



## WRITING CONTEST TO ADVANCE FEMINIST LEGAL SCHOLARSHIP ON THE SUBJECT OF PREGNANT WOMEN'S CIVIL AND HUMAN RIGHTS

**National Advocates for Pregnant Women seeks student-written law review style articles positing challenges to bans on pregnant women having vaginal births after previous caesarean sections. The judging panel will include experts and activists in gender equality, reproductive justice and birthing and human rights. Articles will be judged according to the strength and creativity of the legal analysis, inclusion of race and class considerations, clarity and style of writing, and how well the article answers the specific question at hand. The winner will receive \$1000\*. Second prize is \$500\*, and third prize is \$250\*. The first-prize winner will also have an opportunity to attend a conference in the field.**

*This challenge asks you to address the question of what statutory, constitutional, and/or human rights arguments can be made to challenge the trend of banning pregnant women from having a vaginal birth after a caesarean section (VBAC), and forcing them to undergo repeat surgery if they want to deliver in a hospital setting. The discussion below will help guide your analysis.*

While recognizing that childbirth is an experience that “men cannot fully comprehend,”<sup>1</sup> legal academic John Robertson suggests that the choice of birth attendant, location of birth, and agency in what medical procedures are used merely reflect the “woman’s interest in an aesthetically pleasing or emotionally satisfying birth” but do not apparently implicate any constitutional or human rights.<sup>2</sup> This writing challenge offers an opportunity to address whether this view is correct.

According to many experts, vaginal delivery after previous caesarean section is a safe option for most women, and the VBAC success rate is between 60% and 80%. The American College of Obstetrics and Gynecology (ACOG) recommends that “VBAC should be attempted in institutions equipped to respond to emergencies with physicians immediately available to provide care.”<sup>3</sup> However, many hospitals and insurers have interpreted this recommendation to mean that, unless the facility has an anesthesiologist and an obstetrician present around the clock to conduct an emergency caesarean, a woman with a prior caesarean should not be allowed to go into labor. According to a survey conducted by the International Caesarean Awareness Network, at least 300 hospitals have “banned” VBAC altogether.<sup>4</sup>

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\* Prize amounts may increase. Please check our website, [www.advocatesforpregnantwomen.org](http://www.advocatesforpregnantwomen.org) for periodic updates concerning the contest, cosponsors, additional prompts, and prize awards.

<sup>1</sup> John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 451 (1983).

<sup>2</sup> *Id.*

<sup>3</sup> Am. Coll. Obstetricians & Gynecologists, *Vaginal Birth After Previous Cesarean Delivery*, 2004 ACOG PRACTICE BULLETIN 54, [http://www.acog.org/acog\\_districts/dist9/pb054.pdf](http://www.acog.org/acog_districts/dist9/pb054.pdf).

<sup>4</sup> Int'l Caesarean 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 August 12, 2008).

Although these policies are colloquially called “VBAC bans,” they are not a limitation on the services provided by the hospital (e.g., “We don’t do cosmetic surgery here”); rather they are a limitation on certain *women* (e.g. “Because you have a uterine scar, you may not give birth here unless you submit to a scheduled caesarean section”).

In areas where there is no other hospital within a practicable distance, some women feel that they are left with little choice but to submit to surgery that they believe to be unnecessary or deliver outside of the hospital setting, with or without assistance.

Here are some stories from around the country:

- A woman in Nebraska who had birthed five children, the last via caesarean, reported that she was told that her sixth delivery had to be by a caesarean section despite her wishes for a vaginal birth and her doctor’s assessment that she was a good candidate for VBAC. No nearby facilities existed that would permit her to attempt vaginal birth. She ended up delivering at home and had a successful vaginal delivery.
- Oklahoma’s Physician’s Liability Insurance Corporation (PLICO) refuses to cover doctors for VBAC. PLICO provides insurance for 80% of Oklahoma physicians.
- According to a birthing rights activist, a Maryland hospital meets ACOG guidelines for VBAC. The hospital nonetheless has a policy banning pregnant women from delivering vaginally after a previous caesarean section. One patient there, who had a caesarean section 13 years ago, was told that she would have to deliver surgically even though she has had three successful vaginal deliveries in the intervening years.
- Some women have contacted advocacy groups reporting that they are assured by their providers that they will be able to deliver vaginally, only to be met by a host of objections by the doctor as the pregnancy progresses, often after it is impracticable to change prenatal and childbirth care providers. In some cases the healthcare provider has threatened to abandon the pregnant woman unless she agrees in advance to a caesarean surgery.

There is no law in any state that prohibits a woman from delivering a child vaginally after a prior caesarean section. Neither is there a law that prohibits a woman from giving birth in her home. Nevertheless, in one particularly frightening case, armed agents of the state entered a woman’s home, took her into state custody and forcibly compelled her to undergo a caesarean section.

In this case,<sup>5</sup> Laura Pemberton scoured Tallahassee and the surrounding areas for an obstetrician who would attend her in a vaginal birth for her fourth child after a prior caesarean delivery. She was rebuffed by every doctor she contacted; the risk of catastrophic uterine rupture was too high, they told her. Believing in her body’s ability to give birth vaginally, Mrs. Pemberton decided to

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<sup>5</sup> Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., Inc., 66 F. Supp. 2d 1247 (N.D. Fla. 1999); Laura Pemberton, Address at National Advocates for Pregnant Women’s National Summit to Ensure the Health and Humanity of Pregnant and Birthing Women (January 18-21, 2007) (audio recording on file with NAPW).

deliver at home rather than agree to what she viewed as unnecessary surgery. More than a day into her labor with no sign of complications, she nevertheless worried that she was becoming dehydrated. She reasoned that the best way to safely manage her labor would be to go to a hospital for intravenous fluids, and then return home. Mrs. Pemberton entered the hospital expecting to receive care and assuming that she, like other patients, had a right to informed medical decision-making, including the right to consent to or to decline recommended medical procedures. When she arrived, she was placed on a fetal monitor that showed that her baby's heartbeat was strong, and that her labor was progressing, albeit slowly. However, when the obstetrician on call realized that she was attempting a VBAC, she refused to give the IV that Mrs. Pemberton needed—unless she consented to a caesarean. Mrs. Pemberton was alerted by a nurse that obstetricians were about to seek a court-ordered caesarean section. Without receiving the fluids and while still in active labor, she fled the hospital out of the back steps in her bare feet.

Mrs. Pemberton made it home to continue her labor, her confidence bolstered by the baby's strong heart tones. Her progressing labor was interrupted by a knock at the door: it was a sheriff and the State Attorney. They entered her home and even her bedroom, following her throughout her house to make sure she did not flee again. They told her that she had to return to the hospital, because a court order forcing her to undergo a caesarean section had been granted. Neighbors looked on as she was removed from her home, still in active labor, with her legs strapped together on a stretcher. Once at the hospital, she was allowed a "hearing" in her hospital room, with an armed sheriff, the State Attorney, and obstetricians crowding her room. Although a lawyer was appointed to represent the fetus, no lawyer was appointed for her. She spoke between contractions, without the benefit of counsel, telling the judge about the extensive research that she had done to support her decisions. Despite the fact that she could already feel her baby's head in the birth canal and neither she nor the baby showed any signs of danger, the obstetricians were convinced that she exposed her fetus to too much risk by continuing to deliver vaginally: the judge agreed. Laura Pemberton was sedated, and her baby removed via caesarean section. Mrs. Pemberton left the state and went on to deliver four more children, including a set of twins, vaginally.

A strong argument has been made that the bans are not justified by evidence-based research showing that a vaginal delivery after a caesarean is inherently more dangerous than a repeat caesarean, or any other vaginal delivery for that matter. Evidence-based research indicates that the risk that is cited to justify these bans, catastrophic uterine rupture, is thirty times *less* likely than two other possibly fatal complications which can happen in any delivery—premature placental separation from the uterine wall or constriction of the umbilical cord—both of which will cause a stillbirth within minutes without surgical intervention. In other words, every birth carries with it some risk of devastating consequences. Therefore, one argument is that a hospital that is not equipped to handle a VBAC is not equipped to handle *any* birth.

Moreover, there are also risks involved in repeat caesarean sections. The overall impact on women's health may be negative, as the risks of a caesarean surgery are cumulative, with dramatic increases in the rate of maternal morbidity with each subsequent surgery. Ironically, while some malpractice insurance companies refuse to cover physicians who attend VBACs, a recent newspaper story reported that some health insurance companies are also refusing to cover the

costs of giving birth if the woman has already undergone a caesarean section.<sup>6</sup> Some women who had a surgical delivery also report that they have been told by their physicians that they should not plan to have more than three children because of the cumulative risks of caesarean sections.

The impact of bans is widespread. These policies affect more than just the women currently looking for a VBAC. With the rate of caesarean deliveries exceeding 35% in some places (more than twice the rate the World Health Organization concluded would ever be medically necessary<sup>7</sup>), with no commensurate improvement in birth outcomes, a return to the philosophy of “once a caesarean, always a caesarean” has two likely effects: more deliveries by major abdominal surgery and less maternal autonomy.

*Articles should be no less than 25 double-spaced typewritten pages in length, including footnotes. Textual material should be in 12-point Courier or Times New Roman font; footnotes may be in 10-point Courier or Times New Roman font, and should be in Bluebook format. Please use 8.5”x11” paper with one inch margins on all sides.*

*See [www.advocatesforpregnantwomen.org](http://www.advocatesforpregnantwomen.org) for submission guidelines.*

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<sup>6</sup> 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>.

<sup>7</sup> World Health Org., *Appropriate Technology for Birth*, 2 LANCET 436 (1985).