographic representation. Finally, future research could involve broadscale investigation of how restorative justice programs may be implemented in response to complaints of mistreatment in childbirth in collaboration with health professional colleges, hospitals, regional health authorities, and local restorative justice experts.

In the interim, it is urgently important that policymakers working in health care contexts heed the widespread reports of violence and mistreatment in Canadian childbirth settings and take steps to narrow the gap between rights as they are described in legal texts, and the ways they are experienced in the lives of birthing people. Following the negative impacts on health care delivery related to the COVID-19 pandemic, interest in "alternative" forms of childbirth, including "unassisted" birth, has increased among Canadians, and trust in mainstream health models has decreased. However, as relational theorists have long argued, autonomy rights are realized *through*, rather than *in spite of*, our relations with others. Building upon this conceptual foundation, policymakers must provide clear and structured opportunities for providers to engage with patients about their goals, priorities, and values in the months leading to and during labour. Patients must be provided education about the full range of care options available to them in a manner that is responsive to their individual needs, and providers in all aspects of intrapartum care must be supported to empower their patients to make choices that are right for them, without fear of legal and professional liability. Finally, law and policymakers must work to expand access to alternative childbirth

care options throughout Canada and ensure birthing people will not be abandoned or penalized for choosing care options outside the conventional model. Though the gap between legal rights and lived experiences of birthing people is wide, it is not impassable. By focusing policy reforms on the relationships at the core of the experience of childbirth, it is possible to structure relationships in childbirth in a way that fosters, rather than impedes, the autonomy rights of birthing people.[971]

[971] Nedelsky, *Law's Relations*, *supra* note 9 at 118.

APPENDICES

Appendix A: Birth Plan Example

This is my second pregnancy/birth. My first baby was delivered by emergency C-section due to abnormal fetal heart tracing and partial cord prolapse. I had a spontaneous labour at 39 weeks. Labour began around 6am and progressed well. I had dilated to 8cm when my membranes ruptured at 5pm, causing the partial prolapse. My son was healthy and I recovered well. This time, I hope to deliver my baby vaginally, but I am open to a C-section if indicated.

Induction:

- If induction is required, in general, I would like to attempt non-pharmacological interventions first—for example, I would prefer to use a foley catheter balloon for cervical ripening before attempting medication.

Pain relief:

- I would like to attempt to deliver without an epidural.
- I would like to labour in a bathtub for pain management as much as possible.
- I would like the option to use gas and air during transition.

During my labour:

- I would like to have as few cervical checks as possible, performed by the same person or as few people as possible.
- I would like to have intermittent monitoring and remain as ambulatory as possible.
- Please explain all proposed interventions/surgeries to us in advance and provide us the opportunity to ask questions.
- Please introduce everyone who comes into the room to me.

During delivery:
If possible, I would like to try alternative positions for delivery—for example, side lying with a peanut ball.

If my baby is born via C-section, I would like my partner to remain with me the entire time. Please provide opportunity for uninterrupted skin-to-skin as soon after delivery as possible.

Following delivery, I plan to exclusively breastfeed my baby. I will bring expressed colostrum to hospital in case I need to be separated from my baby. Please do not feed baby formula without checking with me or my partner about expressed colostrum first, unless urgently needed.

Appendix B: Table of Cases Included in Narrative Synthesis of Disciplinary Decisions

Style of Cause	Jurisdiction	Profession
Lance v Pelletier, 2023 CanLII 55218 (ON HPARB)	Ontario	Midwife
Borg v Ross, 2022 CanLII 93723 (ON HPARB)	Ontario	Midwife
Lemme v Desaulniers, 2022 CanLII 62781 (ON HPARB)	Ontario	Midwife
Chiodo v Carter, 2022 CanLII 94804 (ON HPARB)	Ontario	Midwife
Chiodo v Babe, 2022 CanLII 94805 (ON HPARB)	Ontario	Midwife
Chiodo v Nestel, 2022 CanLII 94803 (ON HPARB)	Ontario	Midwife
Mckendry v Margel, 2021 CanLII 12968 (ON HPARB)	Ontario	Physician
KH v HL, 2021 CanLII 13973 (ON HPARB)	Ontario	Physician
FMY v CG, 2020 CanLII 64727 (ON HPARB)	Ontario	Physician
LN v NB, 2020 CanLII 63853 (ON HPARB)	Ontario	Nurse
CL v KNMB, 2020 CanLII 59938	Ontario	Physician
IS v KBO, 2020 CanLII 23216 (ON HPARB)	Ontario	Physician
College of Nurses of Ontario v Hogue, 2021 CanLII 152830 (ON CNO)	Ontario	Nurse
College of Nurses of Ontario v Dyer, 2020 CanLII 39287 (ON CNO)	Ontario	Nurse
RS v ASMA, 2020 CanLII 26170 (ON HPARB)	Ontario	Physician
Complainant v College of Physicians and Surgeons of British Columbia (No 1), 2022 BCHPRB 18	British Columbia	Physician
Complainant v British Columbia College of Nurses and Midwives, 2021 BCHPRB 140	British Columbia	Nurse
WR v DKB, 2021 CanLII 78761 (ON HPARB)	Ontario	Physician
CCML v RV, 2019 CanLII 110800 (ON HPARB)	Ontario	Physician
KM v COG, 2019 CanLII 92207 (ON HPARB)	Ontario	Nurse
LYD v SN, 2019 CanLII 75832 (ON HPARB)	Ontario	Midwife
LYD v MB, 2019 CanLII 75602 (ON HPARB)	Ontario	Midwife
Complainant v The College of Physicians and Surgeons of British Columbia, 2019 BCHPRB 62	British Columbia	Physician
MD v DSC, 2019 CanLII 52291 (ON HPARB)	Ontario	Physician
MD v KMG, 2019 CanLII 52295 (ON HPARB)	Ontario	Physician
College of Nurses of Ontario v Haas, 2019 CanLII 104797 (ON CNO)	Ontario	Nurse
LMLN v JFRB, 2019 CanLII 26554 (ON HPARB)	Ontario	Physician
AGK v CLK, 2019 CanLII 13687	Ontario	Physician
Complainant v College of Midwives of British Columbia, 2018 BCHPRB 117 (CanLII)	British Columbia	Midwife
Ejsmont (Re), 2018 CanLII 85974	Alberta	Physician
TC v NP, 2018 CanLII 54696	Ontario	Midwife
EV v JM, 2018 CanLII 4731 (ON HPARB)	Ontario	Respiratory Therapist
EO-P v CO, 2018 CanLII 4101 (ON HPARB)	Ontario	Midwife

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