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Choice in Birth: Preserving Access to VBAC

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Table of Contents

I.	TRENDS IN BIRTHING PRACTICES: VBAC IN CONTEXT	959
	A. <i>Growth in Cesarean Births</i>	959
	B. <i>Impact of ACOG Guidelines</i>	962
	C. <i>Profit and Liability in Birthing</i>	967
II.	HARMS OF VBAC RESTRICTIONS	971
	A. <i>Increased Risks from Unnecessary Surgery</i>	971
	B. <i>Sacrificing Advances in Feminism and Patient Autonomy</i> . 973	
III.	CHALLENGING VBAC RESTRICTIONS.....	977
	A. <i>Constitutional Grounds</i>	978
	B. <i>Policy Concerns</i>	983
	1. <i>Future Pregnancy Risks</i>	983
	2. <i>Deterrence</i>	984
	3. <i>Insurance</i>	986
	4. <i>Equality Concerns</i>	986
IV.	COUNTERARGUMENTS	989
	A. <i>Birth is Just Different</i>	989
	B. <i>Treating Two Patients</i>	990
	C. <i>Special Duties of Motherhood</i>	993
	D. <i>Doctor Knows Best</i>	995
V.	CONCLUSION.....	999

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The reproductive rights movement has fought many uphill battles for the rights of women to decide how to use their bodies in matters of sex and reproduction. Since the earliest battles over access to contraception, control over women's bodies and sexuality has been contested terrain where reproductive rights advocates have used autonomy and liberty arguments in attempts to stake out space for women to determine their reproductive lives. During periods of victory in the courts of justice and public opinion, women have experienced fewer barriers to accessing abortion and have benefited from a richer, more nuanced understanding of the conditions required for truly unconstrained decision-making about reproductive and sexual health. During periods of backlash and retrenchment, women have suffered burdensome restrictions on access to critical services, as the concept of reproductive autonomy has been whittled away by legislators, judges, and prosecutors. Throughout these ups and downs, the debate has unfolded with abortion at the center of the struggle for reproductive freedom. To many of us who have grown up in the reproductive rights movement—or who have studied its victories and losses in the context of other civil and human rights struggles of the twentieth century—this seems fairly unremarkable, or at least inevitable, given the history of abortion in the United States. But, as a newly emerged reproductive justice movement has recognized, to speak of reproductive freedom as if synonymous with unfettered access to abortion is to convey an overly narrow notion of reproduction. Reproductive rights as commonly understood in American society today emphasize the right to be free from unwanted reproduction—through the availability of contraception and abortion—at the expense of the freedom to reproduce and freedom within reproduction. Recognition that the essence of reproductive freedom for many women is the freedom to have and care for a child—whether through adoption, reproductive technology, an adequate social safety net, or simply in the absence of coercive measures such as sterilization—has inspired advocates within marginalized communities to articulate a broader notion of reproductive justice.¹ But many continue to view freedom within reproduction—the rights of women during pregnancy and childbirth—as an entirely different arena.

One consequence of the cordoning off of pregnancy and childbirth from other forms of sexual and reproductive empowerment—and from human rights in general—is that many women are unaware of their rights

1. See, e.g., *A New Vision for Reproductive Justice*, ASIAN COMMUNITIES FOR REPRODUCTIVE JUSTICE (2005), http://www.reproductivejustice.org/download/ACRJ_A_New_Vision.pdf; Loretta J. Ross, Sarah L. Brownlee, Dázon Dixon Diallo & Luz Rodriguez, *The "Sistersong Collective": Women of Color, Reproductive Health and Human Rights*, 17 AM. J. HEALTH STUDIES, 79, 79 (2001).

in childbirth. A 2002 study by the Maternity Center Association (now called Childbirth Connection), which surveyed over 1,500 women about their recent birth experiences, found that only 62% of respondents said they had fully understood their right to receive complete explanations of any procedure, drug, or test offered to them during pregnancy and childbirth, and only 66% of respondents said they had fully understood their right to refuse any procedure, drug, or test offered.² As medical technology has advanced, the implications of being uninformed have multiplied. A woman who enters the hospital to give birth may face a series of possible medical interventions, from electronic fetal monitoring to induction to cesarean surgery, with dozens of potential combinations of other interventions along the way. Often, medical intervention during childbirth is life-saving, but at other times it is medically unnecessary, or may even compound labor complications. One area of particular controversy in today's hospitals and doctors' offices is the availability of vaginal birth after cesarean surgery ("VBAC") for women who have previously given birth by cesarean and wish to deliver subsequent babies vaginally. After a period in the 1990s when VBAC was promoted as a relatively low-risk alternative to repeat cesarean surgery and the number of successful VBACs increased significantly, the last several years have seen a reversal in the trend. The decline in VBAC rates is not simply a function of women opting for cesareans over vaginal delivery but is rather, at least in part, the result of a growing number of hospitals that refuse to accept women who intend to have VBACs and physicians who refuse to attend such births. A recent survey found that more than 800 hospitals—in every state of the United States—have banned VBAC, with women served by smaller and more rural medical facilities suffering disproportionately from such outright refusals to perform the services they seek.³ Another nearly 400 hospitals have de facto VBAC bans in place, due to the unavailability of providers willing to attend VBACs or rules about conditions for VBAC that are strict enough to make VBACs highly unlikely to occur.⁴ The benefits and risks of different methods of delivery vary depending on the characteristics of the individual woman. As scientific research reveals more about the various factors influencing

2. E.R. Declercq, C. Sakala, M.P. Corry, S. Applebaum & P. Risher, *Listening to Mothers: Report of the First National U.S. Survey of Women's Childbearing Experiences* 46 (Oct. 2002) [hereinafter *Listening to Mothers I*], available at www.maternitywise.org/listeningtomothers.

3. International Cesarean Awareness Network, State by State VBAC Hospital Policy Summary, <http://ican-online.org/advocacy/VBAC-hospital-policy-summary> (last visited Dec. 12, 2009) (reporting results of telephone survey that identified numbers of hospitals with official no-VBAC policies, de facto no-VBAC policies (i.e., due to unavailability to providers), or VBAC-supportive policies).

4. *Id.*

birth outcomes, our understanding of the balance between benefits and risks continues to evolve. In fact, the scientific research is far from clear that repeat cesareans are always the safer option, and they certainly cannot justify on medical safety grounds alone the wholesale restriction on VBAC as an option for birthing women. Empirical evidence aside, VBAC bans forgo women's ability to attempt a trial of labor and thus should be understood to represent a major restriction on women's reproductive freedom. By eliminating the choice of VBAC, hospitals and providers essentially compel women to undergo major abdominal surgery—regardless of medical necessity and the stated preference of the individual woman herself—or choose to labor outside a hospital setting. With four million births annually in this country, VBAC restrictions have the potential to affect many thousands of women at a moment in their reproductive lives when they are most vulnerable—and should be most empowered.⁵ Such a trend in birth practices should sound alarms for all those who care about reproductive freedom.

VBAC restrictions constrain women's choices in childbirth and often lead them to undergo a medical procedure they do not want. Such a broad violation of the right to liberty and reproductive choice calls for a legal challenge. Of course, any legal strategy to address VBAC restrictions demands a degree of caution. The birthing process has layers of powerful social and cultural meaning, many of which are commonly deemed to be outside the realm of politics. But decades of feminist thinking, writing, and activism have demonstrated how the family, childrearing, and women's health—as well as science and medicine—are very much sites of political contestation. A successful legal challenge must articulate the ways in which VBAC restrictions breathe new life into the medical profession's patriarchal roots and promote a downgrading of women's knowledge about their own bodies. A successful legal challenge must also tread carefully amidst several decades of jurisprudence dealing with the legal status of fetuses and more recent developments that have subjected pregnant women to increasing scrutiny in the name of fetal rights. With such considerations in mind, this article will explore the complex issues involved in a potential legal challenge to VBAC restrictions. In Part I, I will briefly review the history of birthing practices over the last several decades, suggesting some political and economic factors that help explain why VBAC has fallen in and out of favor in recent years. In Part II, I will

5. See E.R. Declercq, C. Sakala, M.P. Corry, S. Applebaum & P. Risher, *Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences*, at 8 (Oct. 2006) [hereinafter *Listening to Mothers II*], available at <http://www.childbirthconnection.org/listeningtomothers>.

outline how VBAC restrictions harm women and then turn in Part III to various legal grounds on which VBAC restrictions could be challenged, as well as a number of policy concerns supporting a formal challenge to such restrictions. Finally, in Part IV, I address a number of counterarguments likely to arise in the face of a challenge to VBAC restrictions and offer an initial set of responses—grounded in law, policy, and common sense—as to why restricting women’s choices in childbirth fails women, their babies, and their doctors.

I. TRENDS IN BIRTHING PRACTICES: VBAC IN CONTEXT

The twentieth century saw a major shift in our society’s approach to the birthing process—from a practice that took place largely in the home and was overseen by midwives to one that occurs in a hospital setting with doctors and nurses (and the occasional midwife) shepherding a woman through labor and delivery.⁶ As such, the medicalization of birth is a relatively recent phenomenon. The history of VBAC highlights the extent to which cutting-edge thinking about the best way to manage childbirth varies over time and suggests that this is an area where expert knowledge is still in flux.

A. *Growth in Cesarean Births*

At the turn of the twentieth century, developments in surgical methods, the use of anesthesia, and understanding about sterility made cesareans a safer, more reasonable option when complications arose during childbirth; its safety continued to improve over the course of the century. In the 1970s, the introduction of electronic fetal monitoring (“EFM”) to monitor fetal heart rate and uterine contractions was widely believed to improve doctors’ ability to predict fetal distress in labor.⁷ Widespread introduction of this technology led to a dramatic increase in the cesarean rate out of concern for fetal distress, although EFM was later shown to produce a high rate of false positives and ultimately to be no more beneficial than frequent listening to fetal heart rate by a doctor or nurse using a specially designed stethoscope called a fetoscope.⁸ The

6. See, e.g., Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 578 (1993) (discussing the “ascendance of medical birthing as the outcome of a power struggle between doctors and midwives”).

7. See JENNIFER BLOCK, PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE 32-33 (2008) (stating that by 1976 “almost every maternity ward in the country had purchased one or more electronic fetal monitors and was using them on the majority of labor and delivery patients”).

8. See *id.* at 32-35 (detailing introduction of EFM technology and subsequent research on its efficacy and impact on cesarean rates); A. Prentice A & T. Lind, *Fetal*

rate of cesareans more than doubled from 5.0% of births in 1970⁹ to 10.4% in 1975;¹⁰ by 1980, 16.5% of babies were delivered through cesarean surgery.¹¹ Furthermore, the prevailing wisdom had always been “once a cesarean, always a cesarean,” due to concern about uterine rupture and other complications for women who had scarring from an earlier surgery.¹² In 1980, only 3.4% of women with uterine scars from previous cesareans delivered a subsequent baby vaginally, which meant that the rapidly increasing cesarean rate would be compounded when women gave birth multiple times over the course of their reproductive lives.¹³ VBAC does increase the risk of uterine rupture during childbirth.¹⁴ While an incomplete rupture, or scar dehiscence, is often asymptomatic and is not associated with maternal or fetal morbidity, a complete rupture—which can occur in either a scarred or unscarred uterus, although scarring increases the risk—may lead to sudden blood loss and fetal distress.¹⁵ But this increased risk did not explain (or justify) the skyrocketing rates of cesarean surgeries, so in 1980, the National Institutes of Health convened an expert panel to discuss concern over the rapid growth in cesareans in American birthing practices. The panel concluded that promoting VBAC was an appropriate way to attempt to reverse the increasing cesarean rates.¹⁶ The advantages of

Heart Rate Monitoring During Labour: Too Frequent Intervention, Too Little Benefit?, 2 THE LANCET 1375-77 (1987).

9. Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 1958 (1986).

10. Sora Song, *Too Posh to Push?*, TIME, Apr. 19, 2004, at 58.

11. Rhoden, *supra* note 9, at 1958.

12. See BLOCK, *supra* note 7, at 87 (recalling that the dictum “once a cesarean, always a cesarean” was first uttered by Columbia University obstetrics and gynecology professor Edwin B. Craigin in 1916 and remained the dominant thinking for the next sixty years).

13. P.J. Placek & S.M. Taffel, *Vaginal Birth After Cesarean (VBAC) in the 1980s*, 78 AM. J. PUB. HEALTH 512, 513, Fig. 1 (1988). About 36% of American mothers have given birth three or more times. Carol Sakala and Maureen P. Corry, *Evidence-Based Maternity Care: What It Is and What It Can Achieve* 58 (2008), available at <http://www.childbirthconnection.org/pdfs/evidence-based-maternity-care.pdf>.

14. See Gerard G. Nahum & Krystie Quynh Pham, *Uterine Rupture in Pregnancy*, eMedicine Obstetrics and Gynecology, at tbl 1. (“Absolute Rates of Uterine Rupture for Different Patient Subgroups”) (Jan. 15, 2008); see generally Suneet P. Chauhan et al., *Maternal and Perinatal Complications with Uterine Rupture*, 189 AM. J. OBSTETRICS & GYNECOLOGY 408 (2003).

15. See Jeanne-Marie Guise, Marian S. McDonagh, Patricia Osterweil, Peggy Nygren, Benjamin K. S. Chan, Mark Helfand, *Systematic Review of the Incidence and Consequences of Uterine Rupture in Women with Previous Cesarean Section*, 329 B.M.J. 1, 4-6 (2004); see generally Chauhan et al., *supra* note 14.

16. U.S. NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, CDC, NIH PUBLICATION NO. 82-2067, *CESAREAN CHILDBIRTH*, NIH CONSENSUS STATEMENT 11 (Oct. 1981), available at <http://consensus.nih.gov/1980/1980Cesarean027html.htm> [hereinafter NIH CONSENSUS STATEMENT].

VBAC include a shorter hospital stay, faster recovery time, and lower medical costs.¹⁷ Accordingly, it called for those hospitals with appropriate facilities, services, and staff for prompt cesarean birth to “permit a safe trial of labor and vaginal delivery for women who have had a previous low segment transverse cesarean birth.”¹⁸

By the mid-1980s, obstetricians had adopted a more widespread practice of using low transverse cuts instead of vertical incisions, and VBACs had become more common.¹⁹ Support for VBAC was bolstered by new studies at the time suggesting that about 75% of women with previous cesareans who tried to give birth vaginally would succeed,²⁰ as well as continued concern about the growing rates of cesarean surgery by public health officials and insurance companies.²¹ The World Health Organization (“WHO”) echoed concerns about high cesarean rates, issuing guidelines that called for cesareans to constitute no more than 15% of all births and less than 9.5% of births in industrialized nations.²² In 1988, the American College of Obstetricians and Gynecologists (“ACOG”) recommended that women be encouraged to have VBACs unless there were medical reasons for the surgical option.²³ Not only did the ACOG Committee Opinion suggest that women with one low transverse uterine scar be “counseled and encouraged” to try vaginal delivery, but it even recommended that patients with two or more low transverse scars “not be discouraged” from a trial of labor.²⁴

In 1990, the VBAC rate for women who had previous cesareans had risen to 19.9%, a dramatic increase from ten years earlier.²⁵ But in the same year, the cesarean rate rose to 22.7% of all births; it declined slightly during the mid-1990s, reaching its lowest point for the decade in 1996 at a rate of 20.7%—the year when VBACs reached an all-time high of 28.3%—but returned to 22.9% by 2000.²⁶ VBAC rates saw a dramatic

17. See *infra* Part I.C & Part II.A.

18. NIH CONSENSUS STATEMENT, *supra* note 16, at 11.

19. See Sheryl Gay Stolberg, *A Risk is Found in Natural Birth After Cesarean*, N.Y. TIMES, July 5, 2001, available at <http://www.nytimes.com/2001/07/05/us/a-risk-is-found-in-natural-birth-after-caesarean.html>.

20. BLOCK, *supra* note 7, at 87.

21. See Stolberg, *supra* note 19.

22. Song, *supra* note 10, at 58.

23. Karin Larson Hangsleben, Margaret A. Taylor & Nancy M. Lynn, *VBAC Program in a Nurse-Midwifery Service*, 34 J. NURSE-MIDWIFERY 180 (July-Aug. 1989).

24. N. Clemenson, *Promoting Vaginal Birth After Cesarean*, 47 AM. FAM. PHYSICIAN 139-44 (1993).

25. Fay Menacker, *Trends in Cesarean Rates for First Births and Repeat Cesarean Rates for Low-Risk Women: United States, 1990-2003*, CDC, 54 NATIONAL VITAL STATISTICS REP. NO. 4, at 3, tbl. B (2005) [hereinafter NVSR 1990-2003], available at http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_04.pdf.

26. *Id.*

33% increase from 1991 to 1996 and a subsequent 17% decline from 1996 to 1999; both trends were true across age groups and major races and ethnicities, as well as for almost all states and for most risk factors and complications.²⁷ During the height of VBAC popularity, the overall VBAC rate was highest for non-Hispanic white women and lowest for Hispanic women, with non-Hispanic African American women falling in the middle.²⁸ The push to reduce the cesarean rate continued throughout the 1990s, driven in part by awareness that the United States was out of step with other countries, including those with lower infant mortality rates,²⁹ and that the U.S. cesarean rate was higher than the WHO recommendation.³⁰ Nevertheless, cesarean rates continued to rise in the early years of the twenty-first century, climbing from 22.9% in 2000 to 27.5% in 2003.³¹ In 2004, with the cesarean rate significantly higher than the world average, the United States ranked twenty-ninth in infant mortality among industrialized nations.³² In 2007, the United States ranked forty-first in the world for maternal mortality.³³

B. *Impact of ACOG Guidelines*

In 2000, a government health report announced a target VBAC rate of 37% by 2010,³⁴ but an important development the year before would put this goal far out of reach. In 1999, ACOG issued new, stricter guidelines for VBAC, which precipitated a marked decline in VBAC

27. Fay Menacker & Sally C. Curtin, *Trends in Cesarean Birth and Vaginal Birth After Previous Cesarean, 1991-99*, CDC, 49 NATIONAL VITAL STATISTICS REP. NO. 13, at 1 (Dec. 27, 2001) [hereinafter NVSR 1991-99], available at http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_13.pdf.

28. *Id.* at 3.

29. See BLOCK, *supra* note 7, at 111 (detailing how the U.S. Centers for Disease Control and Prevention set a 15% cesarean rate as a “Healthy People 2000” goal); R. Turner, *Caesarean Section Rates, Reasons for Operations Vary Between Countries*, 22 FAM. PLANNING PERSPECTIVES 281–82 (1990).

30. See BLOCK, *supra* note 7, at 111 (discussing the 1985 World Health Organization resolution setting the ideal cesarean rate as falling between 10% and 15% of births).

31. NVSR 1990-2003, *supra* note 25, at 3.

32. MARIAN F. MACDORMAN & T.J. MATTHEWS, CDC, NATIONAL CENTER FOR HEALTH STATISTICS, RECENT TRENDS IN INFANT MORTALITY IN THE UNITED STATES 2, FIG. 2, DATA BRIEF NO. 9, (Oct. 2008), available at <http://www.cdc.gov/nchs/data/databriefs/db09.pdf> (announcing that the United States ranked twenty-ninth in the world for infant mortality, tied with Poland and Slovakia).

33. Ashley Gosik, *U.S. Ranks 41st in Maternal Mortality*, SEATTLE POST INTELLIGENCER, Oct. 12, 2007, http://www.seattlepi.com/national/335391_maternal13.html.

34. See Denise Grady, *Trying to Avoid 2nd Cesarean, Many Find Choice Isn't Theirs*, N.Y. TIMES, Nov. 29, 2004, at 1 [hereinafter Grady, *Trying to Avoid*].

rates in the following years.³⁵ Having previously called for medical personnel to be “readily” available,³⁶ the guidelines now announced a “need for those institutions offering VBAC to have the facilities and personnel, including obstetric, anesthesia, and nursing personnel *immediately available* to perform emergency cesarean delivery when conducting a trial of labor for women with a prior uterine scar.”³⁷ Previously, the guidelines for those attempting VBAC were no different from the general standard for obstetric services, which ACOG defined as requiring the availability of a physician to evaluate labor and perform a cesarean surgery within thirty minutes of a decision to do so.³⁸ But the new standard requiring the presence of a physician capable of performing a cesarean during the entire VBAC trial of labor exceeded the capabilities of many doctors. Practitioners who regularly attended VBACs had to close their VBAC practices because they could not treat patients in the clinic setting while attending the entire labor of a VBAC patient at a community hospital.³⁹ The 1999 ACOG guidelines had a “chilling effect”⁴⁰ on the ability of women to give birth vaginally if they had previously had a cesarean surgery, with the vast majority of VBACs available only in university and tertiary-level hospitals,⁴¹ where surgeons and anesthesiologists are continually available. A woman wishing to have a VBAC in an area without one of these facilities must bear the burden and expense of traveling to give birth at a medical center far from where she has been receiving pre-natal care (if there is such a center close enough for her to reach when labor begins), choose the riskier option of a VBAC homebirth, or abandon the hope for a VBAC and consent to a repeat cesarean. Declining VBAC rates reported by the

35. See generally AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, PRACTICE BULLETIN NO. 5, VAGINAL BIRTH AFTER PREVIOUS CESAREAN DELIVERY (1999) [hereinafter ACOG VBAC BULLETIN 1999].

36. See Grady, *Trying to Avoid*, *supra* note 34, at 1.

37. ACOG VBAC BULLETIN 1999, *supra* note 35.

38. Clemenson, *supra* note 24, at n.10 (citing Committee on Obstetrics: Maternal and Fetal Medicine, Guidelines for Vaginal Birth After a Previous Cesarean Birth, ACOG Committee Opinion No. 64 (1988)).

39. Michael J. Myers, *ACOG's Vaginal Birth After Cesarean Standard: A Market Restraint Without Remedy?*, 49 S.D. L. REV. 529, 528 (citing Julie Barto, Impact of Revised Policy on Vaginal Birth After Cesarean (2003) (unpublished masters professional report, on file with the University of South Dakota) [hereinafter *Barto Report*]).

40. See Grady, *Trying to Avoid*, *supra*, note 34 (quoting D. Charles Lockwood, chairman of Yale department of obstetrics, gynecology, and reproductive sciences and author of the 1999 ACOG VBAC guidelines).

41. World Health Organization, Unit Costs for Patient Services, http://www.who.int/choice/costs/unit_costs/en/index.html (defining tertiary-level hospital as one with “[h]ighly specialized staff and technical equipment, e.g., cardiology, ICU and specialized imaging units”) (last visited Dec. 12, 2009).

National Center for Health Statistics reflect this tightening of VBAC availability: VBAC rates decreased from 23.4% in 1999 to 16.4% just two years later and sank to 10.6% in 2003, only four years after the ACOG guidelines were published.⁴²

In 2001, the *New England Journal of Medicine* published a study about risk in VBACs, especially with the use of hormones to induce labor.⁴³ Accompanied by an editorial that included strong language warning about the risks of VBAC,⁴⁴ the study provoked a vocal reaction from birthing rights advocates who were already concerned about the impact of the 1999 ACOG guidelines on the availability of VBAC. Indeed, publicity about the study underscored the validity of the alarmed reaction from the birthing community; media reporting interpreted the NEJM study as refuting the safety of VBAC and drew links that were suggested by the editorial but not actually supported by the study. For example, although the study did not contain a single reported maternal death, the *New York Times* coverage discussed uterine rupture as a dangerous complication that can “kill the mother, her baby or both.”⁴⁵ Subsequent commentary on the study—which did not get the same level of press coverage—suggested that the study was methodologically questionable in that it relied only on birth certificates and hospital discharge data to determine the risk of uterine rupture without examining actual medical records and charts or determining the prevalence of coding error.⁴⁶ The study was criticized for containing “little new or ground-breaking information and rel[ying] on questionable data collection,”⁴⁷ while the accompanying editorial was characterized as an “extremely bold statement,” especially “[c]onsidering the overwhelming limitations of the study.”⁴⁸ The study did offer one new piece of information about the use of synthetic prostaglandins during induction, which was found to increase the risk of uterine rupture to 2.5%.⁴⁹ Nevertheless, experts such as Dr. Bruce Flamm—an obstetrician with Kaiser Permanente and clinical professor at UC Irvine, who has written

42. NVSR 1990-2003, *supra* note 25, at 3.

43. M. Lydon-Rochelle, V.L. Holt, T.R. Easterling, D.P. Martin, *Risk of Uterine Rupture During Labor Among Women with a Prior Cesarean Delivery*, 345 *NEW ENG. J. MED.* 3-8 (2001).

44. M.F. Greene, *Vaginal Delivery After Cesarean Section—Is the Risk Acceptable?*, 345 *NEW ENG. J. MED.*, 54-55 (2001).

45. Stolberg, *supra* note 19.

46. Bruce L. Flamm, *Vaginal Birth After Cesarean and the New England Journal of Medicine: A Strange Controversy*, *BIRTH* 28:4, at 276-77 (Dec. 2001).

47. Jill MacCorkle, *Fighting VBAC-lash: Critiquing Current Research*, *MOTHERING* (Jan-Feb. 2002), available at http://www.mothering.com/articles/pregnancy_birth/cesarean_vbac/fighting.html.

48. Flamm, *supra* note 46, at 278.

49. *Id.* at 277.

extensively about VBAC—cautioned that the study lacks sufficient information about how the prostaglandins were administered to be able to conclude that prostaglandin use in VBAC is dangerous.⁵⁰ Otherwise, the study's findings—that 1) the risk of uterine rupture during a planned VBAC trial of labor is 0.5 to 1.0%;⁵¹ 2) induction without prostaglandins may cause a slightly higher rupture rate;⁵² and 3) nevertheless, elective repeat cesarean does not completely eliminate all risk of rupture⁵³—simply confirm previous research and do not justify the position of the accompanying editorial.

By 2002, the International Cesarean Awareness Network (ICAN) was reporting an increase in calls from women who were unable to find a hospital where they could have a VBAC.⁵⁴ Periodic reporting in the aftermath of the ACOG guidelines has highlighted the impact of ACOG's new standard. In 2004, the *New York Times* reported that half of all hospitals in New Hampshire and Vermont have banned VBAC.⁵⁵ The *Washington Post* ran a story in 2005 about the VBAC ban adopted by Frederick Memorial Hospital in Frederick, MD, which inspired a media-friendly protest of mothers and children.⁵⁶ The *Listening to Mothers* survey found that when asked a hypothetical question about choosing a cesarean in the future—even if no medical reason existed for the surgery—women preferred vaginal birth by a margin of five to one (83% to 16%).⁵⁷ A follow-up study four years later found that 85% of women supported the right to choose VBAC.⁵⁸

A 2003 study of an obstetrical and gynecological practice in a South Dakota community with a population of 110,000 provides local confirmation of nationwide statistics that reflect a decline in the number of VBACs.⁵⁹ In the geographical area where the study was conducted, there is one other OB/GYN practice, as well as two nonprofit community

50. *Id.*

51. *Id.*

52. *Id.*

53. *Id.*

54. See Grady, *Trying to Avoid*, *supra*, note 34.

55. *Id.* (quoting Dr. Peter Cherouny, University of Vermont professor of obstetrics and gynecology).

56. See Rob Stein, *Once a C-Section, Always a C-Section?; Women Who Want to Try Labor on Later Deliveries are Increasingly Refused*, WASH. POST, Nov. 24, 2005, at A1; see also Grady, *Trying to Avoid*, *supra*, note 34 (reporting protest outside Frederick Memorial Hospital on November 9, 2004 involving approximately 50 mothers with their children); Petition: Bring Back VBAC at Frederick Memorial Hospital, Birthing Circle of Frederick, <http://www.petitiononline.com/fmhvbac/petition.html> (last visited Dec. 12, 2009).

57. *Listening to Mothers I*, *supra* note 2, at 7.

58. See *Listening to Mothers II*, *supra* note 5, Executive Summary at 6.

59. Myers, *supra* note 39, at 529 (citing *Barto Report*).

hospitals. After ACOG released its 1999 guidelines, the OB/GYN practices adopted policies that exclude attendance by its practitioners of elective VBACs.⁶⁰ The community hospitals also adopted VBAC restrictions according to the 1999 ACOG guidelines, resulting in a whole population without the option of VBAC. The study's author concludes that the decline in VBACs is attributable to the ACOG guidelines:

Before the 1999 revised VBAC guidelines were released by ACOG, family physicians throughout the service area successfully performed VBAC deliveries unattended by OB/GYN. Under the new standards . . . [not only must there be] attendance of the family physician responsible for monitoring the course of labor, but also an OB/GYN trained to perform cesarean sections.⁶¹

The first *Listening to Mothers* survey also revealed declining access to VBAC, finding that of the women who gave birth one to two years prior to the study, 25% had been denied the option to have a VBAC, while among women who gave birth in just the twelve months prior to the study, 58% had been denied VBAC.⁶² Of all those who had been denied VBAC, the most common reasons were medical (unrelated to fear of rupture) (38%) and caregiver unwillingness (36%), followed by hospital unwillingness (12%).⁶³ There is currently no useful research on the relationship between caregiver unwillingness and hospital unwillingness, or the ways in which pressures on both sets of actors combine to produce VBAC unavailability.

Another chapter in the history of cesareans came in 2003, when the ACOG ethics committee issued an opinion finding that it is ethical for doctors to perform "elective" cesarean surgeries as long as there is no danger to the health of the mother or fetus.⁶⁴ The committee offered no guidelines, claiming a lack of evidence. Although reporting in the media has suggested that women's selfish desire to reduce the inconvenience of childbirth has driven cesarean rates to skyrocket, the data do not support such claims.⁶⁵ In fact, the concept of "elective" cesareans itself is problematic in that the criteria for what constitutes "elective" are vague.

60. *Id.* (citing *Barto Report*, at 8).

61. *Id.* (citing *Barto Report*, at 16).

62. *Listening to Mothers I*, *supra* note 2, at 27.

63. *Id.*

64. Press Release, American College of Obstetricians and Gynecologists, *New ACOG Opinion Addresses Elective Cesarean Controversy* (Oct. 31, 2003), http://www.acog.org/from_home/publications/press_releases/nr10-31-03-1.cfm.

65. See BLOCK, *supra* note 7, at 52 (reporting "little evidence of a significant 'patient-choice' cesarean trend"); Miriam Pérez, *The Myth of the Elective C-Section*, RH Reality Check (July 7, 2008), <http://www.rhrealitycheck.org/blog/2008/06/27/the-myth-elective-csection>.

For example, when HealthGrades, a company that rates the quality of hospitals and doctors, reviewed several years of birth data across different states to determine the frequency of what they called “patient choice” cesareans, they arrived at the figure simply by taking all cesareans performed before or without labor and eliminating repeat cesareans, breeches, multiples, and any medical complications that warrant surgery.⁶⁶ At no point did they interview women about how they came to have a cesarean birth despite the fact that they fell into the “no indicated risk” category or look at the role of billing practices in influencing what cesareans are labeled “elective.” Nor did the study consider what role doctors might play in guiding the outcome of delivery choice by emphasizing certain risks but not others—a phenomenon for which there is plenty of anecdotal evidence.⁶⁷ At the very least, it is clear that the 2003 ACOG opinion contributes to an imbalance in the options available to birthing women. The problem is not with the availability of, and demand for, “elective” cesareans, but rather that ACOG promotes this particular birthing choice with weak evidentiary support, while restricting VBAC as another possible choice for women giving birth.

C. *Profit and Liability in Birthing*

Commentators have suggested a number of factors contributing to high cesarean rates, including the privileging of technological methods of birth on the part of both patients and doctors, the pursuit of higher fees for cesareans than vaginal deliveries, and legal defensiveness on the part of doctors who believe performing cesareans will better protect them from claims of malpractice should something go wrong during birth.⁶⁸ Despite the healing and caretaking dimensions of practicing medicine, “profit maximization has approximately the same presence in health care as it does [in] banking, auto sales, lawyering, and other market endeavors.”⁶⁹ In 1991, Public Citizen reported that the average cost for a vaginal delivery was \$4,720, while the cost for a cesarean surgery was

66. See BLOCK, *supra* note 7, at 52-53.

67. *Id.* at 91 (quoting a maternal-fetal medicine specialist who stated, “I could talk most women into either option [vaginal or cesarean delivery] if that was what I truly wanted to do,” in order to underscore the point that “physicians, if they have an agenda, wield enormous power in this regard”); see also *id.* at 49-55.

68. See generally, e.g., BLOCK, *supra* note 7; Myers, *supra* note 39.

69. Myers, *supra* note 39, at 527. Indeed the role of economics as a driving force in the provision of health care is well-documented. *Id.* (citing DANIEL HALEY, POLITICS IN HEALTH: THE SUPPRESSION AND MANIPULATION OF AMERICAN MEDICINE (2000); JAMES P. CARTER, M.D., RACKETEERING IN MEDICINE: THE SUPPRESSION OF ALTERNATIVES (1992); FITZHUGH MULLAN, M.D., BIG DOCTORING IN AMERICA (2002); EUGENE D. ROBIN, M.D., MATTERS OF LIFE AND DEATH: RISKS VS. BENEFITS OF MEDICAL CARE (1984)).

\$7,826.⁷⁰ Today, cesareans cost \$14,000-\$17,000, whereas charges for a vaginal delivery fall in the \$6,000-\$8,000 range.⁷¹ Cesarean surgeries are also associated with longer hospitalization, which produces more revenue for hospitals; women who have cesareans are also almost twice as likely to be re-hospitalized when compared to women who have vaginal deliveries, which in turn generates more hospital revenue.⁷² A study by Chicago researchers estimated that over the reproductive lives of 100,000 women, there would be an estimated 117,748 cesarean surgeries and 5,500 maternal morbid events, resulting in a total of \$179 million in hospital and doctor fees.⁷³ It is also worth noting that physician compensation is for the delivery itself, which creates a disincentive for a provider to attend a woman in labor without reasonable assurance that he will in fact be delivering the baby: “A family physician is unwilling to fully attend a patient’s labor with the possibility that the obstetrician will deliver the patient by cesarean. . . . The obstetrician is unwilling to fully attend a patient’s labor only to have the family physician deliver her vaginally.”⁷⁴

The high stakes involved in practicing medicine—particularly in the context of birth—mean obstetricians pay hefty malpractice premiums, reaching as much as \$150,000-\$200,000 annually.⁷⁵ Patients’ rights get folded into a larger framework of risks and benefits analyzed by hospital administrators and risk managers.⁷⁶ Although a woman is unlikely to sue after a cesarean that results in a healthy baby (and would have a hard time proving damages if she did), a physician incurs greater legal exposure when she honors a women’s refusal of cesarean and the baby is damaged during birth. Such cases resonate with juries, and a litigant may claim that she did not understand the consequences of her refusal. Such concerns contribute to the idea that a cesarean is a “strong offense that constitutes the best defense”⁷⁷ and may often influence physicians to encourage women into consenting to surgical delivery. Distortion of the risk involved in VBAC has led to some changes in malpractice insurance coverage for physicians. For example, in Oklahoma, the malpractice

70. See Lucy Danziger, *Parent & Child: Natural Birth vs. On-Time Delivery*, N.Y. TIMES, Aug. 3, 1995, available at <http://www.nytimes.com/1995/08/03/garden/parent-child-natural-birth-vs-on-time-delivery.html?>

71. Myers, *supra* note 39, at 528, 531.

72. M. Lyndon-Rochelle, et al., Association Between Method of Delivery and Maternal Re-Hospitalization, 283 J. AM. MED. ASS’N 2411-16 (2000).

73. Steven Reinerg, *Routine Repeat Cesarean Delivery May not be Cost Effective*, OBSTETRICS & GYNECOLOGY (2000), available at <http://www.ican-online.org/news/050103.htm>.

74. Myers, *supra* note 39, at 531 (citing *Barto Report*, at 16-17).

75. See Song, *supra* note 10.

76. See Rhoden, *supra* note 9, at 2009.

77. *Id.* at 2021.

insurer Physicians Liability Insurance Company (PILCO) has stopped covering VBACs; given that PILCO has a monopoly on coverage in the state, the policy of a single insurance company has essentially instituted a statewide VBAC ban.⁷⁸ The work of author and journalist Jennifer Block suggests that insurance company demands may play a significant—and hard to detect—role in promoting restrictive VBAC policies. She writes about New Jersey’s St. Barnabas Medical Center, where a practice of 60 obstetricians insured by MDAdvantage has entered into a verbal agreement with the company to stop attending VBACs (as well as vaginal twin births).⁷⁹ The president of the group, who was involved in creating the agreement, justified it by the need to curb liability and said the members of the practice were informed of the decision by “word of mouth.”⁸⁰

Successful claims resulting from unwanted cesareans are rare, although they do sometimes arise. In 1993, a jury awarded a woman \$1.53 million for complications arising from an unwanted cesarean, which resulted in a healthy child but serious health consequences for the woman.⁸¹ The fact that it took the plaintiff a year to find a lawyer willing to take her case is indicative of how minimal a threat such claims currently pose to doctors, especially in comparison to claims for failure to perform a cesarean. It is worth noting, however, that the range of risks to long-term health for a woman undergoing cesarean and the number of women who end up with an unwanted cesarean suggest that this type of lawsuit could likely be replicated if there were lawyers willing to take on such clients. This should not be interpreted as a call for more litigiousness in the health care arena; rather, the point is simply to question what might happen to the cesarean rate if feminist and reproductive rights groups dedicated more of their resources to fighting cases where women’s constitutional rights are violated during labor and childbirth, rather than continuing to perpetuate an artificial disjunction between reproductive rights and birthing rights.⁸²

78. See BLOCK, *supra* note 7, at 88.

79. *Id.*

80. *Id.* (quoting Donald Chervenak, M.D., president of the St. Barnabas Medical Center’s obstetrics group practice).

81. Betsy A. Lehman, *Woman Wins \$1.53m Suit on Unwanted Cesarean*, BOSTON GLOBE, June 16, 1993, at 1.

82. See BLOCK, *supra* note 7, at 270 (considering “why mainstream American feminist groups have been slow to recognize the right to reproduce along with the right to be free from reproducing”); *id.* at 260 (“Groups say they’re about reproductive rights, but it’s really not about the full spectrum of reproductive rights; it’s all just about abortion,” quoting an activist who lobbied women’s health, reproductive rights, and feminist legal organizations to include VBAC on their agendas). See generally *id.* at 227, 267-71.

Some research has suggested that, regardless of media hype suggesting otherwise, the risk of malpractice claims does not alter the treatment choices of obstetricians, who face one of the highest rates of malpractice lawsuits among medical specialties.⁸³ But despite some conflicting views about the impact of malpractice on doctors' practices in the delivery room, there is less ambiguity about the extent to which the 1999 ACOG standard was "embedded in the politics of the medical malpractice insurance crises."⁸⁴ A 2003 assessment of existing research performed by HHS's Agency for Healthcare Research and Quality reported that the "crisis in malpractice rates is decreasing the availability of maternity care providers and raising concerns that patients may have limited options."⁸⁵ Popular reporting on the issue reinforces the idea that the "real death knell to VBACs was the malpractice crisis," with doctors and hospitals freely acknowledging that fear of lawsuits has driven their decisions to ban VBACs in response to the 1999 ACOG guidelines.⁸⁶

Other research suggests that there has been insufficient empirical study of the impact that legal arrangements have on the availability and occurrence of VBAC. The AHRQ assessment identified flaws in various studies looking at the influence of malpractice issues on VBAC or repeat cesareans, although the AHRQ did conclude that VBAC rates are higher in teaching hospitals, as compared to private, community, regional, or other non-teaching hospitals, which supports the conclusion of the South Dakota study.⁸⁷

This brief history of the availability and prevalence of both cesareans and VBACs suggests the choice of delivery methods is a rapidly evolving area. The "accepted wisdom" has changed enormously over short periods of time, subject to developments in science and medical technology, as well as shifting views about birth. Knowing that reliable scientific research is limited in this area suggests that restrictions on women's freedom to choose how to give birth rest on flimsy grounds. We should instead learn from earlier periods when new technology and best practices were incorporated into dominant thinking about birthing practices and maintain a continued openness to variation and choice in childbirth that meets the needs of different women.

83. See Beomsoo Kim, *Current Research on Medical Malpractice Liability: The Impact of Malpractice Risk on the Use of Obstetrics Procedures*, 36 J. LEGAL STUD. 79 (2007).

84. Myers, *supra* note 39, at 530.

85. J-M Guise, M. McDonagg & J. Hashima, *Vaginal Birth After Cesarean (VBAC)*, Evidence Report/Technology Assessment, No. 71, Agency for Healthcare Research and Quality, HHS, AHRQ Publication No. 03-E018, at 1 (March 2003) [hereinafter AHRQ Evidence Report].

86. Grady, *Trying to Avoid*, *supra* note 34 (quoting Dr. Lockwood).

87. AHRQ Evidence Report, *supra* note 85, at 4.

II. HARMS OF VBAC RESTRICTIONS

The negative impacts of VBAC restrictions can be loosely organized into two categories of harms: increased risk from unnecessary surgery and an undermining of women's autonomy. While these two categories are certainly related and at times are closely interwoven in their significance for women's lives, teasing out the dynamics of both sets of harms helps to expose the full implications of VBAC restrictions and understand why they should not be allowed to stand.

A. *Increased Risks from Unnecessary Surgery*

The fact that a cesarean is major surgery seems often to be glossed over in the context of birth. While it may be true that many women find the pain and discomfort resulting from a cesarean to be a small price to pay for the birth of their child, it does a disservice to women to minimize the intrusiveness of this form of abdominal surgery. Women who do not receive proper counseling about cesareans as major surgery may not fully understand the implications of surgical birth and be left feeling powerless and regretful that their birth experience was so heavily medicated by drugs. Women may also be less likely to seek assistance with the physical and emotional aftermath of a cesarean birth, influenced by the notion that cesareans avoid the worst hardships of labor and therefore that the postpartum difficulties they experience are problems with them individually and not the reasonable effects of a birthing process that involved major surgery. Even the language commonly used to refer to the procedure—often referred to as “cesarean section” instead of “cesarean surgery,” or among providers as “to section a woman”—obscures the similarity of cesareans to other major abdominal surgeries, for which we require a much more rigorous showing that the likely benefit outweighs potential harm. While cesarean birth is the right choice for some women, it is critical that advocacy of different birth methods reflects the idea that a cesarean is major surgery.

The significance of viewing cesareans as major surgery is particularly apparent in the context of VBAC restrictions, which often have the effect of compelling women to consent to surgery. Even where alternative locations exist within a reasonable distance where a woman could give birth by VBAC, the restrictions on VBAC at her hospital of choice may have the effect of coercing her into having surgery. All surgery entails a degree of risk, which must be considered with particular care when the proposed surgery is not medically required. According to ACOG, “cesarean delivery significantly increased a woman's risk of experiencing a pregnancy-related death (35.9 deaths per 100,000 deliveries with a live-birth outcome) compared to a woman who

delivered vaginally (9.2 deaths per 100,000).”⁸⁸ While other studies examined by the AHRQ found no difference in maternal death rates between a trial of labor and “elective” repeat cesarean (i.e. where the group of women studied all have had previous cesareans), they did report increased rates of infection overall in “elective” repeat cesarean versus trial of labor.⁸⁹ The Coalition for Improving Maternity Services (CIMS) reports that women have a five to seven times greater risk of death with cesareans than with vaginal birth.⁹⁰ Specific complications include surgical injury to the bladder, uterus, and blood vessels, as well as increased rates of infertility, miscarriage, and placenta previa, a condition where the placenta covers all or part of the opening to the cervix.⁹¹ One to two percent of all cesareans lead to infection, damage to other organs during surgery, or severe bleeding.⁹² One in ten women report difficulty with normal activities two months after a cesarean birth, and twice as many women need re-hospitalization as those who give birth vaginally.⁹³ The *Listening to Mothers* survey found that women who had cesareans were more likely than women who had vaginal deliveries to experience particular health concerns after birth, such as abdominal pain, bladder and bowel difficulties, headaches, and backaches.⁹⁴

An unnecessary cesarean may also pose additional risks to the fetus. Although the research is thin, studies report that one to two babies per 100 get cut during a cesarean birth.⁹⁵ Additionally, some research indicates that babies born by cesarean are 50% more likely to have low Apgar scores than babies delivered vaginally, are five times more likely to require assistance breathing, and are five times more likely to be admitted to intermediate or intensive care.⁹⁶ Research on labor and delivery suggests that amniotic fluid is squeezed from the baby’s lungs

88. Myers, *supra* note 39, at 527 (quoting International Cesarean Awareness Network, *ICAN Criticizes ACOG Statement on Ethical Cesareans* (Nov. 10, 2003)).

89. AHRQ Evidence Report, *supra* note 85, at 3.

90. Myers, *supra* note 39, at 532 n.31 (citing Coalition for Improving Maternity Services, *The Risks of Cesarean Delivery to Mother and Baby: ACIMS Fact Sheet*).

91. *Id.* at 532 n.32.

92. *See* Song, *supra* note 10.

93. Myers, *supra* note 39, at 532, nn.33-34 (citing M. Lyndon-Rochelle et al., *Association Between Method of Delivery and Maternal Re-hospitalization*, 283 J. AM. MED. ASS’N 2411-16 (2000)).

94. *Listening to Mothers I*, *supra* note 2, at 6.

95. Myers, *supra* note 39, at 533 n.37 (citing M.A. Van Harm et al, *Maternal Consequences of Cesarean section, A Retrospective Study of Intra-Operative and Postoperative Maternal Complications of Cesarean Section During a 10-Year Period*, EUR. J. OBSTETRICS & GYNECOLOGY REPROD. BIOLOGY 1-6 (1997)).

96. Myers, *supra* note 39, at 532, nn.33-34 (citing M. Lyndon-Rochelle et al., *Association Between Method of Delivery and Maternal Re-hospitalization*, 283 J. AM. MED. ASS’N 2411-16 (2000)).

during vaginal delivery, making breathing easier after birth.⁹⁷ Other studies have concluded that there is insufficient evidence to draw conclusions about the impact of cesarean surgeries on Apgar scores or respiratory issues.⁹⁸ There has also yet to be a study measuring infant death rates directly attributable to choice of delivery method.⁹⁹

B. Sacrificing Advances in Feminism and Patient Autonomy

VBAC restrictions also pose a serious harm to autonomy, the importance of which has been recognized in the medical context through the struggle of patients' rights advocates and women's health advocates, who have fought to have basic human dignity respected by a medical profession whose expert position and patriarchal roots have often resulted in a "we know best" attitude about the health and lives of women patients. Women who carry their pregnancies to term generally want what is best for the fetus and will accept medical treatment accordingly, but there are nevertheless a range of significant reasons why a woman may refuse treatment. The medical profession's potent combination of superior expertise and patriarchal bias can produce distrust of women's knowledge about their own bodies. This distrust is reflected in the way commentators discuss the reasons a woman might have for refusing to consent to a cesarean. Women are said to

base their decisions on religious beliefs, fear of stigmatization, fear of surgery, fear of dying, disbelief of the medical diagnosis, and their desire not to have the baby. Women may also refuse because of the undesirability of an abdominal scar, because of a pathological denial of pregnancy (especially teenagers), or because of depression or other mental disability.¹⁰⁰

Another writer explains that "some may refuse because of religious beliefs, eccentric preferences, idiosyncratic weightings of the values at issue, fear of surgery, or desire not to have the child."¹⁰¹ He also mentions feelings of guilt, concerns about interference with early bonding, medical complications, unappealing scars, the need for subsequent cesareans, and greater expense.¹⁰² What these descriptions

97. See D. Ashley Hill, M.D., *Issues and Procedures in Women's Health: Vaginal Birth After Cesarean (VBAC)* (Dec. 18, 2003), http://www.obgyn.net/women/articles/VBAC_dah.htm.

98. AHRQ Evidence Report, *supra* note 85, at 3.

99. *Id.*

100. Joel Jay Finer, *Toward Guidelines for Compelling Cesarean Surgery: Of Rights, Responsibility, and Decision Authenticity*, 76 MINN. L. REV. 239, 276 (1991).

101. John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 455 n.162 (1983).

102. *Id.* at 454.

have in common is that they are heavily fear-based or seemingly superficial. What they do not contemplate is that a woman has superior knowledge of her own body and that her desire for a vaginal delivery may have its roots in simply knowing what is best for her, along with other moral, ethical, or religious beliefs. They do not acknowledge the possibility that a woman who desires more children will suffer a much higher degree of risk during subsequent births and may abandon future childbearing plans. Furthermore, the lumping together of concerns about safety and reasons such as the undesirability of a scar diminishes legitimate exploration of the risks involved and implies that such concerns are not completely rational. There is certainly no room for the possibility that rather than representing disregard for the baby's well-being, the refusal of a cesarean might actually suggest "rejection of a demeaning vision of one's self and one's body and a claiming of one's right to human dignity, respect, and autonomy."¹⁰³

When pregnant women refuse treatment, the reasons are often very personal and may be hard for a third party to comprehend, which leads to judgment and suspicion of the woman. To distinguish a "good" reason for refusing treatment from a "bad" reason, or a "rational" choice from an "irrational" one, is a highly subjective endeavor¹⁰⁴—and one which often does not favor the woman who questions medical authority or dares to listen to her body over the advice of doctors. In her discussion of pregnancy limitations on living wills, Katherine Taylor identifies a "legal and cultural trend in which pregnant women are no longer trusted to obey the dictates of the age-old ideology of 'selfless motherhood.'"¹⁰⁵ Medical authority must be leveraged to reinforce the idea that a woman's obligation to her fetus trumps her interest in autonomy.¹⁰⁶ Paternalism provides the vehicle for communicating this "correct" set of priorities to a pregnant woman: "if you truly understood, you wouldn't insist on a VBAC—you're resisting the cesarean out of fear or a state of denial, and that's wrong." But paternalism is hard to contain once it is mobilized to justify intrusive action. In the birthing context, the risk of resulting harm to a women's autonomy and dignity is too great to succumb to a moral order that "subordinat[es women . . .] as both moral actors and citizens."¹⁰⁷

103. Ehrenreich, *supra* note 6, at 553.

104. Lawrence J. Nelson, Brian P. Buggy & Carol J. Weil, *Forced Medical Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest,"* 37 HASTINGS L.J. 703, 720 (1985); Ehrenreich, *supra* note 6, at 523.

105. Katherine A. Taylor, *Compelling Pregnancy at Death's Door*, 7 COLUM. J. GENDER & L. 85, 90 (1997).

106. *Id.* at 159.

107. *Id.* at 158.

It is a mistake to minimize the potential harms of VBAC restrictions under the theory that a woman's labor lasts several hours, or at most several days, whereas the baby she births will be with her for a lifetime. Such rationalization underestimates the extent to which the act of giving birth itself is a transformative event for many women, one which elicits emotions that a woman may not have experienced at any other point in her life.¹⁰⁸ Some women find that the heightened sensitivity they experience while giving birth makes them vulnerable to experiences that might not hold the same significance in another context.¹⁰⁹ These experiences may stay with a woman long after giving birth and have a transformative effect on her sense of self. In this sense, pregnancy restrictions may perpetuate a sense of alienation on the part of the woman giving birth. As one commentator observes, when women are "defined . . . by false interpretations of pregnancy with which they cannot identify, and which render their own interests virtually invisible, [they] may be psychically injured, experiencing a profound and harmful alienation from their community, from the state, and even from themselves."¹¹⁰ Framed differently, consider the experience of a pregnant woman whose doctor tried to convince her to consent to a cesarean by comparing her uterus to a "hydrogen bomb."¹¹¹ It is not hard to imagine that rather than pacify a woman's concerns about choosing a surgical delivery, such a statement could easily damage the trust a woman has in her doctor and strengthen her adherence to an understanding of her body and pregnancy that is an intimate, organic, positive part of her—rather than a dangerous weapon posing a deadly threat. Some researchers have begun to study "birth trauma," concluding that anywhere from 1.5% to 6% of women suffer from post-traumatic stress disorder resulting from their birthing experiences—with a strong correlation to high levels of medical intervention that leave women feeling powerless.¹¹² One nursing professor who has spent 20 years researching the psychological dimensions of childbirth writes about how many of the women she has studied analogize their birth trauma to rape,

108. See generally, e.g., MARSHALL H. KLAUS, JOHN H. KENNEL & PHYLLIS H. KLAUS, *THE DOULA BOOK: HOW A TRAINED LABOR COMPANION CAN HELP YOU HAVE A SHORTER, EASIER, AND HEALTHIER BIRTH* (2d. ed. 2002); PAM ENGLAND & ROB HOROWITZ, *BIRTHING FROM WITHIN: AN EXTRA-ORDINARY GUIDE TO CHILDBIRTH PREPARATION* (1998).

109. See, e.g., RACHEL GUREVICH, *THE DOULA ADVANTAGE* 10-15 (2003).

110. Taylor, *supra* note 105, at 156.

111. Lehman, *supra* note 81 (reporting on the legal case of a woman whose doctor reneged on his agreement to assist her VBAC too close to her due date for her to find another doctor willing to support her VBAC attempt).

112. See BLOCK, *supra* note 7, at 145 (citing Cheryl Tatano Beck, *Post-Traumatic Stress Disorder Due to Childbirth*, 53 *NURSING RESEARCH* 216, no. 4 (2004)).

describing how they felt physically violated and stripped of their dignity.¹¹³ Others have written about the sense of anger and alienation experienced upon learning about pregnancy restrictions on living wills, which essentially void the preferences of a pregnant woman and her family in favor of a fetus when confronted with difficult decisions about life-saving or life-prolonging treatment.¹¹⁴ The harm evoked here is intangible and indeterminate because it affects one's core sense of self—a notion that is resistant to being quantified—but this indeterminacy does not make it any less real. Ceding control of one's reproductive processes can be hugely disempowering and “deeply destructive.”¹¹⁵ A physician's use of coercion to enforce moral convictions about the optimal way for a woman to give birth—without using her knowledge of her own body to guide the decision-making—is rights-violative. Such use of force is disproportionate to the harm that might be caused by a lack of treatment, when the decision to decline a cesarean is a fully informed one.

Oftentimes in the debate about forced cesareans—or about compelling women to abide by any number of rules specifically because they are pregnant—arguments are framed in a way that leaves room for only one right answer. The question “Is the state prohibited from compelling surgery as the only means to save the life of a verge-of-birth fetus, given that such surgery is voluntarily entered into by nearly a million women per year, and involves little more than minimal risk of death or serious complication?”¹¹⁶ need not even be framed as a question because in assuming certain facts about women's experiences (and ignoring others), it provides the answer in the very same breath. Not only does it conflate all the reasons why women have cesareans and then rely on them without differentiation to diminish concerns about the risk involved, but it trivializes the fact that cesareans are major abdominal surgery, which individuals may have a number of legitimate reasons for wanting to avoid. The question also assumes that when a woman refuses a cesarean, she is necessarily pitting her interests against those of her fetus, without leaving any room for the strong possibility that her decision is based on personal knowledge of what is best for them both. Ignoring this possibility—and enshrining it in professional guidelines and hospital policies in a way that restricts a woman's ability to give

113. *Id.* (“Everyone was rejoicing, meanwhile I'm lying on the table thinking I'm being raped. Raped on the delivery table [with vagina having just been torn with forceps after only an hour of pushing], with everybody watching.”).

114. Taylor, *supra* note 85, at 157 n.233 (describing one woman's anger “that I, and even my family, didn't ‘count’ for anything if I happened to be pregnant”).

115. Ehrenreich, *supra* note 6, at 495 (citing ADRIENNE RICH, *OF WOMAN BORN* 176 (1976)).

116. Finer, *supra* note 100, at 264.

birth in the best way possible for her—strikes at the heart of a women’s right to respect for her autonomy.

It is important to notice that the language of autonomy and rights complicates our understanding of how VBAC restrictions infringe on the autonomy that is so deeply valued in our society. This particular trend in birthing practices is frequently referred to as a “VBAC ban,” suggesting a ban on a particular type of medical procedure. Not only must we ask whether referring to birth as a “procedure” contributes to excessively medicalized views of birth and perpetuates an image of childbirth where a woman is struggling against—rather than working with—her body, but we must also consider whether conceptualizing such policies as procedure bans makes it more difficult to articulate why they are rights-violative. In contrast, if we frame VBAC policies as restrictions on pregnant women who refuse to surrender their rights to medical decision-making when giving birth, it may be easier to understand the impact of a restrictive policy on an individual woman’s autonomy. The relevant question becomes: does a woman lose certain constitutional rights when she goes into labor and gives birth?—and the answer should be clear. Continuing to grapple with the nuances of how VBAC restrictions—and resistance to them—are framed is a critical component of challenging those restrictions and promoting an approach to childbirth that respects women’s autonomy.

III. CHALLENGING VBAC RESTRICTIONS

Restrictive VBAC policies diminish women’s autonomy by limiting their options for childbirth and by justifying such restriction on factors that mischaracterize or ignore certain critical aspects of their childbearing experiences. Specifically, VBAC restrictions deny women the opportunity to attempt a VBAC; in practice, a woman’s willingness to consent to cesarean without attempting a trial of labor may be what enables her to access physician care and hospital services. This constitutes an undue burden on women’s reproductive decision-making. U.S. Constitutional law recognizes the right to make decisions about establishing a family and controlling the upbringing of one’s children, as well as the right of a woman to make decisions about her reproductive life. Recent jurisprudence in the abortion-rights context has arguably whittled away the expansiveness with which one might otherwise interpret these rights,¹¹⁷ but the constitution nevertheless protects a woman’s right to privacy and procreative liberty. A lawsuit challenging a restrictive VBAC policy would have to target publicly-funded hospitals

117. See *Gonzales v. Carhart*, 550 U.S. 124, 164-65 (2007).

in order to satisfy the state action requirement.¹¹⁸ A strong challenge would include both a woman who was injured by a hospital's refusal to allow her to attempt a VBAC and a doctor who, although willing to assist women in VBAC births, is prevented from doing so by hospital policy. In addition to harming women, VBAC restrictions limit a doctor's ability to practice medicine according to professional ethical standards in a way that avoids harm; they also interfere impermissibly with the doctor-patient relationship. Although the doctor's role in such litigation is important, I will focus here on the arguments relevant to the woman's constitutional claim in an attempt to tease out the tensions inherent in the current doctrine on reproductive freedom.

A. *Constitutional Grounds*

The constitutional right to privacy is grounded in a series of cases interpreting the Fourteenth Amendment, although the earliest recognition of the right to bodily autonomy in U.S. case law is considered to be a late-nineteenth century tort case where the Supreme Court held that “[n]o right is held more sacred or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person. . . .”¹¹⁹ The Court first contemplated liberty in the context of family life in the 1920s, with decisions that defined liberty as including the right “to establish a home and bring up children”¹²⁰ and prohibiting state action that interferes with the rights of parents to “direct the upbringing and education of children under their control.”¹²¹ Although not directly on point, these cases contribute to an understanding of individual autonomy that includes a wide scope of freedom to shape one's own family life as one wishes. Just a few years later, Justice Brandeis articulated the right to privacy as “the right to be let alone—the most comprehensive of rights and the right most valued by civilized men.”¹²²

118. See, e.g., *Shelley v. Kraemer*, 334 U.S. 1, 13 (1948) (“[T]he principle has become firmly embedded in our constitutional law that the action inhibited by the first section of the Fourteenth Amendment is only such action as may fairly be said to be that of the States. That Amendment erects no shield against merely private conduct, however discriminatory or wrongful.”).

119. *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891).

120. *Meyer v. Nebraska*, 262 U.S. 390, 390 (1923).

121. *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925). But see *Roe v. Wade*, 410 U.S. 113, 170 (Stewart, J., concurring) (quoting *Abele v. Markle*, 351 F.Supp. 224, 227 (D. Conn. 1972)) (describing impact of pregnancy, birth and child-rearing on women as “of a far greater degree of significance and personal intimacy than the right[s] . . . protected in *Pierce* . . . or . . . *Meyer* . . .”).

122. *Olmstead v. United States*, 277 U.S. 438, 478 (Brandeis, J., dissenting) (1928).

Later cases deal more directly with procreative rights. In *Skinner v. Oklahoma*,¹²³ the Court struck down a statute that ordered compulsory sterilization as a criminal punishment, finding that the law “involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race.”¹²⁴ The Court further strengthened the right to procreate in two cases that struck down statutes regulating the use of birth control.¹²⁵ The Court was clear about the meaning of privacy in the realm of procreation: “[i]f the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”¹²⁶

VBAC restrictions put women who intend to have larger families at unnecessary risk by subjecting them to cesarean surgeries and thereby compounding the likelihood that they will experience complications during future pregnancies. For some women this increased risk will cause them to forego having more children, making the VBAC restriction an unconstitutional interference with the “decision whether to bear or beget a child.” Furthermore, such constitutional protection does not exist in a vacuum but rather includes within it the idea that access to the conditions that enable exercise of the right is itself also part of the constitutional guarantee. In *Carey v. Population Services Int’l*,¹²⁷ the Court struck down a New York statute prohibiting distribution of “nonmedical” contraceptives to persons over 16 years old except through a licensed pharmacist, finding the prohibition to violate the constitution “not because there is an independent fundamental ‘right of access to contraceptives,’ but because such access is essential to exercise of the constitutionally protected right of decision in matters of childbearing that is the underlying foundation of the holdings in *Griswold*, *Eisenstadt v. Baird*, and *Roe v. Wade*.”¹²⁸ Like the condom law at issue in *Carey*, hospital VBAC restrictions undermine access to the conditions necessary to exercise the “constitutionally protected right of decision in matters of childbearing”¹²⁹ that is well-established in constitutional jurisprudence.

The Court has also recognized that cases involving pregnancy contemplate a notion of privacy that differs from the privacy at issue in

123. *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942).

124. *Id.* at 541.

125. *See Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

126. *Eisenstadt*, 405 U.S. at 453.

127. *Carey v. Population Services Int’l*, 431 U.S. 678 (1977).

128. *Id.* at 688-89.

129. *Id.*

the contexts of marital intimacy, marriage, contraception, or education because the “pregnant woman cannot be isolated in her privacy.”¹³⁰ Thus, while a woman’s right to privacy means she has the right to make decisions about her reproductive life, the Court in *Roe v. Wade* recognized that—at least in the context of abortion—the state has an interest in the fetus that will justify certain restrictions on abortion.¹³¹ Although the Court’s abortion doctrine is certainly relevant to the birthing right context because it is essential to understanding the scope of reproductive freedom protected by the constitution, there is a distinction between restrictions on a woman’s ability to terminate a pregnancy—where there is no uncertainty that the outcome will be destruction of the fetus—and restrictions on a woman’s ability to give birth the way she wants to—where there is a much smaller possibility of harm to the fetus, and even less possibility of death. In the context of pregnancy, the state is not filling the same role as it does in the abortion context, where it serves as the last obstacle to termination of the pregnancy. At the very least, this distinction suggests that the state’s interest in protecting the fetus during pregnancy should not trump the woman’s interest in giving birth according to her physical, emotional, and spiritual needs, as she determines them for herself and for the fetus she carries.

In *Planned Parenthood v. Casey*¹³², the Court upheld *Roe*’s central premise that abortion is a fundamental right, but it adopted the “undue burden” standard for deciding when the “power of the State reach[es] into the heart of the liberty protected by the Due Process Clause.”¹³³ The Court explained that an undue burden is a restriction that “has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”¹³⁴ Most importantly for the purposes of a VBAC challenge, the Court held that a “statute with this purpose is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman’s free choice, not hinder it.”¹³⁵ Although the pregnancy and abortion contexts are not perfectly analogous, this suggests that the Court would

130. *Roe v. Wade*, 410 U.S. 113, 159 (1973) (“The pregnant woman cannot be isolated in her privacy. She carries an embryo and, later, a fetus. . . . [I]t is reasonable and appropriate for a State to decide that at some point in time another interest, that of health of the mother or that of potential human life, becomes significantly involved. The woman’s privacy is no longer sole and any right of privacy she possesses must be measured accordingly.”).

131. *Id.* at 162-65.

132. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992).

133. *Id.* at 874.

134. *Id.* at 877.

135. *Id.*

disapprove of restrictions aimed at promoting the state's interest in the fetus by directly undermining a woman's free choice in how to approach labor and delivery. Furthermore, in *Casey* the Court said that *Roe* has been properly understood also to protect a woman's decision to carry her pregnancy to term, not simply her right to terminate a pregnancy, as they both flow from protecting a woman's interest in deciding whether to bear and beget a child.¹³⁶

The Court has recognized the paramount importance of a woman's health starting with *Roe*,¹³⁷ and this concern has shaped much of the jurisprudence in this area. However, in the Court's most recent abortion decision, *Gonzales v. Carhart*,¹³⁸ the Court upheld a federal statute restricting abortion procedures despite the lack of a health exception. In doing so, the Court overruled its previous holding that where evidence was divided on whether restrictions on a particular method would endanger a woman's health (but there was evidence that danger to the woman existed), the statute must then have a health exception.¹³⁹ *Carhart* is a devastating decision for advocates of reproductive freedom because it not only whittles away at the guarantee of health exceptions for the woman, but it also contains highly paternalistic language about the health and interests of a pregnant woman seeking an abortion.¹⁴⁰ Justice Kennedy's opinion is noteworthy for the extent to which it disregards the role of scientific evidence in evaluating women's

136. *Id.* at 859 (citing, e.g., *Arnold v. Bd. of Educ. of Escambia County*, 880 F.2d 305, 311 (11th Cir. 1989) (relying upon *Roe* and concluding that government officials violate the Constitution by coercing a minor to have an abortion)).

137. *Roe*, 410 U.S. at 162-65 (finding the "State does have an important and legitimate interest in preserving and protecting the health of the pregnant woman . . ." and explaining that the government can go as far as prohibiting abortion after viability but only if the law makes an exception for abortion necessary to protect a woman's health or life).

138. *Gonzales v. Carhart*, 550 U.S. 124 (2007).

139. Compare *id.* at 164-65 ("The medical uncertainty over whether the Act's prohibition creates significant health risks provides a sufficient basis to conclude in this facial attack that the Act does not impose an undue burden."), with *Stenberg v. Carhart*, 530 U.S. 914, 937 (2000) (where evidence was divided on the safety implications of banning a particular method of abortion, as long as there was proof of danger to the woman's health the Court would require the statute to have a health exception because "division of medical opinion about the matter at most means uncertainty, a factor that signals the presence of risk, not its absence").

140. See, e.g., *Carhart*, 550 U.S. at 159-60 ("It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form."); see also *id.* at 184 (Ginsburg, J., dissenting) ("The solution the Court approves, then, is *not* to require doctors to inform women, accurately and adequately, of the different procedures and their attendant risks. . . . Instead, the Court deprives women of the right to make an autonomous choice, even at the expense of their safety.).

experiences with abortion and the burdens of abortion restrictions. His willingness to subordinate objective knowledge to subjective belief informed by religious and moral values has alarming implications in the context of birthing rights, where evidence-based practices supported by scientific research are critical to challenging the increasing medicalization of birth.¹⁴¹ One can argue that even under *Carhart* the core decision-making aspect of the right to abortion remains, as does the rule that the state may not restrict access to abortions that are “necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.”¹⁴² But it remains to be seen what impact *Carhart* will have on future abortion cases. Even so, the fact that a fetus is not recognized as a person under the constitution is clear,¹⁴³ which means that a woman’s constitutional status is superior to that of a fetus.¹⁴⁴ That said, any challenge in the near future would be heard by the same Court (or a similarly balanced one) that demonstrated a willingness to undermine *Roe* and *Casey* in the *Carhart* decision.¹⁴⁵

Although the reproductive choice cases have been decided under Fourteenth Amendment due process analysis, some commentators have called for a reinvigoration of the doctrine with a sex equality line of argument. Under this theory, the “social organization of reproduction . . . play[s] a key role in determining women’s status and welfare”¹⁴⁶ and “government may not entrench or aggravate these role differences by using law to restrict women’s bodily autonomy and life opportunities in virtue of their sexual or parenting relations in ways that government does not restrict men’s.”¹⁴⁷ Justice Ginsburg evokes this notion in her *Carhart* dissent when she affirms that challenges to restrictive laws “center on a woman’s autonomy to determine her life’s course, and thus to enjoy equal citizenship stature.”¹⁴⁸ Such logic also extends to the VBAC context, where women—unlike men—are specially burdened by restrictive hospital policies requiring them to submit to

141. See, e.g., *Carhart*, 550 U.S. at 159 (“While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice . . .”).

142. *Casey*, 505 U.S. at 879.

143. See *Roe*, 410 U.S. at 158 (holding that “the word ‘person,’ as used in the Fourteenth Amendment, does not include the unborn”).

144. See, e.g., Nelson, *supra* note 104, at 749.

145. See *Carhart*, 550 U.S. at 191 (Ginsburg, J., dissenting) (“Though today’s opinion does not go so far as to discard *Roe* or *Casey*, the Court, differently composed than it was when we last considered a restrictive abortion regulation, is hardly faithful to our earlier invocations of ‘the rule of law’ and the ‘principles of *stare decisis*.”).

146. Reva Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 815, 815 (2007).

147. *Id.* at 815-16.

148. *Carhart*, 550 U.S. at 172 (Ginsburg, J., dissenting).

medically unnecessary surgery or seek an alternative birthing location—either a hospital some distance away or a homebirth.

B. Policy Concerns

In addition to the constitutional arguments against restrictive VBAC policies, a number of strong policy concerns support the elimination of such policies in favor of a woman's choice to give birth in the manner most appropriate for her.

1. Future Pregnancy Risks

One important factor to emphasize in any challenge to VBAC restrictions is that cesareans increase the risk of complications during future births. When a cesarean is medically necessary, this heightened risk in future pregnancies is simply an unavoidable consequence. The trade-off between, on the one hand, the present need for medical intervention for her own safety or to ensure a healthy birth and, on the other, some unknown degree of risk during a hypothetical future pregnancy is—with some exceptions—a relatively uncomplicated decision for most women to make. But where the medical need for the cesarean is less absolute and VBAC would present a potential option for non-surgical birth, restricting a woman's ability to choose VBAC may put her at an unacceptably much higher risk in the future. Each cesarean increases the risk for the next pregnancy, and cesareans are generally not recommended for women who plan to have more than two children.¹⁴⁹ Studies suggest that at least 1% of women with a history of more than one cesarean will have an ectopic pregnancy, which is associated with hemorrhage.¹⁵⁰ A previous cesarean also increases the risk of placenta accreta—when the placenta attaches itself too deeply to the wall of the uterus—from one in 1,000 to one in 100.¹⁵¹ Placenta accreta almost always results in the need for a hysterectomy and the risk of massive hemorrhage; as many as one in eleven babies and one in fourteen women die as a result.¹⁵² Anecdotal accounts in the medical literature¹⁵³ suggest

149. See Song, *supra* note 10.

150. Myers, *supra* note 39, at 533 n.40 (citing E. Hemminki & J. Merilainen, *Long-Term Effects of Cesarean sections: Ectopic Pregnancies and Placental Problems*, AM. J. OBSTETRICS AND GYNECOLOGY 1569-74 (1996)).

151. *Id.* at 533 n.41 (citing H. Asakura & S.A. Myers, *More Than One Previous Cesarean Delivery: A Five-Year Experience with 435 Patients*, 85(b) OBSTETRICS & GYNECOLOGY 1569-74 (1996)).

152. *Id.* at 533 n.42 (citing J.M. O'Brien, *The Management of Placenta Percreta, Conservative and Operative Strategies*, 175(6) AM J. OBSTETRICS & GYNECOLOGY 924-29 (1995)).

that women recognize what physicians know—that “cesareans cast a long shadow over the rest of a woman’s reproductive life.”¹⁵⁴

2. Deterrence

Restrictive VBAC policies also raise the specter that women will be deterred altogether from giving birth in hospitals. Perceiving the hospital setting as hostile to their desire to attempt VBAC, some women will opt for homebirths or birthing centers that are not equipped to perform emergency cesarean surgeries. The media recently reported the story of a woman in Arizona whose local hospital has refused to support her VBAC, even though she successfully delivered her third son vaginally after the second was born by emergency cesarean—both at the very same local hospital—suggesting both that she is a good candidate for VBAC and that the hospital is equipped to perform emergency cesareans.¹⁵⁵ Unwilling to be coerced into an unnecessary cesarean, she will instead drive 300 miles to Phoenix the week before her due date to be closer to a hospital that will support her decision to deliver vaginally; her husband, who was present at all three previous births but must stay behind to care for their children and tend to the family business, is distraught by the likelihood that he will not make the five hour drive in time to attend the delivery.¹⁵⁶ When they met with the local hospital’s CEO, she threatened to get a court order if necessary to ensure that the pregnant woman delivered by cesarean surgery.¹⁵⁷ At the very least, even if restrictive VBAC policies do not drive women away from hospital health care completely, they run the risk of contributing to an adversarial relationship between the doctor and patient, if the woman resents her doctor for refusing to attend a VBAC or if the woman associates her doctor with the hospital’s policy banning VBACs. Good doctor-patient relationships are the cornerstone of a functioning health care system, and steps should be taken wherever possible to ensure that hospital policies do not unnecessarily burden that relationship. In cases involving court-ordered cesareans, surveillance is sometimes necessary to prevent mothers from fleeing the hospital before the forced cesarean takes place,

153. See, e.g., Rhoden, *supra* note 9, at 2024 & n.369 (citing Medical Humanities Report, Michigan State University, Winter 1984, at 1) (recounting the story of an African woman and her husband who refused a cesarean in the face of their doctor’s dissatisfaction with her failure to progress in labor, resisting cesarean on the grounds that it would place the woman at significant risk in future pregnancies because upon their return to Africa they would have much less access to medical support).

154. Myers, *supra* note 39, at 539.

155. Elizabeth Cohen, *Mom Won’t be Forced to Have C-Section*, CNN.com (Oct. 15, 2009), <http://www.cnn.com/2009/HEALTH/10/15/hospitals.ban.vbacs/index.html>.

156. *Id.*

157. *Id.*

transforming hospital staff into “obstetrics police.”¹⁵⁸ The high degree of coercion present in many such cases has staggering consequences for individual rights and perverse implications for increasing—rather than reducing—the risk to the fetus.¹⁵⁹ Dr. Flamm of UC Irvine, who has expressed concern about women turning to midwife-assisted homebirths after being denied the chance to try VBAC, has proposed that hospitals find solutions to minimize the risk of deterrence—for example, by adjusting their staffing schedules on the occasions when they have VBACs in labor.¹⁶⁰ Of course, this would not address the situation of rural and community hospitals that do not have the degree of

158. See Rhoden, *supra* note 9, at 2028.

159. See, for example, *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999) for the story of a woman in Florida that provides a particularly compelling example of how coercion in the birthing process can lead to conditions of greater risk for both the woman and fetus. When Laura Pemberton was unable to find an obstetrician who would attend her VBAC, she decided to deliver at home. A day into the labor, with no signs of complications, she was worried about becoming dehydrated, so she decided to go to the hospital to receive intravenous fluids before returning home. The obstetrician on call refused to give her the IV unless she consented to a cesarean; when Pemberton learned that the doctors intended to seek a court-ordered cesarean, she fled the hospital in her bare feet out the back steps of the hospital. She returned home was continuing to labor without complications, when the sheriff and State Attorney came to remove her from her home—strapping her legs together on a stretcher—to return to the hospital for a “hearing,” where she was unrepresented but a lawyer was appointed to represent the fetus. The judge ultimately ordered the cesarean, subjecting both the woman and fetus to the risk of surgery, even though the woman could feel the fetus progressing into her birth canal without complication. She later left the state and went on to deliver four more children vaginally, including a set of twins. See also Laura Pemberton, Address at National Advocates for Pregnant Women’s National Summit to Ensure the Health and Humanity of Pregnant and Birthing Women (Jan. 18-21, 2007) (audio recording on file with NAPW).

In a case currently pending before the Florida First District Court of Appeal, a woman is challenging a court order that required her to be confined indefinitely to Tallahassee Memorial Hospital, forcing her to undergo any and all medical treatments deemed necessary to save the fetus she was carrying. Samantha Burton had willingly checked into the hospital after experiencing pregnancy complications, but after her condition had stabilized and she expressed her readiness to leave, the hospital lawyers went to court for an order that denied Burton the right to end her treatment at the hospital, even denying her the right to transfer to a different hospital. Had the pregnancy gone to term, Burton—a mother of two—could have been confined against her will in the hospital for up to fifteen weeks. The order issued by the Circuit Court of Leon County was so broadly worded that even after an emergency cesarean revealed a stillbirth—rendering the ordered bed rest moot—Burton’s lawyer had to secure an order allowing Burton to be released legally from the hospital. Although the original circuit court order is moot, Burton is asking the Florida First District Court of Appeal to rule the lower court’s actions unconstitutional in order to prevent the state from securing such broad control over pregnant women who find themselves in similar situations in the future. See *Burton v. Florida*, No. ID09-1958 (Fla. 1st Dist. Ct. App. filed Apr. 23, 2009); Brief for American Civil Liberties Union, et al., as Amicus Curiae Supporting Appellant, *Burton v. Florida*, No. ID09-1958 (Fla. 1st Dist. Ct. App. filed July 31, 2009).

160. See Grady, *Trying to Avoid*, *supra* note 34.

specialization that would make reshuffling staff schedules a useful option, but it would represent a good-faith effort to try to prevent women from going elsewhere to deliver under conditions of greater risk.

3. Insurance

In June 2008, the *New York Times* ran a story about insurers refusing to offer individual coverage to women who have given birth by cesarean surgery.¹⁶¹ The justification for such discriminatory rejections—which individual insurers are allowed to make on any basis they wish, unlike insurers offering group coverage—was that a previous cesarean increased the risk that these women would give birth by cesarean again in the future, at greater expense to the insurance company.¹⁶² It is unclear exactly how many women have already been affected by such policies, but with 18 million people seeking individual health insurance and rising cesarean rates, this is an important factor to include when analyzing implications of restrictive VBAC policies. More cesareans lead to more cesareans and may put an increasing number of women at risk of being unable to secure health insurance. Some companies treat previous cesareans like other preexisting conditions. Other insurance providers will cover women with previous cesareans but only with increased premiums; for example, when Blue Cross Blue Shield of Florida recently began to cover women with previous cesareans, it charged a 25% increase in premiums for five years.¹⁶³ Furthermore, the fact that some insurers ask about any previous coverage denials and hold that against new applicants means that the consequences of a medically unnecessary cesarean may persist long into the future.¹⁶⁴

4. Equality Concerns

If the history of interventions into the reproductive lives of women provides any guide, there is reason to fear that VBAC restrictions might have a disproportionate effect on poor women, women of color, and non-English speaking women. The historical antecedents of modern coercive interventions during pregnancy include the forced sterilization of African American, Latina, and Native American women, which have been

161. Denise Grady, *After Cesareans, Some See Higher Insurance Cost*, N.Y. TIMES, June 1, 2008, available at <http://www.nytimes.com/2008/06/01/health/01insure.html>.

162. *Id.* (referring to one woman's rejection letter explaining that if she had been sterilized or were over 40 and had given birth more than two years earlier, she might have qualified for coverage).

163. *Id.*

164. *Id.*

documented in significant numbers through the 1970s.¹⁶⁵ More recently, women of color have been disproportionately subjected to forced cesareans and surveillance of their behavior during pregnancy, sometimes resulting in prosecution for the use of drugs or related offenses.¹⁶⁶ A 1987 study covering 45 states and Washington, D.C. found that 80% of women subjected to court-ordered cesareans were women of color (with African Americans accounting for 47% of the total number of cesareans); only 20% of court-ordered cesareans were performed on white women.¹⁶⁷ Of the women who were forced to have cesareans, 50% were unmarried and 27% spoke a language other than English as their primary language; all of the cesareans were performed in a teaching hospital or while the women were receiving public assistance.¹⁶⁸ Another study, published in the *New England Journal of Medicine*, found that African American women were ten times more likely to be screened and reported for substance abuse during pregnancy than white mothers, although drug use levels were comparable for the two groups.¹⁶⁹ A recent study of new mothers found that African American non-Hispanic women were the racial group most likely to have given birth by cesarean surgery.¹⁷⁰ Researchers believe that women of low socioeconomic status are affected disproportionately by the practice of defensive medicine, meaning the idea that physicians make deliberate changes in their practice of medicine solely in order to avoid liability.¹⁷¹ Although unsupported by data regarding litigiousness, physicians seem to be affected by a commonly-held belief that low-income patients are more litigious towards their doctors;¹⁷² where this leads to higher rates of cesarean surgery or other pregnancy interventions, low-income women may suffer higher probabilities of adverse outcomes.

165. See Ehrenreich, *supra* note 6, at 498, 515.

166. See, e.g., *id.* at 516; Jeanne Flavin, OUR BODIES, OUR CRIMES: THE CRIMINALIZATION OF WOMEN'S REPRODUCTION (2009); Lynn M. Paltrow, *Pregnant Drug Users, Fetal Persons, and the Threat to Roe v. Wade*, 62 ALB. L. REV. 999 (1999).

167. Ehrenreich, *supra* note 6, at 520-21 (citing Veronika E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1193 n.14 (1987)). Admittedly, these statistics are old, but there does not appear to be more current research in the area; there is also nothing to suggest that the underlying conclusions about the disproportionate impact of coercive pregnancy interventions on minority and disadvantaged women have changed in the last twenty years.

168. *Id.* (citing Kolder at 1193).

169. *Id.* at 520 (citing Ira J. Chasoff et al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202 (1990)).

170. *Listening to Mothers II*, *supra* note 58, Executive Summary at 8.

171. See Kim, *supra* note 83, at 98-99.

172. *Id.* at 99.

Nationwide statistics on pregnancy-related deaths are unavailable due to lack of consistency in record-keeping and categorization across different state health departments, but in cities and states that regularly analyze pregnancy-related deaths, the data suggest significant disparities across racial groups.¹⁷³ For example, in North Carolina from 1995 to 1999, 42 of every 100,000 black women died of pregnancy-related causes, while the rate for white women was 12 deaths per 100,000.¹⁷⁴ In Florida between 1999 and 2002, there were 12.2 pregnancy-related deaths per 100,000 white and Hispanic women and 38.1 per 100,000 black women.¹⁷⁵ Such racial disparities in pregnancy-related deaths have been reported in cities as different as New York City and Jackson, Mississippi.¹⁷⁶

With various studies concluding that there are differences in treatment of pregnant and birthing women of different racial and ethnic groups, there are a number of reasons to anticipate that women of color and otherwise disadvantaged women might suffer disproportionately under restrictive VBAC policies. First, the ability to advocate for an attempted VBAC requires a certain level of education about birthing methods. Women who cannot afford childbirth education classes or who are not otherwise exposed to the range of options may lack the basic information necessary to be able to advocate for the opportunity to try VBAC. Second, women of lower socioeconomic status or whose English skills are limited may feel disempowered to question medical professionals about the availability of alternative birthing methods and may feel reluctant to challenge medical authority. A long legacy of dismissive and sometimes downright repressive treatment of poor women and women of color by the medical establishment suggests that a woman's fear of suffering consequences as a result of challenging authority may have a legitimate basis.¹⁷⁷ A small study by Susan Irwin and Brigitte Jordan found that middle-class women resist cesarean

173. See BLOCK, *supra* note 7, at 120.

174. *Id.* (citing Cynthia J. Berg et al., Preventability of Pregnancy-Related Deaths: Results of a State-Wide Review, *Obstetrics & Gynecology* 106 (2005): 1228-34).

175. *Id.* (citing FLORIDA DEPT. OF HEALTH, PREGNANCY ASSOCIATED MORTALITY REVIEW REPORT 1999-2002 (Tallahassee, 2005)).

176. *Id.*

177. See, e.g., Ehrenreich, *supra* note 6, at 514-19 (detailing historical examples of how the medical profession has justified coercive behavior directed towards outsider women). See also Lisa C. Ikemoto, *Furthering the Inquiry: Race, Class, and Culture in the Forced Medical Treatment of Pregnant Women*, 59 *TENN. L. REV.* 487 (1992); Molly McNulty, *Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses*, 16 *N.Y.U. REV. L. & SOC. CHANGE*, 277 (1987-88); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 *HARV. L. REV.* 1419 (1991).

surgeries more successfully than low-income women.¹⁷⁸ Third, even when a woman is sufficiently empowered and able to identify alternatives to giving birth under a VBAC ban—such as traveling to another hospital facility where VBAC is an option—her actual ability to do this depends on having access to transportation and other resources to enable a partner or family member to accompany her at the birth. These barriers are even higher for poor women who live in rural areas with fewer hospital options in the first place. Fourth, immigrant and other minority women who come from cultural and religious backgrounds that favor large families or oppose the use of birth control may find that VBAC restrictions require them to choose between limiting their family size against their wishes or putting themselves at increased risk for complications in subsequent births. While this is not an exhaustive treatment of the ways in which poor women and women of color may be disproportionately harmed by VBAC restrictions, it does illustrate how critical it is to understand how members of minority groups may experience birthing policies differently from members of dominant social groups. Such experiences should be reflected in legal arguments or litigation strategies pursued, and the experiences of marginalized women must be included when efforts to mitigate the effects of restrictive policies are undertaken.

IV. COUNTERARGUMENTS

This section will address a number of counterarguments likely to arise in the course of challenging blanket VBAC restrictions. Many of the points raised to justify VBAC restrictions are based in patriarchal views of women held by members of the medical profession and by society at large. As such, the arguments are at times closely interrelated, and attempts to undermine one argument may also contribute to the chipping away of another argument relied upon to justify restrictions on pregnant and birthing women.

A. *Birth is Just Different*

Conversations about birth often focus on the idea that birth is exceptional. The vocabulary used to describe the experience of giving birth includes terms such as life-changing experience, transformative, profound, spiritual, powerful, and indescribable. While the process of giving birth may be all of those things and more, it is important to distinguish the ways in which birthing is unlike other bio-medical experiences and the ways in which it is simply a common physiological

178. See Ehrenreich, *supra* note 6, at 553 n.236.

process that may require medical care, governed by the same rules of informed consent, respect for human dignity and bodily integrity, and the ethical rules of the medical profession as any other medical intervention. The status of pregnancy has been characterized as unique for the purposes of federal equal protection doctrine, on the basis that there are no comparable categories for a relevant comparison of treatment. But a challenge to restrictive VBAC policies does not address the treatment of pregnant women in various social spheres but rather pertains only to the availability of a particular form of routine medical care, the denial of which unduly restricts women's ability to make decisions about their bodies and families. We must reject the idea that pregnancy is *sui generis* and that a different set of rules therefore apply.¹⁷⁹ Otherwise, the subordination of a woman's choice about delivery method to third-party judgments about what is best for her and for the fetus—judgments which lack sufficient grounding in scientific evidence—risk transforming women into “splendid Samaritans,” expected to accept greater restrictions on their liberty than society expects of other individuals.¹⁸⁰

B. Treating Two Patients

Advances in medical technology in the second half of the twentieth century dramatically increased the amount of information about individual fetal development available to physicians. Such technology allows for more precise identification of developmental difficulties and enables direct interventions in certain cases where fetal abnormalities can be corrected in utero. As a result, there has been a concomitant shift in how doctors treating pregnant women perceive their responsibilities to their patients. A 1980 edition of an obstetrical textbook proclaimed: “Happily, we have entered an era in which the fetus can be rightfully considered and treated as our second patient. . . . We are of the view that this is the most exciting of times to be an obstetrician. Who would have dreamed—even a few years ago—that we could serve the fetus as physician?”¹⁸¹ The National Institute of Child Health and Human Development has recognized the complicated ethical dimensions of this new era in pregnancy-related technology, observing that “[i]n the case of cesarean delivery there are almost always at least two patients involved—only one of which (the mother) may be able to speak for

179. See Nelson, *supra* note 104, at 719-20.

180. See Rhoden, *supra* note 9, at 1988.

181. See Finer, *supra* note 100, at 255 n.92 (quoting JACK A. PRITCHARD & PAUL C. MACDONALD, *WILLIAMS OBSTETRICS AT VII* (16th ed. 1980)).

herself.”¹⁸² If a doctor believes that she is serving the fetus as a patient separately from (and on par with) a pregnant woman patient, the chances multiply that the doctor will order interventions that are more invasive than the woman needs or wants. It is true that providing the best possible care for a pregnant patient, while trying to ensure the birth of a healthy baby, sometimes raises complicated questions about choices made in childbirth. But there is danger that medical advances allowing more involved monitoring and treatment of the fetus will lead to greater coercion of women in childbirth, with physicians acting as “fetal champions.”¹⁸³

This recalibration of the relationships between a pregnant woman, her doctor, and her fetus raises several concerns. First, and perhaps most fundamental, is the unconstitutional restriction on liberty a woman experiences when the interests of a fetus trump her right to make decisions about her body.¹⁸⁴ Furthermore, allowing technological advances to elevate the legal status of the fetus for the purposes of medical decision-making results in a situation where a pregnant woman’s constitutional rights “hinge[] on the status of medical science.”¹⁸⁵ Not only would allowing medicine to dictate law shake the foundations of our legal system, but the stability of core constitutional doctrines would be undermined because the law would be subject to change whenever new diagnostic achievements emerged. New medical technologies also have notable flaws and limitations,¹⁸⁶ which means there is a significant grey area where medical intervention might be productive but a physician would be unable to assess with any certainty whether a problem exists or whether the proposed course of treatment would address the problem. The tendency both to privilege medical authority and to downplay women’s inherent knowledge of their own bodies suggests that women would be at risk of losing their rights whenever they found themselves in one of these grey areas.

182. NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, PUB. NO. 82-2067, REPORT OF A CONSENSUS DEVELOPMENT CONFERENCE ON CESAREAN CHILDBIRTH 465 (1981).

183. See Kim, *supra* note 83, at 82.

184. See *supra* Part III.A.

185. See Taylor, *supra* note 105, at 90 n.13. See generally, e.g., George Annas, *Predicting the Future of Privacy in Pregnancy: How Medical Technology Affects the Legal Rights of Pregnant Women*, 13 NOVA L. REV. 329 (1989); BARBARA KATZ ROTHMAN, *RECREATING MOTHERHOOD: IDEOLOGY AND TECHNOLOGY IN A PATRIARCHAL SOCIETY* (1989); Lisa C. Ikemoto, *The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of the Law*, 53 OHIO ST. L.J. 1205, 1286-95 (1992).

186. See, e.g., Rhoden, *supra* note 9, at 2012-16 (describing the high rate of false positives in the use of electronic fetal monitoring).

The danger that medical advances in the realm of fetal monitoring and treatment can serve as a “powerful rationale for states to coerce women to be selfless mothers”¹⁸⁷ is not simply a hypothetical concern. The availability of such technology has helped to reify the idea of a fetus as an entity separate from the pregnant woman whose interests differ from—and may even be diametrically opposed to—the interests of the woman herself. The ideas have seeped into written commentary and analysis in this area, as the title of this law review article illustrates: “Maternal Abdominal Wall: A Fortress Against Fetal Health Care.”¹⁸⁸ Not only is it insulting and offensive to women to perpetuate an analogy between the nurturing work of pregnancy and constraining someone’s liberty by holding them prisoner, but this notion of an antagonistic relationship between a woman and the fetus she carries has been adopted by prosecutors who use child neglect and endangerment laws to police pregnant women—to the detriment of both women and their children.¹⁸⁹ This trend aligns with (and in some cases grows out of) efforts on the part of abortion opponents to strengthen the concept of fetal personhood as a strategy for rolling back abortion rights.¹⁹⁰

In reality, the clashing interests are much less likely to be woman and her fetus than they are to be woman and the state or woman and hospital, often acting as an extension of the state. When Angela Carder learned she had an inoperable lung tumor 25 weeks into her pregnancy, she and her family decided to do whatever was necessary to keep her alive.¹⁹¹ But hospital attorneys arranged for an emergency hearing before a judge, who ruled in favor of the fetus—represented by counsel—and ordered a cesarean surgery for Carder, who by that point was breathing on a respirator and refused to consent to the cesarean.¹⁹² The baby only lasted two hours, and Carder died two days later.¹⁹³ An

187. See Taylor, *supra* note 105, at 90 n.13.

188. Jeffrey P. Phelan, *The Maternal Abdominal Wall: A Fortress Against Fetal Health Care*, 65 S. CAL. L. REV. 461 (1991).

189. See, e.g., *In re Ruiz*, 500 N.E.2d 935, 939 (Ohio Com. Pl. 1986); *In re Baby X*, 293 N.W.2d 736 (Mich. App. 1980); *In re Smith*, 492 N.Y.S.2d 331 (Fam. Ct. 1985); *Johnson v. State*, 602 So.2d 1288 (Fla. 1992); *Reinesto v. Superior Court*, 894 P.2d 733 (Ariz. 1995); *State v. McKnight*, 576 S.E.2d 168 (S.C. 2003); *State v. Aiwohi*, 123 P.3d 1210 (Hawai’i 2005); *Kilmon v. Maryland*, 905 A.2d 306 (Md. 2006); *Ward v. State* 188 S.W.3d 874 (Tex. App.-Amarillo 2006). Although a number of these convictions were overturned on appeal, women are nevertheless harmed by having their behavior policed while they are pregnant. See also Nancy D. Campbell, *The Construction of Pregnant Drug-Using Women as Criminal Perpetrators*, 33 FORDHAM URB. L.J. 463, 474 (2006).

190. See, e.g., Electa Draper, *Personhood Amendment on Nov. Ballot*, DENVER POST Dec. 2, 2008, http://www.denverpost.com/ci_9416032; Personhood ‘08 Colorado, a Project of Colorado for Equal Rights, <http://www.coloradoforequalrights.com>.

191. See BLOCK, *supra* note 7, at 254-55.

192. *Id.*

193. *Id.*

instance of woman-hospital conflict is the story of Amber Marlowe, who had to travel to three separate hospitals while in labor before she found one willing to let her deliver vaginally after an ultrasound suggested that her baby was big.¹⁹⁴ The first hospital ignored her previous six successful vaginal deliveries of large babies and told her she should find somewhere else to give birth if she would not consent to cesarean surgery; the second hospital delivered the same message but told her not to leave, while in the meantime hospital attorneys petitioned a judge for custody of the fetus so the hospital could legally compel a cesarean.¹⁹⁵ She escaped to the third hospital in time to give birth vaginally without complications.¹⁹⁶ Such stories illustrate how rhetoric about supposed conflict between maternal and fetal interests may serve to obscure the true conflict between a woman and the state, whose power might be expressed by a judge, hospital, or individual doctors. We must not allow birthing options to become limited by VBAC restrictions in a way that reinforces the misguided notion that a pregnant woman and the fetus she carries are two completely separate patients with different interests. The risks to a woman's liberty are too great.

C. *Special Duties of Motherhood*

One argument in defense of VBAC restrictions is that parents have special duties towards their children and these duties extend to a pregnant woman in relation to the fetus she carries. Such logic elides the difference between a fetus and living child, a difference which is recognized in law,¹⁹⁷ even despite some concern for the rights of a fetus in tort, criminal, and property law.¹⁹⁸ Furthermore, it stretches the duty of one individual to rescue or help another person beyond the scope

194. *Id.* at 252.

195. *Id.*

196. *Id.*

197. *See, e.g.,* Keeler v. Superior Court, 470 P.2d 617 (Cal. 1970) (holding that viable fetus was not a "human being" for purposes of murder statute, though stillborn as result of assault upon mother).

198. *See, e.g.,* Bonbrest v. Kotz, 65 F. Supp. 138 (D.D.C. 1946) (providing recovery for tortious injury to viable fetus subsequently born alive); Smith v. Brennan, 157 A.2d 497 (1960) (recognizing right of live-born child to recover damages for injuries inflicted upon it prior to birth); I. W. BLACKSTONE, COMMENTARIES (noting that an "infant *in ventre sa mere*, or in the mother's womb, is supposed in law to be born for many purposes). On the treatment of fetuses under wrongful death statutes, see, for example, Dena M. Marks, *Person v. Potential: Judicial Struggles to Decide Claims Arising from the Death of an Embryo or Fetus and Michigan's Struggle to Settle the Question*, 37 AKRON L. REV. 41 (2004); Mamta K. Shah, *Inconsistencies in the Legal Status of an Unborn Child: Recognition of a Fetus as Potential Life*, 29 HOFSTRA L. REV. 931 (2001); Lori K. Mans, *Liability for the Death of a Fetus: Fetal Rights or Women's Rights?*, 15 U. FLA. J.L. & PUB. POL'Y 295 (2004).

recognized by the law. The common law places a high value on freedom from physical invasion or involuntary physical activity, including the freedom to refuse to subordinate one's own preferences and needs to another.¹⁹⁹ There is no duty to assist someone in distress and certainly no requirement that an individual risk life or limb to rescue another.²⁰⁰ The exceptions to this under the law of rescue are that one who injures another has a duty to render aid and that someone who begins a rescue must perform it with reasonable care and must not abandon the rescue if it will leave the person in a worse position than before, neither of which can be analogized to the cesarean context without stretching the relationship between a woman and the fetus she carries beyond recognition. Some special relationships, including that of a parent and child, do impose a duty to rescue, but even when a duty to rescue exists, there is no requirement that one risk life or limb to complete the rescue.²⁰¹ In the few states that have created a statutory duty, the rescue is required only if it poses no danger to the rescuer.²⁰²

Cases where medical treatment is mandated to save another are rare and generally fall within the rescue doctrine's principle that there is no legal duty to rescue others. In the leading case, *McFall v. Shimp*,²⁰³ the plaintiff sought to force his cousin to donate bone marrow. Initial testing had established that the cousin was the only compatible match, but he refused to undergo other testing—and the court refused to order the treatment, finding that to do so “would change every concept and principle upon which our society is founded.”²⁰⁴ There is also no mandatory organ donation, even among family members.²⁰⁵ When a thirty-three year old adoptee developed leukemia, he sought a court order to open his adoption records and locate a compatible bone marrow donor.²⁰⁶ The judge contacted the natural parents; the mother consented to be tested and was not a match, but the father was unwilling to be tested. The court's refusal to give the dying man his natural father's name supports the conclusion that courts are reluctant to force even a

199. Nelson, *supra* note 104, at 753-54.

200. See RESTATEMENT (SECOND) OF TORTS, §§ 315-19.

201. *Id.* See also, e.g., *State v. Walden*, 293 S.E.2d 780, 786 (N.C. 1982) (finding parental duty to rescue child in peril but no legal duty of parents to place themselves in danger of death or great bodily harm in coming to the aid of their children).

202. See MINN. STAT. ANN. § 604A.01.01 (2001); VT. STAT. ANN. tit. 12 § 519(a) (1967).

203. *McFall v. Shrimp*, 10 Pa. D. & C.3d 90 (1978).

204. *Id.*

205. See Rhoden, *supra* note 9, at 1978 (discussing judicial treatment of organ donation among family members).

206. *In re George*, 630 S.W.2d 614 (Mo. Ct. App. 1982).

parent to participate in an organ transplant to save his child's life.²⁰⁷ Compelled cesareans present a somewhat different scenario because of the relationship of biological dependency between a woman and the fetus she carries. But the legal conclusion that one person cannot be forced to undergo medical treatment for the sake of another should hold just the same—and actually carry even more strength because a fetus is not a person under the law.

Defenders of court-ordered cesareans argue that a pregnant woman has the obligation to rescue her fetus by submitting to surgery because she is responsible for creating it and has accepted that responsibility by choosing to carry the pregnancy to term.²⁰⁸ Despite the visceral appeal of a moral universe where people take seriously their responsibilities to others, there are several problems with this argument, and with applying the duty to rescue to pregnant women. First of all, it would be wholly unreasonably to impute any such quasi-contractual obligation to women in the absence of full abortion access, regardless of geographical location, age, or ability to pay. Limited abortion access for some women means that the decision to carry to term may not be made freely—or may not constitute a choice at all. Second, the power to protect a fetus in utero should not be stronger than the power to protect living individuals. To require a woman to rescue her fetus by submitting to surgery would radically restructure the duty to rescue: compulsory surgery far exceeds the duties imposed on other rescuers.²⁰⁹ Finally, legal duties are different from moral obligations, and this is a particularly important distinction to maintain in the birthing context, where it is relatively easy for a physician to impose his moral judgment on a patient by disguising it as medical advice. The law of rescue has exceptions that may fall within the realm of morally reprehensible, but that does not make them legally actionable.

D. Doctor Knows Best

The increasing medicalization of pregnancy over time has resulted in greater physician control over the birthing process. As medical

207. *Id.* But see *Hart v. Brown*, 289 A.2d 386 (Conn. Super. Ct. 1972); *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. Ct. App. 1969) (authorizing transplant of kidney from incompetent child to sibling in order to save sibling's life, using a substituted judgment test to assess what the incompetent person would have wanted to do). *Contra* *Lausier v. Pescinski*, 226 N.W.2d 180, 182 (Wis. 1975) (declining to follow *Strunk* and holding that court lacked power to permit removal of kidney from incompetent child to save brother's life, even if risk posed was slight).

208. See, e.g., *Finer*, *supra* note 100, at 259.

209. See, e.g., *Rhoden*, *supra* note 9, at 1980 (illustrating this point with an analogy to a person starting to rescue child in burning building who then realizes fire is worse than thought and isn't required to still go in).

anthropologist Emily Martin has observed, the “technological oversight of birth in our culture [is] a process of production, where the physician, not the woman, is clearly in control.”²¹⁰ The medical model of pregnancy and children repackages female reproductive processes as pathological conditions,²¹¹ with childbirth “seen as a dangerous, pathological, and unpredictable medical event.”²¹² While there is undoubtedly value in being able to rely on a medical professional for reassurance and expertise during the process of giving birth, an increase in physician control of birth reduces a woman’s power to control and shape the process. The women’s health movement has challenged this shift in power, with groups such as the National Women’s Health Network, the Boston Women’s Health Book Collective, and the National Black Women’s Health Project working to “expose the contingency of the medical model of birthing and . . . set the stage for a reinterpretation of the refusal of medical advice as resistance to prevailing forms of social power.”²¹³ But the perceived legitimacy of medicine is a powerful disabling mechanism that keeps doctors, hospital staff, and judges from being able to conceive of alternative explanations for why women might refuse cesareans.²¹⁴ However, a close look at the scientific literature on VBAC and repeat “elective” cesareans suggests the need to interrogate further the sources of this perceived legitimacy. Existing research reveals a striking lack of consensus about the risks and benefits of different birthing methods—all of which cautions even more strongly against subverting a woman’s autonomy in birth with the force of presumed medical authority.

One study that seems to have impacted attitudes towards VBAC is the *New England Journal of Medicine* study discussed in Part I. The study confirmed previous findings that the risk of uterine rupture during a planned VBAC trial of labor is 0.5 to 1.0%, that induction without prostaglandins may cause a slightly higher rupture rate, and that “elective” repeat cesareans pose a lower risk of causing uterine rupture but do not eliminate all risk.²¹⁵ The study also found that the use of

210. Taylor, *supra* note 105, at 151 (quoting EMILY MARTIN, *THE WOMAN IN THE BODY: A CULTURAL ANALYSIS OF REPRODUCTION* (1987)).

211. See Ehrenreich, *supra* note 6, at 535 & n.169 (discussing EMILY MARTIN, *THE WOMAN IN THE BODY* (1992); BARBARA K. ROTHMAN, *IN LABOR: WOMAN AND POWER IN THE BIRTHPLACE* (1991)).

212. *Id.* at 536.

213. *Id.* at 538-39. See generally National Women’s Health Network, <http://www.womenshealthnetwork.org>; Boston Women’s Health Book Collective, <http://www.ourbodiesourselves.org>; National Black Women’s Health Project, <http://www.blackwomenshealth.org>.

214. See Ehrenreich, *supra* note 6, at 530.

215. Lydon-Rochelle, *supra* note 43.

prostaglandins during induction increased the risk of uterine rupture to 2.5%, but it did not provide sufficient information about the administration of the prostaglandins to conclude that their use in VBAC is dangerous.²¹⁶ Unfortunately, the NEJM study's reliance on birth certificates and discharge data—without closer examination of medical records or a determination of the prevalence of coding errors²¹⁷—limits its reliability. In a similar vein, a broader literature review undertaken by the Agency for Healthcare Research and Quality (AHRQ) concluded that the medical literature concerning VBAC is flawed.²¹⁸ Specifically, the AHRQ identified an imprecise measurement of outcomes, lack of standards for terminology, and limited attention to comparability between groups as major limitations of the research on the risks and benefits of VBAC.²¹⁹ There is no direct evidence about the benefits and potential harms of cesarean surgery compared with attempting a trial of labor in women who are comparable for research purposes.²²⁰ There is no ambiguity in the AHRQ's assessment that the

deficiencies in the literature about the relative benefits and harms of [trial of labor] versus [elective repeat cesarean delivery] are striking. Patients, clinicians, insurers, and policymakers do not have the data they need to make truly informed decisions about appropriate delivery choices following one of the most common surgical procedures performed on women.²²¹

Physician attitudes about the risks of cesarean surgery reveal significant disagreement about the wisdom of elective cesareans. A 2004 Gallup poll of female obstetricians found that 36% report being unwilling to perform a cesarean if not medically necessary, 32% would perform such cesareans, and 28% say it depends on the circumstances.²²² While this polling did not ask about the choice between VBAC and cesarean, the results do suggest notable variation in assessments about the wisdom of performing medically unnecessary cesareans.

The relative uncertainty surrounding a range of birthing methods and interventions is compounded by the maximin decision strategy in American obstetrics.²²³ The maximin strategy focuses on the worst possible outcome in a situation of uncertainty and takes measures

216. See Flamm, *supra* note 46, at 277.

217. *Id.* at 276-77.

218. AHRQ Evidence Report, *supra* note 85, at vi.

219. *Id.*

220. *Id.* at 3.

221. *Id.* at vi.

222. See Song, *supra* note 10.

223. See Rhoden, *supra* note 9, at 2017 (citing Brody & Thompson, *The Maximin Strategy in Modern Obstetrics*, 12 J. FAM. PRAC. 977 (1981)).

necessary to prevent that outcome, regardless of its probability; in health care management, it is considered a “pessimistic strategy.”²²⁴ One example of this theory in practice is the routine use of electronic fetal monitoring in low-risk pregnancies, despite documented inaccuracies in predicting fetal distress and a high rate of false positives.²²⁵ The maximin approach also encourages an approach to cesareans referred to casually as “when it doubt, cut it out.”²²⁶ Such invasive prenatal and during-birth interventions may do as much—or more—harm than good.²²⁷ Given that medical wisdom on the risks of various birthing methods is still evolving, the best guiding principle for decisions where reasonable scientific certainty is lacking should be the woman herself—and her needs and wishes as she expresses them. The alternative birth movement has recognized the value of facilitating births where women drive the process; in doing so, it promotes the idea of pregnancy as a “creative and purposive human activity,”²²⁸ rather than a situation in need of medical intervention in order to be cured. Yet the medical profession has increasingly sought to limit midwives²²⁹ and homebirth proponents²³⁰ from spreading their alternative perspectives on birthing. As a result, the “unquestioned legitimacy of modern medicine operates . . . to obscure a conflict between the pathologizing view of women and reproduction that contemporary physicians hold and a competing vision of birthing that the alternative birth movement has articulated.”²³¹ The prevailing wisdom that doctors are best positioned to control the birthing process, and that more medical intervention makes

224. YASAR A. OZCAN, *QUANTITATIVE METHODS IN HEALTH CARE MANAGEMENT: TECHNIQUES AND APPLICATIONS* 52 (2005).

225. See Rhoden, *supra* note 9, at 2012-16.

226. See *id.* at 2022; Kim, *supra* note 83, at 82.

227. See Rhoden, *supra* note 9, at 2028. See also ICAN Fact Sheet, “Induction of Labor,” (discussing how medical interventions into childbirth frequently lead to further interventions), <http://ican-online.org/print/551>.

228. Taylor, *supra* note 105, at 154 n.226 (discussing descriptions of pregnancy in Hilda Lindemann Nelson, *The Architect and the Bee: Some Reflections on Postmortem Pregnancy*, 8 *BIOETHICS* 247 (1994)).

229. See, e.g., Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 *CARDOZO WOMEN’S L.J.* 61 (2004); Sara K. Hayden, *The Business of Birth: Obstacles Facing Low-Income Women in Choosing Midwifery Care After the Licensed Midwifery Practice Act of 1993*, 19 *BERKELEY WOMEN’S L.J.* 257 (2004); Michael A. Pike, *Restriction of Parental Rights to Home Births Via State Regulation of Traditional Midwifery*, 36 *BRANDEIS J. FAM. L.* 609 (1997).

230. See American Medical Association, Resolution 205 (A-08), “Home Deliveries,” (Apr. 28, 2008) (calling for legislation to ban home births without offering any science-based information supporting the initiative); Luretha Senyo-Mensah, *Criminalizing Home Births in Georgia*, *COLLECTIVE VOICES*, Vol. 2(8), at 21, available at http://www.sistersong.net/documents/Collective_Voices_Vol2_Issue8.pdf.

231. Ehrenreich, *supra* note 6, at 505.

for a safer birth, must be refuted with an accurate (re)telling of the facts—one that provides an accurate sense of how incomplete the data really are.

V. CONCLUSION

Since ACOG issued its 1999 VBAC guidelines, the birthing landscape in the United States has changed dramatically. Over 800 hospitals (and an unknown number of providers) have instituted new restrictions on the ability of women to attempt to deliver vaginally after previously having given birth by cesarean.²³² These policies represent an alarming contraction in the choices available to women when giving birth. And the introduction of such restrictions has had a powerful effect on birthing practices in the United States, with VBAC rates plummeting from 23.4% in 1999 to just 10.6% in 2003.²³³ Many women, particularly those in rural areas or those who lack the resources to travel to an alternative VBAC-permissive hospital, now face a decision between consenting to a repeat cesarean surgery—with all the risks that repeat cesareans entail—or giving birth in a birthing center or at home, where it would be even more difficult to secure medical intervention should complications arise. VBAC restrictions pose an impermissible threat to women's constitutional rights under the Fourteenth Amendment and should be challenged as such.

The underlying rationale for restrictive VBAC policies—and for a number of medical interventions into the birthing process—is based on remarkably thin empirical evidence. Available data about the risks and benefits of VBAC, as well as of repeat “elective” cesarean surgery, are incomplete and provide an insufficient basis for the kind of wholesale restriction on choice in childbirth that VBAC bans contemplate. Where there are usable findings about VBACs and the risk of uterine rupture—as in the *New England Journal of Medicine* study's data about the use of prostaglandins during induction²³⁴—there is not enough known information to conclude that particular practices are dangerous. This uncertainty in the data should make us more vigilant about preventing physicians' subjective judgments—masquerading as professional

232. See International Cesarean Awareness Network, “Your Right to Refuse: What to do if Your Hospital has ‘Banned’ VBAC Q&A,” <http://ican-online.org/vbac/your-right-refuse-what-do-if-your-hospital-has-banned-vbac-q> (last visited Nov. 25, 2009) (reporting ICAN's survey results which reveal that over 800 hospitals across the United States have instituted VBAC restrictive policies).

233. See *supra* Part I.B.

234. See Lydon-Rochelle, *supra* note 43.

expertise—from eroding women’s autonomy and dignity in birth. Anything else “would . . . leave us far poorer as human beings.”²³⁵

The potential for further whittling away of women’s birthing choices demands immediate attention to the issue of VBAC restrictions and the development of a strategy for education and advocacy that will restore and expand women’s rights in childbirth. This need is even more compelling in the face of other restrictions imposed on pregnant and birthing women—from the arrest and civil confinement of drug-using women to the shackling of female prisoners while giving birth to court-ordered cesareans, as well as other formal and informal means of controlling pregnant women’s behavior. Restrictive VBAC policies that compel women to undergo surgery—or else opt for a less safe or less accessible location for giving birth—create space to justify other measures that control women’s behavior during pregnancy in the interests of fetal welfare.

At least one commentator has called for advocacy groups to direct resources towards litigation, as advocates have thus far been ineffective at slowing the steady increase in cesarean rates.²³⁶ But litigation alone will not solve the problem. The complexity of the issues that have led to the adoption of restrictive VBAC policies, combined with society’s largely uncritical acceptance of the medical establishment’s authority, suggest that advocates would be wise to supplement any potential litigation with public education strategies.²³⁷ The protection of rights is essential, but in the market for health care services, consumer awareness is another critical key to preserving choice and should be considered a component of a successful litigation strategy. Advocates would be wise to exercise caution until the composition of the U.S. Supreme Court has shifted, or at least until we know more about how *Carhart* will be interpreted in a broader reproductive freedom context. In the meantime, there is a plenty of work to do gathering information about the impact of restrictive VBAC policies and other restrictions on pregnant women and strengthening the reproductive justice framework in a way that situates freedom in pregnancy and childbirth alongside other forms of reproductive and sexual freedom. As George Annas, a Boston University Professor of Health Law, Bioethics and Human Rights, has observed, “The choice between fetal health and maternal liberty is laced with moral and ethical dilemmas. The force of law will not make them

235. Nelson, *supra* note 104, at 763.

236. Myers, *supra* note 39, at 530-31 (arguing for antitrust litigation to challenge the impact of ACOG’s VBAC guidelines on the health care market).

237. See, e.g., *Guide to a Healthy Birth, 2008-09 Edition*, Choices in Childbirth, available at http://www.choicesinchildbirth.org/birthguide/HealthyBirth_4b.pdf.

go away.”²³⁸ But law can help us protect and empower women whose choices about how to give birth are overruled by the medical profession. Law provides the guiding principles of liberty and autonomy that enable us to create space for women to pursue the birth experiences that honor and respect their humanity as mothers, as women, and as citizens.

238. George J. Annas, Forced Cesareans: The Most Unkindest Cut of All, *The Hastings Center Report*, 16, 45 (June 1982).