

WHEN THE INVISIBLE HAND WIELDS A SCALPEL: MATERNITY CARE IN THE MARKET ECONOMY

Farah Diaz-Tello[†]

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[†] JD, City University of New York School of Law, BA University of Texas at Austin. Farah Diaz-Tello is a Senior Staff Attorney at National Advocates for Pregnant Women (NAPW), a non-profit organization dedicated to protecting the rights, health, and dignity of pregnant and parenting women. Her work at NAPW has focused on safeguarding human rights to dignity and freedom from violence and coercion in birth. This article reflects her own opinion and not that of the organization. The author wishes to thank her colleagues at NAPW for their support and relentless quest for justice, Rebecca Spence and Jill Arnold for their friendship and contributions to her thinking, and her family for their patience and sacrifice.

A 2006 Comment in *The Lancet* exposed a “fundamental but unrecognized flaw in current thinking about cesarean delivery.”¹ According to the authors:

*Modern obstetrics teaching dictates that a caesarean delivery is either medically indicated or not—i.e., elective or on demand. [A] grey area exists that has a larger effect on modern-day obstetrics than most people think.*²

The critique was aimed at dichotomous thinking about the medical necessity of cesarean surgery, but the same flaw could be said to apply to the understanding of consent to surgery. Surgeries are assumed to be either consented or unconsented; indeed there exists a significant body of medical, bioethical, and legal scholarship on the issue of unconsented, court-ordered cesarean surgeries.³ But examining consent to cesarean surgery and the choice of method of delivery through the lens of reproductive justice⁴ complicates the picture.

“Choice” and “consent” are concepts that often defy binary thinking. Just as reproductive justice advocates point out that “choice” in the context of abortion lacks resonance for many communities because it implies a range of options that do not exist,⁵ “consent” crumbles where external factors, many driven by financial concerns, limit the options available to people giving birth.

Constitutional jurisprudence and common law recognize the fundamental right of all people of sound mind to decide what hap-

¹ Robin B. Kalish et al., *Decision-Making About Cesarean Delivery*, 367 LANCET 883, 883 (2006), available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(06\)68359-1/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)68359-1/abstract), archived at <http://perma.cc/4BUJ-J3U8>.

² *Id.*

³ See, e.g., Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951 (1986); Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L. J. 9 (1987).

⁴ The term “reproductive justice” was coined by women of color in 1994 to describe a holistic model for understanding reproductive autonomy, taking into account the many factors (individual, familial, cultural, societal, economic) that play a role in whether, when, and how a person births a child, becomes a parent, and cares for their family. See *What is RJ?*, SISTERSONG WOMEN OF COLOR REPROD. JUSTICE COLLECTIVE, http://sistersong.net/index.php?option=com_content&view=article&id=141 (last visited Aug. 28, 2015). This is distinguished from *reproductive rights*, which primarily concern the laws that control access to abortion and contraception, and *reproductive health*, which primarily concerns the provision of such services. See FORWARD TOGETHER, A NEW VISION FOR ADVANCING OUR MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS AND REPRODUCTIVE JUSTICE 2 (2005), <http://forwardtogether.org/assets/docs/ACRJ-A-New-Vision.pdf>, archived at <http://perma.cc/JQX9-PQKC>.

⁵ See, e.g., Andrea Smith, *Beyond Pro-Choice Versus Pro-Life: Women of Color and Reproductive Justice*, 17 NWSA J. 119 (2005); Zakiya Luna & Kristin Luker, *Reproductive Justice*, 9 ANN. REV. LAW SOC. SCI. 327 (2013).

pens to their bodies.⁶ With this comes a virtually sacrosanct right to refuse medical intervention, whether or not that decision is medically reasonable.⁷ In theory, the right to avoid cesarean surgery is a “negative”⁸ right—the right to demand that medical personnel abstain from performing surgery and permit labor to proceed on its own. Pregnancy does not abridge the Constitutional and common law right to refuse medical procedures;⁹ the right, therefore, applies equally to a person in labor. In reality, however, the enjoyment of this right is impeded by a number of economic, institutional, and even political factors.

Over the course of the past century, childbirth has been medicalized to the point where vaginal delivery, the physiological process by which a fetus is expelled from the body, is now treated as a “procedure” that facilities may decide to offer . . . or not.¹⁰ Medicalization transforms a fundamental right—the right to forego an invasive surgery—into a request that a medical facility can grant or deny. And while the denial of the right to decline cesarean surgery is sometimes accomplished through the use of legal or physical force, pregnant people who do not have the means to travel long distances in labor, or who live in places where their only option for an out-of-hospital birth is an unassisted home delivery, face a form of passive coercion that works as surely. The use of the iron fist of the law is rare when health care providers find that the invisible hand works just as well.

As this article will demonstrate, economic and even political

⁶ See, e.g., *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 289 (1990) (O’Connor, J., concurring) (“[T]he liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual’s deeply personal decision to reject medical treatment”); *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891) (“No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”); see also *Schloendorff v. Soc’y of N.Y. Hosp.*, 211 N.Y. 125, 129-30 (1914) (“Every human being of adult years and sound mind has a right to determine what shall be done with [their] own body.”).

⁷ Nancy K. Rhoden, *Cesareans and Samaritans*, 15 L. MED. & HEALTH CARE 118, 122 (1987) (“[T]he whole point of the informed consent doctrine [is that] people should be able to make their own decisions about surgery, even if their choices are idiosyncratic or even harmful.”).

⁸ See, e.g., Rebecca A. Spence, *Abandoning Women to Their Rights: What Happens When Feminist Jurisprudence Ignores Birthing Rights*, 19 CARDOZO J.L. & GENDER 75, 81 (2012).

⁹ See *In re A.C.*, 573 A.2d 1235, 1252 (D.C. Ct. App. 1990) (holding that the medical decision of a pregnant patient will control in “virtually all cases”).

¹⁰ JENNIFER BLOCK, PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE 257-62 (2008).

considerations can impede the exercise of the right to refuse unwanted surgery. It will provide an overview of the U.S. maternity system, the surge in the cesarean rate, and the fluctuating status of vaginal births after cesarean delivery at hospitals across the country. It will examine some of the forces that converge to make it difficult or impossible to avoid surgery, including the commodification of healthcare, inequities in the healthcare market, and a proliferation of claims of fetal rights used to vindicate malpractice concerns. These forces lead to hospital closures and refusals of care, economic threats by providers, and even threats of unconsented care intended to drive away prospective patients.

I. DEEPLY SIGNIFICANT, HIGHLY CONTESTED: INTRODUCTION TO BIRTH IN THE UNITED STATES

Birth occupies a unique position in culture and medicine. It is a rite of passage of personal and societal significance,¹¹ accompanying the addition of a new family member or the loss of an anticipated child. It is a common and normal physiological process, experienced by approximately 85% of women.¹² At the same time, it is fraught with the potential for danger: any birth can quickly go from routine to pathological, and birth has been the leading cause of death of women of childbearing years until relatively recently in human history. The landscape of birth is not only colored by the medicalization of childbirth¹³ and constantly shifting medical recommendations;¹⁴ it is affected by structural factors such as racism,

¹¹ See ROBBIE DAVIS FLOYD, *BIRTH AS AN AMERICAN RITE OF PASSAGE* (2d ed. 2004).

¹² U.S. DEP'T OF HEALTH AND HUMAN SERV., CTRS. FOR DISEASE CONTROL & PREVENTION, *Recommendations to Improve Preconception Health and Health Care – United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care*, 55 MORBIDITY & MORTALITY WEEKLY REPORT, no. RR-6, Apr. 21, 2006, at 1, 2, available at <http://www.cdc.gov/mmwr/PDF/rr/rr5506.pdf>, archived at <http://perma.cc/8FDW-R593>.

¹³ See, e.g., TINA CASSIDY, *BIRTH: THE SURPRISING HISTORY OF HOW WE ARE BORN* 131-160 (reprint ed. 2006) (describing the advent of a male dominated practice of obstetrics that supplanted female midwives, and the move from home to “lying in” hospitals and maternity wards); RANDI HUTTER EPSTEIN, *GET ME OUT: A HISTORY OF CHILDBIRTH FROM THE GARDEN OF EDEN TO THE SPERM BANK* (reprint ed. 2010).

¹⁴ For instance, recommendations on induction of labor prior to thirty-nine weeks gestation changed in 2009 in response to evidence-based research and activism by public health advocacy organizations. See Am. Coll. Obstetricians & Gynecologists, *ACOG Practice Bulletin No. 107: Induction of Labor*, 114 OBSTETRICS & GYNECOLOGY, no. 2, Aug. 2009; *Don't Rush Your Baby's Birth Day*, MARCH OF DIMES, <http://www.marchofdimes.org/pregnancy/pregnancy-39weeks.aspx> (last visited Apr. 22, 2015), archived at <http://perma.cc/MV7T-6ALG>; Jane E. Brody, *A Campaign to Carry Pregnancies to Term*, N.Y. TIMES, Aug. 8, 2011, at D7, available at <http://www.nytimes.com/2011/08/09/health/09brody.html>; see also HEIDI MURKOFF & SHARON MAZEL,

gender-based discrimination, and economic marginalization. In theory, people seeking medical care and people giving birth have a larger range of options to choose from for their care than ever before. Of course, availability of options is constrained by the socioeconomic position of the chooser, and pregnant people are often treated as less competent or entitled to make decisions about their own bodies. This becomes particularly clear in decision-making around method of delivery.

A. Overview of Cesarean Surgery

Cesarean surgery is a medical intervention that has saved countless maternal and infant lives. But from the beginning it has been a means of shifting risk between the fetus and the person giving birth. One theory as to the origin of the name of the surgery—and there are many—points to a Roman decree (*Lex Caesare*) in 700 BC that required that fetuses be removed from the womb of dead or dying women. It is unknown how many fetuses survived in antiquity, but such surgeries were almost invariably fatal to women.¹⁵

According to medical lore, the first patient to survive a cesarean section was Mrs. Jacob Nufer, the wife of a Swiss pig gelder in the 1580s, who suffered an obstructed labor despite the ministrations of 13 midwives.¹⁶ After the kitchen table surgery, which produced a healthy son, Mrs. Nufer went on to deliver several more children, including a set of twins, vaginally.¹⁷ The

WHAT TO EXPECT WHEN YOU'RE EXPECTING 68-84 (4th ed. 2008) (warning women to avoid, among other things, changing a cat litter box, consuming unpasteurized cheese, sushi or deli meats, gardening without gloves, inhaling when handling household cleaning products, and ingesting excessive caffeine); cf. EMILY OSTER, EXPECTING BETTER 122-130 (2013) (describing several common prohibited activities and exposures, including changing cat litter, gardening, hair dye, Bikram yoga, hot baths, and traveling by airplane, and finding many of these recommendations to be overblown).

¹⁵ CASSIDY, *supra* note 13, at 110.

¹⁶ *Id.* at 103. Interestingly Mr. Nufer was reported to have sought permission from local authorities before performing the surgery, making this the first cesarean performed under color of law.

¹⁷ *Id.* Some medical historians have dismissed the tale as apocryphal. EPSTEIN, *supra* note 13, at 157-58. Scholars question the veracity of the story because of Mrs. Huber's reported subsequent birth history, disbelieving "that Nufer's wife could have survived the amateur operation and then survive five more vaginal deliveries (including a set of twins) without rupturing her uterus." *Id.* This birth history, however, mirrors that of Laura Pemberton, another woman forced to undergo cesarean under color of law 500 years later, *Pemberton v. Tallahassee Mem'l Reg'l Ctr.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999), who subsequently delivered several more babies, including a set of twins, in hiding after *two* cesareans. BLOCK, *supra* note 10, at 249; MARSDEN WAGNER, BORN IN THE USA: HOW A BROKEN MATERNITY SYSTEM MUST BE FIXED TO PUT

Nufers's happy ending was atypical: cesarean surgeries would not become routinely survivable until the advent of antiseptics in the twentieth century.¹⁸

Cesareans have become much safer,¹⁹ as well as more common: cesarean surgery is the most common operation performed on American women of reproductive age.²⁰ Nevertheless, this surgery carries its own set of risks²¹ and "has potential for great harm when overused."²² Concerns about the rate of cesarean delivery have existed for nearly as long as the procedure has been routinely survivable.

As early as the turn of the twentieth century, enterprising physicians were suggesting cesarean surgeries as a solution to the supposed frailty of upper-class women.²³ They reasoned that wealthy women, who were prone to "nervous exhaustion," were too weak to endure labor pain and were demanding operative deliveries²⁴—an idea that persists to this day in the media portrayal of wealthy women who have cesareans as being "too posh to push."²⁵ Just as timeless is the skepticism of this perspective, and of the increase in the cesarean rate it supposedly begets. A 1933 review of maternal mortality in New York City blamed poor maternal and infant outcomes on physicians who employed the "technically less demanding" cesarean in cases where "better judgment and greater skill would permit delivery by the less hazardous normal route."²⁶ This accusation that surgeries were being performed for money and conve-

WOMEN AND CHILDREN FIRST 124 (2008); Laura Pemberton, Address at NAPW's National Summit to Ensure the Health and Humanity of Pregnant and Birthing Women (Jan. 18-21, 2007), *available at* <http://vimeo.com/4895023>.

¹⁸ EPSTEIN, *supra* note 13, at 159.

¹⁹ CASSIDY, *supra* note 13, at 115-16 (noting a cesarean mortality rate of .04%; vaginal deliveries have a mortality rate of .01%).

²⁰ EPSTEIN, *supra* note 13, at 154.

²¹ For pregnant women those risks include infection, hemorrhage, thromboembolism, bladder and uterine lacerations, and even death. F. GARY CUNNINGHAM ET AL., WILLIAMS OBSTETRICS 592 (22d ed. 2005). Other nonclinical risks include poor birth experience, less early contact with babies, intense and prolonged postpartum pain, poor overall mental health and self-esteem, and poor overall functioning. CAROL SAKALA & MAUREEN P. CORRY, EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE 44 (2008). *See also* NICETTE JUKELEVICS, UNDERSTANDING THE DANGERS OF CESAREAN BIRTH 50 (2008).

²² SAKALA & CORRY, *supra* note 21, at 44.

²³ EPSTEIN, *supra* note 13, at 160-61; BLOCK, *supra* note 10, at 122.

²⁴ *Id.*

²⁵ EPSTEIN, *supra* note 13, at 165-66; CASSIDY, *supra* note 13, at 123-24. Research does not support the claim that women are demanding cesarean surgeries without medical indication in significant numbers. THERESA MORRIS, CUT IT OUT: THE C-SECTION EPIDEMIC IN AMERICA 19 (2014).

²⁶ EPSTEIN, *supra* note 13, at 162.

nience would not be out of place today.²⁷ The only difference is the figures: the “inordinately high” cesarean rate in 1933 was 2.2%.²⁸

The U.S. cesarean rate has hovered around one in three births for the past few years,²⁹ a rate which significantly exceeds recommendations by the World Health Organization (WHO).³⁰ According to a recent statement by the WHO, “[A]t population level, caesarean section rates higher than 10% are not associated with reductions in maternal and newborn mortality rates.”³¹ A primary driver of the high rate of cesarean section is the low rate of vaginal birth after cesarean (VBAC),³² which, as will be explained further below, is more a function of non-clinical concerns than of the actual risks of laboring with a scarred uterus.

The health risks of cesarean surgery are mostly borne by the birthing person,³³ and largely deferred into subsequent pregnancies: with each cesarean, the risk of maternal morbidity increases significantly.³⁴ Medical and public health authorities recognize that use of cesarean delivery without medical indication should be reduced to the extent possible. Concerns about the potential overuse of cesarean surgery have led the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) to issue a joint consensus state-

²⁷ MORRIS, *supra* note 25, at 50; CASSIDY, *supra* note 13, at 126; BLOCK, *supra* note 10, at 42-43; SAKALA & CORRY, *supra* note 21, at 41 (arguing that increased rates of cesarean surgery are the result of a belief that the procedure is “efficient and lucrative”).

²⁸ EPSTEIN, *supra* note 13, at 162.

²⁹ Joyce A. Martin et al., *Births: Final Data for 2013*, 64 NAT’L VITAL STAT. REP., Jan. 15, 2015, at 7, available at http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf, archived at <http://perma.cc/F3S9-8ZM6>. The cesarean rate is 32.7% of births, a slight decrease from 2010-2012. The rate increased every year from 1996 to 2009. *Id.*

³⁰ See WORLD HEALTH ORG., U.N. CHILDREN’S FUND, U.N. POPULATION FUND, MONITORING EMERGENCY OBSTETRIC CARE: A HANDBOOK 25 (2009); see also SAKALA & CORRY, *supra* note 21, at 42 (“Recent analyses substantiate the World Health Organization’s recommendation that optimal national cesarean rates are in the range of 5 percent to 10 percent of all births and that rates above 15 percent are likely to do more harm than good.”) (internal citations omitted).

³¹ WORLD HEALTH ORG., WHO STATEMENT ON CAESAREAN SECTION RATES, Apr. 10, 2015, at 4, available at http://apps.who.int/iris/bitstream/10665/161442/1/WHO_RHR_15.02_eng.pdf?ua=1, archived at <http://perma.cc/QQZ2-2XAD>.

³² Morris, *supra* note 25, at 111.

³³ See Am. Coll. Obstetricians & Gynecologists, Soc’y for Maternal-Fetal Med., *Obstetric Care Consensus No. 1: Safe Prevention of the Primary Cesarean Delivery*, AM. J. OBSTETRICS & GYNECOLOGY, Mar. 2014, at 179, 181 tbl.1.

³⁴ Victoria Nisenblat et al., *Maternal Complications Associated with Multiple Cesarean Deliveries*, 108 OBSTETRICS & GYNECOLOGY 21, 25 (2006); MORRIS, *supra* note 25, at 120-21; JUKELEVICS, *supra* note 21, at 81.

ment on the importance of reducing the rate of primary cesarean delivery.³⁵ The medical groups recognize not only the health risks inherent in a major surgical intervention, but also the impact of the first surgery on subsequent pregnancies. This impact includes the increasing difficulty of finding providers who will support patients in a VBAC, an obstacle largely erected by the providers and facilities themselves.

B. Overview of VBAC

Although cesarean surgery is a lifesaving procedure, many women who have had a prior surgical delivery wish to avoid having a repeat surgery.³⁶ The reasons for this are highly dependent upon individual and cultural factors. For instance, an individual may have experienced medical or psychological trauma during a prior surgery, or may come from a cultural or religious tradition that values having many children, which raises the possibility of multiple cesareans.³⁷ Even an uncomplicated cesarean delivery entails a surgical recovery, and most people who have had a prior cesarean will have at least one other child to care for while recovering from their birth and tending a newborn.³⁸

The medical recommendations around vaginal birth after cesarean have changed significantly since the time when cesarean surgery meant death to a laboring woman. Early in the twentieth century, physicians were admonished to be judicious in their use of surgical delivery, because "once a cesarean, always a cesarean": once a woman had undergone one surgery, all future pregnancies

³⁵ Am. Coll. Obstetricians & Gynecologists, Soc'y for Maternal-Fetal Med., *supra* note 33.

³⁶ See generally INTERNATIONAL CESAREAN AWARENESS NETWORK, <http://ican-online.org> ("The International Cesarean Awareness Network, Inc. (ICAN) is a nonprofit organization whose mission is to improve maternal-child health by preventing unnecessary cesareans through education, providing support for cesarean recovery, and promoting Vaginal Birth After Cesarean (VBAC)."); EUGENE DECLERCQ ET AL., CHILD-BIRTH CONNECTION, LISTENING TO MOTHERS II: REPORT OF THE SECOND NATIONAL U.S. SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES 36 (2006), available at http://www.childbirthconnection.org/pdfs/LTMII_report.pdf, archived at <http://perma.cc/M5S3-6Z8J>; Declercq; BLOCK, *supra* note 10, at 91-97; EPSTEIN *supra* note 13, at 162-64; CASSIDY, *supra* note 13, at 126-30.

³⁷ CASSIDY, *supra* note 13, at 108 (describing an increase in incidences of potentially life-threatening post-cesarean placental abnormalities in Mormon women).

³⁸ JUKELEVICS, *supra* note 21, at 45-50; HENCI GOER, THINKING WOMAN'S GUIDE TO A BETTER BIRTH (1999); CASSIDY, *supra* note 13, at 118 ("If all goes as planned, the mother will be home on Monday, nursing the baby and a sore six-inch scar, willing herself not to sneeze or laugh, which just adds to the pain.").

would have to be delivered surgically.³⁹ This was true for two reasons. First, the maternal indications that necessitated the procedure—such as rickets—were unlikely to resolve between pregnancies.⁴⁰ Second, the vertical or “classical” uterine incision common until the 1970s left a scar that was more susceptible to tearing open during labor, causing a uterine rupture.⁴¹ As surgical techniques and overall pre-pregnancy health improved, so did women’s chances of being able to deliver vaginally after cesarean surgery.

In the early 1980s, the National Institutes of Health and ACOG each released statements directing physicians to encourage women to have VBACs—a trend which continued until 1996.⁴² One physician who trained during this period described great pressure from his residency program to keep a low cesarean rate, noting that the attending physicians were “very aggressive with VBAC.”⁴³ This shift in favor of VBAC took place against a backdrop of attempts to curb health care costs, a high-profile clash between maternity care providers and HMOs that played out in the “drive-through delivery” debates in the media and in statehouses across the country when insurers sharply cut back coverage for post-partum hospital stay.⁴⁴ Health insurers jumped at the liberalized VBAC recommendations, pushing avoidance of repeat surgery as a cost-saving measure: a cesarean lengthens the hospital stay and doubles the cost of a delivery.⁴⁵ HMOs announced incentives intended to curb unnecessary surgery, such as equalizing the reimbursement rate for vaginal and surgical delivery, and paying physicians bonuses for VBACs.⁴⁶ Indeed, some health insurers even stopped covering repeat cesarean sections.⁴⁷

³⁹ Edwin B. Cragin, *Conservatism in Obstetrics*, 114 N.Y. MED. J. 1, 3 (1916); CASSIDY, *supra* note 13, at 127-28; MORRIS, *supra* note 25, at 112.

⁴⁰ CASSIDY, *supra* note 13, at 128.

⁴¹ *Id.*

⁴² MORRIS, *supra* note 25, at 113.

⁴³ *Id.*

⁴⁴ David A. Hyman, *What Lessons Should We Learn From Drive-Through Deliveries*, 107 PEDIATRICS 406 (2001); Joan Beck, ‘Drive-through’ Birth No Bargain For Mother and Child, CHI. TRIB., June 26, 1996, http://articles.orlandosentinel.com/1995-06-26/news/9506260143_1_hospital-stays-mother-and-child-maternity-stays.

⁴⁵ MORRIS, *supra* note 25, at 17.

⁴⁶ Stacey Burling, *Insurer Seeks to Cut Back Caesareans*, PHILA. INQ., July 24, 1995, http://articles.philly.com/1995-07-24/living/25678582_1_c-section-rate-c-sections-caesarean-rate, archived at <http://perma.cc/BSM3-DLKC>.

⁴⁷ BLOCK, *supra* note 10, at 87; Mike Stobbe, *C-Sections in U.S. Are at All-Time High*, WASH. POST, Nov. 15, 2005, http://www.washingtonpost.com/wp-dyn/content/article/2005/11/15/AR2005111500945_pf.html, archived at <http://perma.cc/ZD3N-BLYE>.

Then, in 1996, the tide turned with the publication in the *New England Journal of Medicine* of a study of uterine rupture during trials of labor after cesarean. The study revealed nothing new,⁴⁸ but did focus public attention to the risks of VBAC.⁴⁹ This, coupled with high-profile malpractice cases involving large jury awards for uterine rupture (which some note were attributable to inappropriate use of labor-augmenting medications that increase the risk of rupture⁵⁰ even with an unscarred uterus⁵¹), was enough to push ACOG to issue more restrictive guidelines.⁵² In 1999, ACOG issued a practice guideline recommending that VBAC take place only in facilities with “immediately available” surgical and anesthesiology capabilities.⁵³ VBAC rates steadily plunged from a high of 28% in 1996 to 8% in 2006.⁵⁴

Now, with the benefit of considerably more evidence-based research, and the input of maternity care advocates who emphasized the desire for VBAC among birthing people during the 2010 National Institutes of Health Consensus Development Conference on Vaginal Birth After Cesarean Section,⁵⁵ ACOG’s most recent practice guidelines direct that VBAC is a reasonable option for most people who have had one or two low-transverse (horizontal) incisions.⁵⁶ And, in fact, people who attempt VBAC are successful 60-80% of the time.⁵⁷

The practice guidelines acknowledge the limiting effect of the requirement of “immediately available” surgical capabilities, and assert that this was not the intent of the recommendation, but nevertheless retain this language. This is tempered by a recognition that, even among pregnant people who are not optimal candidates for a trial of labor under the guidelines, “[r]espect for patient autonomy supports the concept that patients should be allowed to

⁴⁸ MORRIS, *supra* note 25, at 114.

⁴⁹ *Id.*

⁵⁰ WAGNER, *supra* note 17, at 28-29; BLOCK, *supra* note 10, at 89.

⁵¹ JJ Zwart et al., *Uterine Rupture in the Netherlands: A National Population-Based Cohort Study*, 116 BJOG: AN INT’L J. OF OBSTETRICS & GYNECOLOGY 1069, 1074 (2009).

⁵² MORRIS, *supra* note 25, at 115-16.

⁵³ *Id.*

⁵⁴ Torri D. Metz et al., *How Do Good Candidates for Trial of Labor After Cesarean (TOLAC) Who Undergo Elective Repeat Cesarean Differ from Those Who Chose TOLAC?*, 208(6) AM. J. OBSTETRICS & GYNECOLOGY, 458.c1 (2013).

⁵⁵ NIH Consensus Development Conference on Vaginal Birth After Cesarean, Mar. 8-10, Bethesda, MD, <http://consensus.nih.gov/2010/vbac.htm>.

⁵⁶ See generally Am. Coll. Obstetricians & Gynecologists, *ACOG Practice Bulletin No. 115: Vaginal Birth After Previous Cesarean Delivery*, 116 OBSTETRICS & GYNECOLOGY, no. 2, Aug. 2010, *reaff’d* 2013 [hereinafter ACOG Practice Bulletin].

⁵⁷ *Id.* at 3.

accept increased levels of risk.”⁵⁸

The risk that raises the greatest clinical concern is uterine rupture, a potentially serious condition in which the scar from a prior surgery breaks open. Uterine rupture occurs in approximately .7% to .9% of VBAC attempts,⁵⁹ and requires rapid medical intervention to prevent harm or death to the woman or fetus. Limited research on the rate of uterine rupture after multiple cesareans exists, but the ACOG practice guidelines suggest that the rate of uterine rupture in women with two prior surgeries is between .9% and 1.8%.⁶⁰

Despite the generally positive prognosis for people without complications of past or present pregnancies, and despite the return to cautious endorsement of VBAC, the rates of VBAC remain low. Calculating a national figure is complicated by states’ use of birth certificates that capture differing, non-comparable data, but evidence suggests a VBAC rate near 9.2%.⁶¹ Certainly, elective repeat cesarean surgeries, with people opting to forego the possible risks of vaginal delivery and instead assume those of surgery, play some role in the low rate of VBAC. But there is no evidence to suggest that 91% of people chose repeat surgery.⁶² To the contrary, one survey of postpartum women found that nearly half of the women surveyed who had had a prior cesarean were interested in the option of VBAC, but 57% were denied the option, most because of an unwilling provider (40%) or facility (23%), rather than a clinical risk factor (20%).⁶³ Of the women who had a repeat cesarean delivery, 25% reported feeling pressure to do so.⁶⁴

Even among people who choose to have repeat surgery, the way risks are presented and whether providers appear to be supportive plays a role in decisions about birth options. One study, comparing decision-making among good candidates for VBAC who chose a subsequent cesarean to those who attempted vaginal delivery found that providers have a strong influence on how women chose to deliver.⁶⁵ The authors posited that the rate of repeat cesarean among the women surveyed could have decreased from

⁵⁸ *Id.* at 8.

⁵⁹ *Id.* at 2 tbl.1.

⁶⁰ *Id.* at 4.

⁶¹ MORRIS, *supra* note 25, at 111.

⁶² *Id.* at 137.

⁶³ Declercq et al., *supra* note 36, at 36; MORRIS, *supra* note 25, at 137.

⁶⁴ *Id.* at 57.

⁶⁵ Metz et al., *supra* note 54, at 458.e4-e5.

70.4% to 25.5% if the providers had expressed support for VBAC.⁶⁶ Another study of women delivering after a prior cesarean found that few had accurate information about the likelihood of successful VBAC (13% of the women attempting VBAC and 3% of those undergoing repeat surgery), and that the women surveyed were extremely likely to choose repeat surgery if they perceived that that was their physician's preference.⁶⁷ Of women who perceived their physician to prefer repeat surgery, only 4% attempted a VBAC.⁶⁸

However one decides to deliver, the decision necessarily takes into account not only their own health, but also the health of their baby, their family, and any future children they may wish to bear. The current rate of cesarean deliveries and the low rate of VBAC (in spite of the high probability of success) means that the decision of whether to undergo repeat cesarean surgery or to deliver vaginally is one that many people will face. It is also a decision that is increasingly made in a context that is slanted against access to a variety of options.

II. BEYOND RISKS AND BENEFITS: FORCES IMPACTING AUTONOMY IN MEDICAL DECISION-MAKING

A number of forces beyond clinical considerations converge to influence the availability of VBAC. First, the U.S. healthcare system treats medical attention as a commodity instead of a right. There is no entitlement to healthcare, which means that some people will be unable to afford the health care providers who take on the added expense of malpractice insurance that covers VBAC. Second, the marketplace in which people seek prenatal care is not set up for even exchange between "buyers" and "sellers." Finally, the prevalent discourse in politics and bioethics incorrectly characterizes the relationship between the birthing person and the fetus as one of tension and conflict, which provides an opportunity for health care providers to assert the welfare of the fetus as justification for depriving people of options for birth.

A. *The Best Care for the Highest Bidder: Health Care as a Commodity*

International human rights doctrine and many countries

⁶⁶ *Id.*

⁶⁷ Sarah Bernstein et al., *Trial of Labor After Previous Cesarean Section Versus Repeat Cesarean Section: Are Patients Making an Informed Decision?*, AM. J. OBSTETRICS & GYNECOLOGY, Supplement to Jan. 2012, at S21.

⁶⁸ *Id.*

throughout the world recognize health care as a right.⁶⁹ The implementation of such a right varies significantly from country to country, but in the best cases it means that people have access to comprehensive health care in their communities.

The United States, however, recognizes no such right. There are limited entitlements to health care for elders and extremely low-income people through the Medicare and Medicaid programs and through state-based programs, but health care is generally treated as a good or service procured through the market economy. People are only entitled to the health that they can afford, leading to harsh health disparities that are reflected in maternal and infant mortality rates.⁷⁰

The Affordable Care Act has marked an important step forward in ensuring access to healthcare for Americans, particularly with respect to maternity care.⁷¹ Prior to the passage of the Affordable Care Act, which includes maternity care among the essential health benefits that must be provided by Qualified Health Plans and eliminates exclusions for preexisting conditions, it was extraordinarily difficult for people who were not eligible for Medicaid and who did not have an employer-sponsored health plan to find affordable insurance that covered maternity care.⁷² Some women who had undergone a previous cesarean surgery were unable to find affordable coverage because their birth history was considered a “preexisting condition.”⁷³

However, the Affordable Care Act leaves a number of challenges unaddressed. For instance, one vexing but under-

⁶⁹ See generally Alicia Ely Yamin, *The Right to Health Under International Law and Its Relevance to the United States*, 95 AM. J. PUB. HEALTH 1156 (2005) (noting that 70 countries include a right to health in their constitution).

⁷⁰ AMNESTY INT’L, DEADLY DELIVERY 19 (2010), <http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf>; Andrea A. Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010*, 210 AM. J. OBSTETRICS & GYNECOLOGY 435.e1, 435.e2 (2014).

⁷¹ Jessica Arons, *A Supreme Win for Women: The Crucial Benefits of Obamacare*, THE DAILY BEAST, June, 26, 2012, <http://www.thedailybeast.com/articles/2012/06/28/a-supreme-win-for-women-the-crucial-benefits-of-obamacare.html>, archived at <http://perma.cc/6RMG-FC7C>; *Fact Sheet: Why the Affordable Care Act Matters for Women: Health Insurance Coverage for Lower- and Moderate-Income Pregnant Women*, NAT’L P’SHIP FOR WOMEN & FAMILIES (Sept. 2014), available at <http://www.nationalpartnership.org/research-library/health-care/lower-and-moderate-income-pregnant-women.pdf>, archived at <http://perma.cc/WAT6-98MJ>.

⁷² NAT’L WOMEN’S LAW CTR., STILL NOWHERE TO TURN: INSURANCE COMPANIES TREAT WOMEN LIKE A PRE-EXISTING CONDITION, (Oct. 2009), available at <http://www.nwlc.org/sites/default/files/pdfs/stillnowheretoturn.pdf>.

⁷³ Denise Grady, *After Caesareans, Some See Higher Insurance Cost*, N.Y. TIMES, June 1, 2008, <http://www.nytimes.com/2008/06/01/health/01insure.html>.

researched problem reported by women is the imposition of additional fees for patients who want to deliver vaginally after cesarean surgery. Despite the fact that a vaginal delivery is less expensive than a surgery, care providers attempt to offset the increased costs of malpractice insurance that covers VBACs, or time spent being “immediately available” to a laboring patient, by adding out-of-pocket fees that can make care unaffordable.

Maternity care, left to private hands in the market economy, has not thus far trended toward fairness and justice with respect to reproductive autonomy. The market, it seems, is more sensitive to some parties’ interests than others.

B. The Myth of the Free Market

The concept of the marketplace assumes a certain parity of power between the seller and the buyer. By contrast, the provider-patient relationship is one that is characterized by an asymmetry of information and power.⁷⁴ This is especially acute when the patient is part of a marginalized community (e.g. low-income, undocumented, living in rural area) whose access to alternative health care providers or facilities is limited, whether by geography or funds.

Directly or indirectly, malpractice concerns play a significant role in the availability and accessibility of VBAC. After ACOG released its 1999 recommendation that VBAC take place in hospitals with “immediately available” resources for emergency surgeries, physicians and hospitals responded by removing VBAC from the list of birthing options.⁷⁵ ACOG practice bulletins are not considered an official statement of the standard of care, and the practice bulletin provided no exact definition of immediate availability, but anxiety about the potential for liability in case of a uterine rupture in a facility that did not meet the practice bulletin’s guidelines led to drastic changes in practice among obstetricians.⁷⁶ As one physician noted, “The standard of care changed because we do things to make big jury decision lawsuits less feasible.”⁷⁷

In a nonsensical example of circular reasoning, this change in standards that led to such great anxieties about liability was itself spurred by anxieties about liability. The vice president of Practice Activities who oversaw the 1999 practice bulletin defended the con-

⁷⁴ Michelle Oberman, *Mothers and Doctors’ Orders: Unmasking the Doctor’s Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 457-58 (2000).

⁷⁵ BLOCK, *supra* note 10, at 87-88; CASSIDY, *supra* note 13, at 129.

⁷⁶ MORRIS, *supra* note 25, at 60.

⁷⁷ *Id.*

servative “immediately available” standard by saying that uterine rupture almost always results in legal action, and “[d]efendant physicians are in a better position from a liability perspective if they were present at the time of the complications.”⁷⁸ That is, physician’s should be immediately available not because it is actually necessary, but so that they can better testify in malpractice suits.

As a result of this change, hospitals across the country decided that they did not have the resources or staff to meet ACOG’s guidelines, with rural areas hit hardest.⁷⁹ In 2009, the International Cesarean Awareness Network conducted a groundbreaking survey of every hospital in the United States with a labor and delivery service to assess the accessibility of VBAC.⁸⁰ Of the 2,877 hospitals surveyed, more than 800 responded that they had a policy of refusing care to women who did not consent in advance to cesarean section (“VBAC ban”).⁸¹ Nearly 400 had no physician who would attend a VBAC (“de facto ban”).⁸² Between the “VBAC bans” and “de facto bans,” the survey found that 42% of U.S. hospitals deny people giving birth a meaningful opportunity to decide what happens with their bodies with respect to a major medical intervention with potentially serious medical consequences and personal significance.⁸³

While malpractice concerns play a role in the availability of VBAC by changing practice among providers, malpractice insurers sometimes have a direct hand in curtailing birthing options altogether. For instance, in Oklahoma, the Physicians Liability Insurance Liability Company (PLICO) decided in 2005 that it would no longer cover physicians who attended VBAC deliveries.⁸⁴ As the malpractice insurance carrier for 80% of Oklahoma ob/gyns, PLICO’s policies have enormous sway in dictating the practice cli-

⁷⁸ *Id.* at 129.

⁷⁹ *Id.* at 122.

⁸⁰ Letter from Christa Billings, International Cesarean Awareness President, to the author, Nov. 29, 2014 (on file with author).

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

⁸⁴ Susan Simpson, *Oklahoma Mom Opts for Traditional Birth after C-Sections*, NEWSOK, Sept. 7, 2009, <http://newsok.com/oklahoma-mom-opts-for-traditional-birth-after-c-sections/article/3398916>; Mary Ellen Schneider, *Medical Malpractice Insurers Address VBAC Risks*, FAMILY PRACTICE NEWS, Feb. 15, 2005, <http://www.familypracticenews.com/specialty-focus/women-s-health/single-article-page/medical-malpractice-insurers-address-vbac-risks/03a0af5782.html>; Leigh Woosley, *Exit Strategy*, TULSA WORLD, Feb. 24, 2005, http://www.tulsaworld.com/archives/exit-strategy/article_c34da24e-7cac-59b2-9fea-64821ebab943.html; *Vaginal Birth After Cesarean*, TULSA KIDS, Feb. 2010, <http://www.tulsakids.com/February-2010/Vaginal-Birth-After-Cesarean/>, archived at <http://perma.cc/RKV6-SJC2>.

mate. Oklahoma physicians who wish to support their clients in vaginal births after cesarean must either find another insurance carrier or forego malpractice insurance coverage to do so. Unsurprisingly, this is something few are willing to do, leaving pregnant people in Oklahoma with few options.

The same is true in New Jersey, where sixty obstetricians practicing at St. Barnabas Medical Center under the MDAdvantage medical insurer made a verbal agreement to stop attending VBACs and vaginal twin deliveries.⁸⁵ The goal of this agreement, explained the group's president and liaison Dr. Donald Chervenak, was "to curb [their] liability."⁸⁶

A California obstetrician described a similar solution in her community, where, in 2002, liability insurance constraints led her facility to stop "allowing" women to deliver vaginally after cesarean surgery despite VBAC successes at that facility.⁸⁷ As a result, according to a sadly accurate running joke among local physicians, "the only way to get a vaginal birth after cesarean delivery is to have the birth at home."⁸⁸ Situations like this not only deprive birthing people of important options, they put physicians at odds with the hospitals in which they practice by placing pressure on them, ironically, to recommend cesarean surgeries even when they are clinically inadvisable.⁸⁹

In light of these pressures—on institutions, providers, and people giving birth—maternity care looks less and less like a good purchased in an open market in which consumers exercise choice. The truth is more complicated than implied by one physician-journalist, who suggests:

[W]omen who can afford to choose their doctor will opt for one who caters to their wishes. If you want a natural childbirth, go to a doctor who will give you one. And if you want a C-section, it just takes a quick Google search to figure out if your doctor has high rates of surgery.⁹⁰

As the illustrative examples below will demonstrate, even women who can afford to choose their doctor may find that there are

⁸⁵ BLOCK, *supra* note 10, at 88.

⁸⁶ *Id.*

⁸⁷ Annette E. Fineberg, *An Obstetrician's Lament*, 117 OBSTETRICS & GYNECOLOGY 1188, 1188 (2011).

⁸⁸ *Id.*

⁸⁹ *Id.* (describing a situation in which she counseled a patient who presented to the hospital in active labor at term to continue with the labor because of her history of successful VBACs and high BMI which increased her surgical risks; she "spent the following months defending that recommendation").

⁹⁰ EPSTEIN, *supra* note 13, at 166.

no VBAC-supportive doctors to choose, or that the doctors they choose may prove to be less supportive than they initially seemed once pregnancy has progressed to a point where money cannot solve the problem. Indeed, once the woman is in or near labor, a political climate that is increasingly hostile to reproductive autonomy may be leveraged to enforce the market constraints.

C. *The Two-Patient Problem*

Since *Roe v. Wade* articulated a fundamental right to privacy that includes the right to terminate a pregnancy, the movement to recriminalize abortion has included attempts to create a separate legal status for fertilized eggs, embryos, and fetuses.⁹¹ Although voters in even the most abortion-hostile states have rejected ballot measures that would amend state constitutions and criminal codes to redefine legal “persons” to include fertilized eggs,⁹² these attempts have by and large been successful in inculcating the notion of the fetus as a subject of the law. Laws related to inheritance, personal injury, and violent crimes confer the status of “person” to the unborn.⁹³

One thing is clear: despite the existence of laws that treat the unborn as persons under limited circumstances, no law in any state establishes that people lose their constitutional or statutory rights to medical decision making at any point in pregnancy. Nevertheless, laws that recognize rights for embryos and fetuses have been used as a justification for court-ordered surgery in women who disagree with their medical provider’s recommendations.⁹⁴ No court-ordered cesarean surgery has been upheld by an appellate court since 1981,⁹⁵ but the threats persist to the present day. More insidi-

⁹¹ See generally Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005*, 38 J. HEALTH POL. POL’Y & L. 299 (2013) (documenting 413 cases in which pregnant women were deprived of their liberty through arrest by law enforcement or detention in a hospital, including thirty cases of forced medical intervention including cesarean surgery, based on arguments that fetuses should be treated as though they are legally separate persons).

⁹² See Miss. Initiative 26, OFFICE OF THE SEC’Y OF STATE (2011), available at <http://www.sos.ms.gov/Elections-Voting/Documents/Definition%20of%20Person-PW%20Revised.pdf>; see also N.D. Measure 1, BALLOTPEdia.COM (2014), [http://ballotpedia.org/North_Dakota_%22Life_Begins_at_Conception%22_Amendment,_Measure_1_\(2014\)](http://ballotpedia.org/North_Dakota_%22Life_Begins_at_Conception%22_Amendment,_Measure_1_(2014)).

⁹³ See generally *Ex parte Ankrom & Kimbrough*, 152 So.3d 397 (Ala. 2013) (Parker, J., concurring specially).

⁹⁴ See generally Paltrow & Flavin, *supra* note 91; see also *Pemberton v. Tallahassee Mem. Reg’l Ctr.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999).

⁹⁵ See *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 274 S.E.2d 457 (1981) (denying motion for stay of order on appeal); cf. *In re A.C.*, 573 A.2d 1235, 1243–44 (D.C. Ct.

ously, perhaps, the duty to provide non-negligent care to fetuses (which exists independently of the physician's duty to the pregnant patient in many states), has been used to justify turning women away from prenatal care, ironically threatening maternal and perinatal health.

Treating fetuses as rights-bearing persons miscasts pregnancy as a struggle between two competing sets of rights. The overwhelming consensus of bioethicists and legal scholars is that it is ethically forbidden to infringe upon a pregnant woman's right to make decisions about the course of her medical care, even when her decisions may pose a risk to fetal health.⁹⁶ Nevertheless, a "cottage industry" of bioethical literature on pregnant patients' right to decline medical advice drives a persistent misconception that their rights are uniquely contested or subject to balancing against fetal interests.⁹⁷ This extreme outlier perspective miscasts conflict between pregnant patients and their care providers as "maternal-fetal conflict," inserts the medical provider as guardians of "fetal interests,"⁹⁸ and dangerously proposes that pregnant people have fewer rights than others.⁹⁹ This does not reflect the reality of lived experiences of pregnant people, whose medical decisions—even when they conflict with medical recommendations—virtually always take into account fetal wellbeing as well as their own needs, those of their family, and anticipated future pregnancies. The conflict, then, is not between the mother and the fetus, but between the mother and the health care provider¹⁰⁰ or the state.¹⁰¹

App. 1990) (posthumously vacating an order for a cesarean section that killed both the pregnant woman and her severely premature newborn); *In re Baby Boy Doe*, 632 N.E.2d 326, 393 (Ill. App. Ct. 1994) (refusing to grant a court order for cesarean surgery because "[a] woman's competent choice to refuse medical treatment as invasive as a cesarean section during pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus"); *Burton v. State*, 49 So.3d 263, 265 (Fla. Dist. Ct. App. 2010) (vacating order for forced bed rest on the basis of "fundamental constitutional right to refuse medical intervention"). *But see Pemberton*, 66 F. Supp. 2d at 1256 (Fla. Cir. Ct. 1999) (noting that the court order was not appealed after being carried out, but relief under § 1983 denied).

⁹⁶ Oberman, *supra* note 74, at 452–53.

⁹⁷ *Id.*

⁹⁸ See, e.g., Frank A. Chervenak et al., *The Professional Responsibility Model of Obstetrical Ethics: Avoiding the Perils of Clashing Rights*, 205 AM. J. OBSTETRICS & GYNECOLOGY 315.e1, 315.e1 (Oct. 2011) (calling the assertion that "there is no circumstance in which someone could be brought to the operating room against their will" fallacious "pregnant women's rights reductionism"); Laurence B. McCullough & Frank A. Chervenak, *A Critical Analysis of the Concept and Discourse of 'Unborn Child'*, 8 AM. J. BIOETHICS 34, 38 (2008) ("Pregnant women are [ethically] obligated to take reasonable risks to themselves to protect the fetal patient.").

⁹⁹ Oberman, *supra* note 74, at 452–53.

¹⁰⁰ *Id.* at 471

The “fetus as patient” framework makes pregnant women susceptible to rights violations by health care providers who wrongly believe that they have a stronger obligation to the fetus than the pregnant woman.¹⁰² Treating the fetus as an independent patient permits women to be caught “in proxy wars between those who place a premium on maternal autonomy rights and those who believe that fetal interests are more compelling.”¹⁰³ As one legal scholar has noted, “the effect of using a two-patient model for pregnancy is that attention shifts to the fetus,” often to the detriment of the pregnant woman, who, unlike the fetus, unquestionably possesses rights.¹⁰⁴

In cases of disagreement over medical procedures, this sometimes means that instead of abiding by their ethical obligation to the pregnant patient, physicians cite a duty to the fetus in attempting to override a patient’s decisions, or abandoning care.¹⁰⁵ Fetal interests, then, become a proxy for physician’s recommendations and serve as a guise for unethical threats, coercion, and even force. These are not mere hypothetical situations—they are real situations faced by people giving birth across the country.

III. ILLUSTRATIVE EXAMPLES

The failure of the market economy to respond to the needs of birthing people is evidenced by the difficulties in finding supportive prenatal care providers faced by people seeking to deliver vaginally after cesarean section, and by the passive coercion they experience from health care facilities that do not support their decisions. This may include threats of outlandish economic penalties.

¹⁰¹ RACHEL ROTH, MAKING WOMEN PAY: THE HIDDEN COST OF FETAL RIGHTS 6 (2003).

¹⁰² Stephen D. Brown, *The “Fetus as Patient”: A Critique*, 8 AM. J. BIOETHICS 47, 49 (2008); Anne Drapkin Lyerly et al., *A Critique of the ‘Fetus as Patient’*, 8 AM. J. BIOETHICS 42, 43 (2008).

¹⁰³ Terri-Ann Samuels et al., *Obstetricians, Health Attorneys, and Court-Ordered Cesarean Sections*, 17 WOMEN’S HEALTH ISSUES 107, 113 (2007).

¹⁰⁴ Lisa C. Ikemoto, *The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law*, 53 OHIO ST. L.J. 1205, 1294 (1992).

¹⁰⁵ See, e.g., Defendant’s Attorney Affidavit in Opposition to Motion for Summary Judgment at 1-2, *Dray v. Staten Island Univ. Hosp.*, No. 500510/2014, 17 (N.Y. Sup. Ct. Kings Cnty. 2014) (responding to a motion for summary judgment in a medical malpractice case by invoking the “controversial” and “thought-provoking” nature of the question of whether a pregnant patient may be forced to undergo cesarean surgery over her explicit objection, and asserting that “an Obstetrician has a legal obligation to an unborn, full-term fetus and must ensure its health and safety”—apparently at the expense of the rights and health of the mother, whose refusal was overridden and who almost died because of injuries sustained in the surgery).

Furthermore, stopping short of actually seeking a court-ordered repeat cesarean, facilities may use threats of legal process (including forced surgeries and child welfare interventions) to minimize liability risk by preventing an “unauthorized” VBAC from transpiring against hospital policy—that is, making the prospect of delivering at that facility so frightful that the pregnant person goes elsewhere.

A. *Between a Rock and a Hard Place: Maternity Service Closures and VBAC Refusal Policies*

As introduced above, the wake of the 1999 ACOG Practice Bulletin saw a rapid decrease in the number of hospitals providing care to people seeking VBAC. This is a problem that has become more troublesome as hospital systems consolidate and shutter labor and delivery units, particularly in rural areas. For instance, a 2015 investigation of the changing maternity care landscape in Alabama found that just twenty-nine of the state’s sixty-seven counties had any maternity service at all.¹⁰⁶ In some cases, women drove more than two hours in labor to the next closest hospital that offered maternity services.¹⁰⁷ Women without the means to travel long distances for maternity care are left with limited options: “go to the nearest emergency room to have their babies delivered by an ER physician, or deliver at home.”¹⁰⁸ State law prohibits midwives and physicians from attending home births, leaving women to deliver unattended;¹⁰⁹ this is an option that is untenable, especially for someone laboring with a scarred uterus.

To add to the problem, lack of reliable access to nearby prenatal care has driven an increase in the rate of scheduled cesareans, as well as an increase in inductions,¹¹⁰ which carry a heightened risk of cesarean section.¹¹¹ According to Dale Quinney, executive director of the Alabama Rural Health Association, “Many of those women are afraid of the distance and elect to go ahead and have a planned delivery.”¹¹² At Russell Medical Center, which treats women who live in rural areas without maternity units, 57% of babies born in 2013 were delivered by cesarean surgery. More than a

¹⁰⁶ Anna Claire Vollners, *Many Alabama Women Drive 50+ Miles to Delivery Their Babies as More Hospitals Shutter L&D Departments*, AL.COM (Feb. 10, 2015 10:23AM), http://www.al.com/news/index.ssf/2015/02/many_alabama_women_drive_50_mi.html, archived at <http://perma.cc/9PCJ-97CK>.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ See JUKELEVICS, *supra* note 21, at 139-46.

¹¹² *Id.*

dozen Alabama hospitals have cesarean rates of over 40 and even 50%.¹¹³

The closing of maternity services raises serious questions of what becomes of people who have exhausted their options for VBAC. ACOG emphasizes that even at facilities with policies refusing care to women who do not consent in advance to cesarean surgery, “such a policy cannot be used to force women to have cesarean delivery or to deny care to women in labor who decline to have a repeat cesarean delivery.”¹¹⁴ Instead ACOG recommends “patients should be clearly informed of such potential increase in risk and management alternatives” and “transfer of care to facilities supporting [VBAC] should be used rather than coercion.”¹¹⁵ Supportive facilities, of course, are becoming increasingly rare.

Even hospitals that have been VBAC-supportive in the past may change their policies without warning, leaving women hoping to deliver at that hospital with no option but to travel hundreds of miles to the next provider. Joy Szabo, a Page, Arizona mother who felt the effect of a sudden change in VBAC policy, made national news in September of 2009 when she protested her local hospital’s turnabout.¹¹⁶ She spoke to the *Lake Powell Chronicle*, defiantly posed holding her seven-months-pregnant belly next to a minivan with a message scrawled in paint on the rear windshield: “Page Hospital, enter my body without permission . . . Sounds like Rape to me.”¹¹⁷ Szabo was pregnant with her fourth child, planning to deliver at Page Hospital, the local hospital where she had delivered three times before.¹¹⁸ Ms. Szabo anticipated a VBAC delivery, and was a good candidate having delivered her first and third children vaginally.¹¹⁹ Page Hospital, however, changed its stance on VBAC midway through Ms. Szabo’s pregnancy, claiming that it did not have the resources to respond to an emergency.¹²⁰ Faced with the possibility that she would have to travel 350 miles to Phoenix for a

¹¹³ Anna Claire Vollers, *Which Alabama Hospitals Have the Highest, Lowest C-Section Rates?*, AL.COM (Jan. 23, 2015, 3:23 PM), http://www.al.com/news/index.ssf/2015/01/alabama_hospitals_with_highest.html, archived at <http://perma.cc/B953-K84V>.

¹¹⁴ ACOG Practice Bulletin, *supra* note 56, at 8.

¹¹⁵ *Id.*

¹¹⁶ Mary Forney, *Hospital Policy Pains Expectant Mom*, LAKE POWELL CHRON., Sept. 30, 2009, http://www.lakepowellchronicle.com/v2_news_articles.php?heading=0&story_id=1849&page=77, archived at <http://perma.cc/V887-DXC3>.

¹¹⁷ *Id.*; Elizabeth Cohen, *Mom Won’t Be Forced to Have C-Section*, CNN (Oct. 15, 2009, 9:30 AM), <http://www.cnn.com/2009/HEALTH/10/15/hospitals.ban.vbacs/>, archived at <http://perma.cc/8DV6-FG8V>.

¹¹⁸ Forney, *supra* note 116.

¹¹⁹ *Id.*

¹²⁰ *Id.*

VBAC or have an unassisted birth at home, Szabo asked the hospital Chief Executive Officer, Sandy Haryasz, what would happen if she presented to the hospital in labor and refused the surgery.¹²¹ Haryasz responded that the hospital would obtain a court order.¹²² In the end, Szabo and her husband relocated to Phoenix, where she easily delivered a healthy baby boy in December of 2009.¹²³

B. Holding Your Uterus for Ransom: Economic Threats

Mrs. Doe¹²⁴ lives in Marquette, a small town in the Upper Peninsula of Michigan. According to her husband, she began her prenatal care with Ob/Gyn Associates of Marquette, the only local ob/gyn practice, with the expectation that she would have a VBAC delivery at the nearby community hospital, Marquette General Hospital. The ob/gyn group was unsupportive of her plan to have a vaginal birth after cesarean, dropping her from care in a letter that stated that they would not treat her, even in an emergency. She received this letter at thirty-six weeks gestation, the cusp of full-term.

Earlier in her pregnancy, the practice had referred her to a Maternal-Fetal Medicine (MFM) specialist, who had a monthly clinic in Marquette but was based in Grand Rapids, 400 miles away. The family reported that that MFM specialist made only a cursory review of her operative report and told Mrs. Doe that she was obliged to deliver surgically because of the risks of cephalopelvic disproportion (a baby too big for the mother's pelvis) and gestational diabetes. None of these predictions were supported by the full medical record, or ever materialized. Her options dwindling, Mrs. Doe sought care from a local Family Physician. When that physician received her file, it included a letter from the MFM specialist detailing his opinion, which was marked with a note from a physician at Ob/Gyn Associates stating, "FYI. We are NOT allowing a VBAC on this [patient]."

Fortunately, Mrs. Doe was able to find a provider in Ann Arbor, and the family made plans to relocate 440 miles away for the final weeks of the pregnancy. The only thing that remained was to plan for the unexpected—a potential premature delivery, a mater-

¹²¹ Cohen, *supra* note 117.

¹²² *Id.*

¹²³ Elizabeth Cohen, *Mom Fights, Gets the Delivery She Wants*, CNN (Dec. 17, 2009, 9:17 AM), <http://www.cnn.com/2009/HEALTH/12/17/birth.plan.tips/>, archived at <http://perma.cc/X3F6-6E3Q>.

¹²⁴ Name withheld at the request of the family.

nal or fetal indication for early delivery—anything that would mean delivery before thirty-nine weeks gestation.

When Mrs. and Mr. Doe attempted to resolve the issue with the hospital, Marquette General Hospital's risk manager informed the family that MGH would not require the ob/gyn practice to assist Mrs. Doe, even in an emergency. They stated that if Mrs. Doe came to MGH in labor, regardless of how far she had progressed in her labor, they would stabilize and transfer her by airplane to the University of Michigan Health System, in Ann Arbor. When Mr. Doe protested, the risk manager demanded his credit card number for the purpose of billing them for plane fuel in advance. Fortunately Mrs. and Mr. Doe had a much more productive meeting with MGH's Chief Medical Officer, who rescinded the demand for plane fuel funds. The family relocated to Ann Arbor at about thirty-seven weeks gestation, and Mrs. Doe had a rapid vaginal delivery of a healthy baby.

Threatening patients with out-of-pocket expenses for transfers is just one way hospitals may attempt to circumvent their responsibilities to patients under federal law by keeping them from becoming patients in the first place. To understand why a hospital would want to ward off a patient, it is important to understand the Emergency Medical Treatment and Active Labor Management Act (EMTALA). EMTALA mandates that anyone who presents in active labor to the emergency department of a hospital that receives Medicaid funds must be examined and stabilized.¹²⁵ Once a labor is fully active, stabilization entails the delivery of the newborn and the placenta. If an emergency beyond the hospital's capacity arises, they may initiate a transfer to a suitable facility. While ACOG's practice guidelines recommend that VBAC labors be carefully monitored and take place in facilities where the resources necessary for emergency cesarean surgery are "immediately available," a VBAC labor is not an emergency *per se* that would warrant automatic transfer to another facility (in fact, it stands to reason that hospitals that are not equipped to handle a VBAC are not equipped to handle any birth, which may require surgical intervention at a moment's notice). The request for money for plane fuel from the Doe family was likely not based on any standard hospital practice, but was instead intended to deter the family from coming to MGH in labor, triggering responsibilities on the part of the hospital under EMTALA.

¹²⁵ Examination and Treatment for Emergency Medical Conditions and Women in Labor, 42 U.S.C. § 1395dd (2011).

Economic threats from health care providers can arise during labor and delivery as well. Many women in labor faced with an unsupportive provider try to seek respite (or optimize their chances for a VBAC) by leaving the hospital to allow labor to progress before returning to deliver. However, a common threat used to induce compliance with medical advice is that health insurance will not cover a birth if a woman leaves the hospital against medical advice (AMA).¹²⁶ This threat has been debunked as a “medical urban legend” by a study of insurance billing and payment data for more than 46,000 patients over nine years, which found no denials of payment due to discharge against medical advice.¹²⁷ Even so, the study not only found that the belief that insurance would not cover charges in the event of an AMA discharge is pervasive among health care providers, it is memorialized in AMA discharge forms, some of which require the patient to agree that they will accept responsibility for the entire bill.¹²⁸ As a result, the threat is given the air of truth and coercive force.

C. The Medically Unnecessary Vagina: Health Insurance Denials

Economic threats are not always as direct as being asked to pay for plane fuel, but, as discussed above, may come in the form of having to the sticker price of birth out of pocket. Birth is extremely expensive.¹²⁹ In 2011, the average facility costs alone (excluding newborn care fees and provider fees for midwives, physicians, anesthesiologists, and pediatricians) ranged from \$10,657 to \$23,923, depending upon whether the delivery was vaginal or surgical, and whether there were complications.¹³⁰ Even at the lower end of the spectrum, these are not costs that people can ordinarily pay out-of-pocket, so most rely on health insurance to cover maternity care. As a result, people’s decisions about location of birth or prenatal care provider are driven by what insurance will or will not cover.

¹²⁶ Cf. Gabrielle R. Schaefer et al., *Financial Responsibility of Hospitalized Patients Who Left Against Medical Advice: Medical Urban Legend?*, 27 J. GEN. INTERN. MED. 825 (2012) (exploring the veracity of nonpayment threats in the general population of hospitalized patients).

¹²⁷ *Id.* at 829.

¹²⁸ *Id.* at 828.

¹²⁹ See generally Maureen P. Corry et al., *The Cost of Having a Baby in the United States*, TRUVEN HEALTH ANALYTICS (2013), available at <http://transform.childbirthconnection.org/wp-content/uploads/2013/01/Cost-of-Having-a-Baby1.pdf>.

¹³⁰ *Average Facility Labor and Birth Charge By Site and Method of Birth, United States 2009-2011*, CHILDBIRTH CONNECTION (2013), available at <http://transform.childbirthconnection.org/resources/datacenter/chargeschart/>, archived at <http://perma.cc/M48C-KHQY>.

Where insurance dictates where a person may deliver, it can have the effect of making a vaginal birth after cesarean unaffordable.

In January of 2014, Michelle¹³¹ was hoping to have a vaginal birth after cesarean at a hospital just a block from her house in Santa Barbara, California. The hospital seemed well suited to her needs, advertising a state of the art perinatal center with an onsite NICU. Based on the information provided by the medical group Michelle's insurance provider contracted with and the shared decision-making quiz on their website, she was a good candidate for VBAC. In fact, the desire for a VBAC delivery was a factor in Michelle's decision to purchase her insurance policy.

During the third trimester of her pregnancy, however, it became clear that there was no physician who would actually attend a VBAC at the well-equipped local hospital. Michelle contacted her insurance company and requested that they cover maternity care with another provider, and her request was submitted for review to the medical group. Their response was astonishing:

The service request is being denied because there is a lack of medical necessity We cannot approve your request for an evaluation for vaginal birth after cesarean (VBAC) Our physician reviewer has determined that your delivery could be safely rendered by cesarean section

Michelle appealed the medical group's decision and was refused several more times. She spent the last months of her pregnancy arguing with the medical group, the insurance company, and even her husband, who did not understand why she didn't just give up and agree to surgery. Finally, with less than a month remaining in her pregnancy, she found a supportive ob/gyn who helped her appeal to the insurance company. The medical group admitted to the insurance company that they would not provide a non-surgical option for delivery, so the insurance company approved a transfer of care to an ob/gyn practice at UCLA, 100 miles away.

An upshot of a commodified healthcare system where surgical and vaginal delivery are treated as coequal widgets is that Michelle is neither the first nor last person to be told that her vagina is medically unnecessary to the birthing process. Even where the determination is overturned on appeal, the initial denial can cause delays in care and uncertainty as to whether the patient's wish to avoid unnecessary surgery will be respected.

¹³¹ Name withheld.

D. Defensive Medicine Goes On The Offense: Threats And Intimidation

On July 10, 2014, a letter was delivered to Jennifer Goodall's home. Jennifer was thirty-seven weeks pregnant with her fourth child, whom she hoped to deliver vaginally after three cesareans. She had explained to the ob/gyns at Comprehensive Women's Health Care that she wished to avoid surgery if possible, because prior surgeries had been complicated, traumatic, and required a lengthy recovery process. The physicians had been resistant, but nothing prepared her for the contents of the letter. It read:

After consideration by our Ethics Committee, we wish to advise you of the following actions:

1. We will contact the Department of Children and Family Services about your refusal to undergo a Cesarean section and other care and treatment recommended by your physicians and the high risks your refusals have on your life and health, as well as the life and health of your unborn child.
2. We will begin a process for an Expedited Judicial Intervention Concerning Medical Treatment Procedures. This is a proceeding for expedited judicial intervention concerning medical treatment procedures relating to the delivery of your child.
3. If you present to our hospital in labor, and your physician deems it clinically necessary, a Cesarean section will be performed with or without your consent.

In summary, while we recognize that you have the right to consent to a Cesarean section, you have elected to refuse this procedure despite the advice of your treating physicians. This decision places both you and your unborn child at risk for death or serious injury. We will act in the best interests of you, your family, and your unborn child. Our decision to take this course of action has been the result of multiple conversations with physicians and other experts within our organization.

We encourage you to find a physician who will agree to your demand. We sincerely hope that you will trust your physicians and our staff to do the right thing for you, your unborn child, and family.¹³²

The letter was signed by the hospital's Chief Financial Officer.

The threats to her fundamental rights to physical integrity and custody of her children were both serious and terrifying to Ms. Goodall. In threatening to call the Department of Child and Fam-

¹³² Declaration of Jennifer Goodall at 9-10, *Goodall v. Comprehensive Women's Health*, No. 2:14-cv-399-FtM-38CM, 2014 WL 3587290 (M.D. Fla. July 18, 2014), ECF No. 6.

ily Services and perform a surgery “with or without her consent,” the hospital essentially memorialized its intent to commit a battery and misuse child protective authorities by invoking them where they have no jurisdiction to supervise women’s decisions about birth, both of which are torts. Ms. Goodall, who had hoped to deliver at the Bayfront Health Port Charlotte Hospital now found herself at full term in pregnancy and “fired” by her practice. Any hope that she had of availing herself of her rights under EMTALA by presenting to the hospital in active labor evaporated as the hospital had threatened her with a court order or unconsented surgery.

Like anyone threatened with a battery would, Ms. Goodall filed for a restraining order against the hospital and physicians that would prevent them from carrying out the threats. Federal District Judge John E. Steele denied the request, stating in part that Ms. Goodall had no “right to compel a physician or medical facility to perform a medical procedure in the manner she wishes against their best medical judgment.”¹³³ Perversely, Ms. Goodall was cast as attempting to *compel* a medical procedure when she was trying to avoid a compelled surgery. She was free, the court reasoned, to find another provider who would support her in her desire to avoid surgery—even though no such provider existed in her area.

After her request for a restraining order was denied, Ms. Goodall went into hiding. Rather than presenting to a hospital for medical supervision as she wanted, she labored at home until it was no longer bearable and went to another local hospital where she underwent cesarean surgery. As had always been her plan, she consented to surgery when it became apparent that her labor was not progressing. Even so, the fear and uncertainty and risk to her pregnancy that she had to endure because of the hospital’s threats diminish the happy ending. Ms. Goodall may have had a healthy baby, but Bayfront Health Port Charlotte Hospital learned that they may avoid accepting VBAC patients by threatening them with force and legal coercion.

Ms. Goodall is not the only woman, or even the only woman in Florida, to face threats of court-ordered surgery and wrongful reporting to child protective authorities because of a medical choice that is not within the standard of care.¹³⁴ This framing, offered by

¹³³ Goodall v. Comprehensive Women’s Health, No. 2:14-cv-399-FtM-38CM, 2014 WL 3587290, at *3 (M.D. Fla. July 18, 2014).

¹³⁴ Letitia Stein, *USF Obstetrician Threatens to Call Police if Patient Doesn’t Report for C-section*, TAMPA BAY TIMES, Mar. 6, 2013, <http://www.tampabay.com/news/health/usf-obstetrician-threatens-to-call-police-if-patient-doesnt-report-for/2107387>, archived at <http://perma.cc/C3GX-RRDZ>; see also Burton v. State, 49 So.3d 263 (Fla. Dist. Ct.

health care providers and facilities, is illuminating. First of all, the standard of care is not binding upon the pregnant person, who has a right to make even unreasonable medical decisions.¹³⁵ Second, it exposes the underlying medicolegal concerns. In fact, hospitals that have sought court orders against their patients have openly acknowledged the fear of malpractice liability as a factor in deciding to override a competent patient's wishes, even where none of the physicians actually wants to perform surgery against their patients' will.¹³⁶ Ironically, this is a concern that has been directly addressed by the Florida Supreme Court, which has explicitly held that "patients do not lose their right to make decisions affecting their lives simply by entering a health care facility . . . a health care provider's function is to provide medical treatment in accordance with the patient's wishes and best interests, not as a "substitute parent" supervening the wishes of a competent adult."¹³⁷ That court further recognized that court orders are used by hospitals "to determine their rights and obligations to avoid liability" and asserted that health care providers are not liable in tort for following in good faith a competent patient's informed refusal of care.¹³⁸

While the order in Ms. Goodall's case does not represent precedent in any jurisdiction, it reveals a dim prognosis for the right to avoid unwanted surgery. Whereas health care facilities can hale a woman to court to adjudicate their liability in advance, courts have signaled that women, by contrast, may not. The significance of this is that a pregnant person wishing to deliver vaginally after cesarean surgery can expect no guarantee of bodily autonomy. Their only hope for vindication is in the hearing on a court order for surgery which—assuming that they are represented and the order is not granted *ex parte*—is procedurally deficient *per se*.¹³⁹

App. 2010); *Pemberton v. Tallahassee Mem. Reg'l Ctr.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999).

¹³⁵ 1 Health L. Prac. Guide §11:7 (2014).

¹³⁶ ROTH, *supra* note 101, at 118-19.

¹³⁷ *In re Dubreuil*, 629 So.2d 819, 823 (Fla. Sup. Ct. 1993).

¹³⁸ *Id.*

¹³⁹ *See, e.g., In re A.C.*, 573 A.2d at 1248 (noting that such proceedings would ordinarily arise under circumstances that would make it difficult or impossible to communicate with counsel or to conduct pre-trial discovery "to which she would be entitled as a matter of course in any controversy over even a modest amount of money"); Gallagher, *supra* note 3, at 49 ("The procedural shortcomings rampant in these cases are not mere technical deficiencies. They undermine the authority of the decisions themselves, posing serious questions as to whether judges can, in the absence of genuine notice, adequate representation, explicit standards of proof, and right of appeal, realistically frame principled and useful legal responses to the dilemmas with which they are being confronted.").

Where these coercive threats of abandonment are successful, patients have no realistic opportunity to find alternative care, and no cause of action in tort unless a medical catastrophe occurs as a result.¹⁴⁰

IV. FINDING SOLUTIONS

The limited entitlement to health in America and the reality of healthcare in the market economy create challenges that defy easy solutions—particularly litigation-based solutions. There are, however, some potential avenues for changemaking. Advocates for gender equity and reproductive justice can use these strategies to ensure that, at minimum, pregnant people have a meaningful right to decide whether or not they will undergo major surgery. Litigation opportunities may be limited, but attorneys can support these efforts with their understanding of contracts, administrative authority, and health policy.

A. *Market-based Solutions*

Given that private corporations will continue to control health insurance and healthcare for the foreseeable future, these corporations should be held to account for the service they provide (or fail to provide) to consumers. Most hospitals have some form of internal quality control mechanism that permits patients to register complaints about poor care. Consumer groups should advocate with local health care facilities to change VBAC refusal policies, and develop mechanisms for accountability for threats or other inappropriate actions.

The prospect of consumer complaints to healthcare facilities must be tempered with a dose of reality: complaints often must be addressed to the very institution that has created the problem, and institutional inertia and indifference toward individuals cannot be underestimated. Nevertheless, complaints paired with public pressure may be effective in ensuring that patients have a seat at the table when hospital policies are created. For instance, activists in Cape Coral, Florida were included in the creation of the Lee Memorial Health System's VBAC policies,¹⁴¹ and maternity care advocates successfully lobbied for the reopening of a maternity service in the Bronx that had a history of using midwives to achieve a low

¹⁴⁰ 1 Health L. Prac. Guide §11:7 (2014).

¹⁴¹ Frank Gluck, *Mothers Hoping To Avoid C-Sections Often Can't Find Doctors*, NEWS-PRESS.COM, July 28, 2014, <http://www.news-press.com/story/life/wellness/2014/07/27/mothers-hoping-avoid-c-sections-often-find-willing-doctors/13227725/>.

cesarean rate and high rate of VBAC success.¹⁴²

Patients may also file complaints with the nonprofit bodies that provide accreditation to health care facilities. These include the Joint Commission, which oversees hospitals,¹⁴³ and the Commission for the Accreditation of Birth Centers, which oversees birthing centers.¹⁴⁴

Additionally, health insurers may be able to provide some relief. Refusal of care by a practice or provider to people seeking to avoid primary or repeat cesarean delivery may constitute a breach of the contract the provider has with the health insurer. In many situations, complaints and appeals of denials have led to insurers easing restrictions that impede access to VBAC. Many maternity patients are unaware that they can appeal insurance denials, or that they may in some instances be entitled to out-of-network coverage of a provider who will provide the care that they need when there are no others available in-network.

B. Administrative Solutions

Medicine is a self-regulating profession, which means that each state has a regulatory agency that oversees the profession according to administrative rules and regulations. The creation of rules and regulations generally provides more of an opportunity for input by the public than lawmaking, making this an area where activists can create positive change. One example of such change from collective effort took place in Arizona, where midwives and midwifery advocates won an expansion of home birth services to include VBACs by pushing for a change in the rules governing midwifery practice.¹⁴⁵

Regulations can also provide avenues for redress, such as viola-

¹⁴² Ben Kochman, *Baby step! First Infant Born at North Central Bronx Hospital's New Maternity Ward*, N.Y. DAILY NEWS, Oct. 27, 2014, <http://www.nydailynews.com/new-york/bronx/infant-born-north-central-bronx-hospital-new-maternity-ward-article-1.1989399>, archived at <http://perma.cc/8J TZ-WU7X> ("The birthing center reopened with a new post-anesthesia care unit, upgraded security and a core team of experienced physicians and licensed midwives after public outcry and a \$2 million infusion.").

¹⁴³ *Report a Patient Safety Event*, THE JOINT COMM'N, http://www.jointcommission.org/report_a_complaint.aspx (last visited Apr. 21, 2015), archived at <http://perma.cc/BD5E-G6LT>.

¹⁴⁴ *How to Report a Complaint About a Birth Center*, THE COMM'N FOR THE ACCREDITATION OF BIRTH CTRS., <https://www.birthcenteraccreditation.org/find-accredited-birth-centers/how-to-report-a-complaint-about-a-birth-center/> (last visited Apr. 21, 2015), archived at <https://perma.cc/PAV6-74LV>.

¹⁴⁵ Rachel Leingang, *Midwives' Role Expands, To Some Controversy, Under New Rules*, CRONKITE NEWS, May 2, 2014, <http://cronkitenewsonline.com/2014/05/role-of->

tions of EMTALA, which are reportable to regional offices of the Centers for Medicare and Medicaid Services.¹⁴⁶ Additionally, the authority of agencies governing the practice of medicine includes the determination and disciplining of misconduct, usually through the Board of Medicine, Board of Nursing, or Board of Midwifery, depending upon the state. Advocates can help ensure that filing of complaints against individual providers is accessible and straightforward. They can also help develop administrative guidelines that include penalties for patient abandonment that do not excuse abandoning patients who disagree with medical recommendations late in pregnancy.

C. Policy Solutions

The Affordable Care Act has provided an opportunity for advocates to shape healthcare policy to meet people's needs during pregnancy and delivery. For instance, not only must all plans cover maternity care, many states have expanded coverage for midwifery services and free-standing birth centers.¹⁴⁷ Federal and state insurance laws should require that insurance cover VBAC and provide out-of-network exceptions when no in-network providers are available.

Another strategy, already adopted by New York¹⁴⁸ and Massachusetts,¹⁴⁹ is the creation of a Maternity Information Act. Mater-

arizonas-midwives-expanding-with-some-controversy-under-new-rules/, archived at <http://perma.cc/8TSG-7KM3>.

¹⁴⁶ *Where to Report EMTALA Violations*, PUBLICCITIZEN.ORG, http://www.citizen.org/hrg/article_redirect.cfm?ID=6147 (last visited Sept. 2, 2015).

¹⁴⁷ *Fact Sheet: Why the Affordable Care Act Matters for Women: Better Care for Pregnant Women and Mothers*, NAT'L P'SHIP FOR WOMEN & FAMILIES (2014), available at <http://www.nationalpartnership.org/research-library/health-care/better-care-for-pregnant-women.pdf>.

¹⁴⁸ N.Y. PUB. HEALTH L. § 2803-j(2)(a-m) (2015) ("Each hospital's informational leaflet must provide the annual percentage of the following maternity related procedures performed at the hospital: cesarean sections (primary, repeat and total); successful vaginal deliveries by women who have had previous cesarean sections; deliveries by midwives; use of electronic fetal monitoring; use of forceps; breech births delivered vaginally; use of analgesia; use of anesthesia; induction of labor; augmentation of labor; episiotomies; and whether birthing rooms and rooming-in is available at the facility.").

¹⁴⁹ MASS. GEN. LAWS ch. 111, § 70E (2009) ("Every maternity patient, at the time of pre-admission, shall receive complete information from an admitting hospital on its annual rate of primary caesarian sections, annual rate of repeat caesarian sections, annual rate of total caesarian sections, annual percentage of women who have had a caesarian section who have had a subsequent successful vaginal birth, annual percentage of deliveries in birthing rooms and labor-delivery-recovery or labor-delivery-recovery-postpartum rooms, annual percentage of deliveries by certified nurse-midwives, annual percentage which were continuously externally monitored only, annual per-

nity Information Acts require facilities to collect, report, and provide to all maternity patients data on utilization of interventions such as episiotomy, forceps, and cesarean surgery. These laws were passed to ensure that people have the information they need about healthcare facilities and to address overuse of cesarean surgery and other procedures.¹⁵⁰ This permits women to make informed decisions about birth facilities based on their current practice.

V. CONCLUSION

It is fundamental to the basic premises of dignity and liberty that each person have the right to choose not to undergo potentially life-threatening surgical invasions, and that no such invasion take place without their consent. Respect for equality demands that this right belongs equally to people who can become pregnant and give birth.

In the context of the millions of births that take place each year in the United States, few cesarean surgeries (though likely more than we are aware of) take place over the objection of the person giving birth. But consent is more than the mere absence of objection, and choice is meaningless in the absence of alternatives.

The violence done to a person who is forced to have a surgery against their will is not limited to that of cutting and scalpels: it includes the violence done by the invisible hand, and the violence done by the state for its failure to prevent it. In order to achieve a world in which people can freely and fully make decisions about their reproductive lives, our accounting of the surgeries performed against the will of the person giving birth must include, and our advocacy for reproductive justice address, the many factors that conspire to deprive people of the right to refuse.

centage which were continuously internally monitored only, annual percentage which were monitored both internally and externally, annual percentages utilizing intravenous, inductions, augmentation, forceps, episiotomies, spinals, epidurals and general anesthesia, and its annual percentage of women breast-feeding upon discharge from said hospital.”).

¹⁵⁰ See LAUREL TUMARKIN ET AL., OFFICE OF THE N.Y.C. PUB. ADVOCATE, *GIVING BIRTH IN THE DARK: CITY HOSPITALS STILL FAILING TO PROVIDE MANDATED MATERNITY INFORMATION* 7 (2006), available at <http://www.nyc.gov/html/records/pdf/govpub/moved/pubadvocate/GivingBirthInTheDark12.06.pdf>.