

National Advocates for Pregnant Women
Student Writing Competition Entry

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“In the Manner Prescribed By the State”
Potential Challenges to State-Enforced Hospital Limitations on Childbirth Options

I. Introduction

In recent decades, advances in medical technology have given pregnant women and their doctors an unprecedented level of information about, and control over, the conduct of a pregnancy. As a result, physicians and women may make thousands of decisions over the course of a nine-month gestational period, ranging from determining the method of conception itself to deciding the method of delivery at the end of the pregnancy. This transformation of reproduction, including labor and delivery, from a natural, woman-centered process to a medical journey is frequently referred to as the “medicalization of childbirth,” and poses a host of moral, ethical, medical, and legal problems.¹ Such issues frequently arise when a woman’s desires concerning the time, place, and manner of her labor and delivery do not mesh with the recommendations and advice of her doctors. One type of desired delivery that often brings patients and obstetricians into conflict is when a woman wishes to deliver an infant via vaginal birth after having delivered one or more previous children via cesarean section, a process popularly referred to as “VBAC.”²

Attempting a VBAC is not without risks, and primary among them is the chance of a rupture of the previous cesarean scar that could potentially endanger the lives of both pregnant woman and fetus.³ As a result of this risk, and out of an abundance of caution and fear of malpractice

¹ “Medicalization” is a common term “describ[ing] a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders.” Peter Conrad, *Medicalization and Social Control*, 18 ANNUAL REV. SOCIOLOGY 209, 209 (1992).

² See American Pregnancy Association, *VBAC: Vaginal Birth After Cesarean*, <http://www.americanpregnancy.org/labornbirth/vbac.html> (last visited May 15, 2009).

³ Jill MacCorkle, *Fighting VBAC-Lash: Critiquing Current Research*, MOTHERING MAGAZINE, Jan./Feb. 2002, available at <http://www.ican-online.org/vbac/fighting-vbac-lash-critiquing-current-research>.

lawsuits, many hospitals—28%, according to a recently reported survey⁴—and insurance plans have banned VBAC attempts.⁵ The issue of whether hospitals and insurance plans may legally and constitutionally ban a pregnant woman from attempting a VBAC provides a compelling lens through which we may consider many pressing current issues surrounding maternal and fetal rights, the medicalization of childbirth, and the extent to which the state’s interest in fetal life allows it to compel women to undergo medical treatment.

Most scholarly analyses of forced or court-ordered cesarean sections to date have focused on the instances where physicians judge a cesarean necessary to preserve the life or health of the fetus alone.⁶ These cases raise complex legal, medical, and ethical issues related to the state’s interests in the preservation of potential life,⁷ in protecting minor children,⁸ and in maintaining the “ethical integrity of the medical profession”⁹ This paper expands on those previous analyses in a new context, and argues that VBAC bans that require women to undergo repeated cesarean sections if they desire to give birth in a hospital setting violate those patients’ legal and constitutional rights. The VBAC problem is best viewed through a reproductive justice lens:

The Reproductive Justice Framework envisions the complete physical, mental, and spiritual well-being of women and girls. It stipulates that reproductive justice will be achieved when women and girls have the economic, social, and political power and resources to make

⁴ Pamela Paul, *The Trouble with Repeat Cesareans*, TIME, Mar. 2, 2009 at 36 (providing the results of a survey conducted by the International Cesarean Awareness Network of 2,850 hospitals).

⁵ See International Cesarean Awareness Network, *VBAC Hospital Policy Information*, [http://www.ican-online.org/vbac-ban-map?filter0\[\]=VBACs+banned&filter1=](http://www.ican-online.org/vbac-ban-map?filter0[]=VBACs+banned&filter1=) (listing hospitals where VBAC attempts are banned either by written policy or because there are no obstetricians willing to accept patients desiring a VBAC). In addition to hospital and insurance bans, many doctors refuse to assist women attempting a VBAC because of the unavailability of liability insurance. See Paul, *supra* note 4, at 37 (“In a 2006 ACOG survey of 10,659 ob-gyns nationwide, 26% said they had given up on VBACs because insurance was unaffordable or unavailable; 33% said they had dropped VBACs out of fear of litigation.”).

⁶ See, e.g., SHEENA MEREDITH, *POLICING PREGNANCY: THE LAW AND ETHICS OF OBSTETRIC CONFLICT* 38-44 (2005) (surveying case law allowing compelled cesarean sections in the United Kingdom and the United States).

⁷ *Id.* at 46-48.

⁸ *Id.* at 48-49.

⁹ *Id.* at 49-50.

healthy decisions about our bodies, sexuality, and reproduction for ourselves, our families, and our communities in all areas of our lives.¹⁰

II. Background: The Medicalization of Childbirth and VBAC Bans

Feminist scholars have described the medicalization of childbirth as one that constructs a clear set of dichotomies between medicine and reproduction, in which “medicine is seen as a scientific endeavor in which nature is controlled through culture” while “reproduction (and the women in whose bodies it occurs) is seen as a pathological, disease-like condition”¹¹ This Part discusses the financial costs of this conflict between medicine and reproduction, and then turns to an analysis of the other costs of the medicalized model of childbirth, costs which are often imposed upon women’s rights to bodily autonomy and control over their medical care.

a. The Financial Costs of Medicalized Childbirth

The medicalization of childbirth has imposed significant financial costs on the healthcare system. Scholars have noted that “[o]ver the past 20 years the use of such technologies as induction of labor, electronic fetal heart rate monitoring, ultrasound, epistomy, and [cesarean] section has risen” even in the face of repeated studies suggesting that “frequent and/or routine use of these technologies cannot be justified”¹² One recent report found that the “national average hospital charge for childbirth ranged from about \$7,000 to nearly \$16,000, depending on whether the birth was vaginal or [cesarean] and, further, was coded as uncomplicated or complicated.”¹³ In contrast, the report found that the average charge at one of the “eighty-six freestanding birth centers across the country . . . was about \$1,600, one-quarter of the hospital

¹⁰ Eveline Shen, *Reproductive Justice: How Pro-Choice Activists Can Work to Build a Comprehensive Movement*, MOTHER JONES, Jan. 24, 2006, available at <http://www.motherjones.com/politics/2006/01/reproductive-justice>.

¹¹ Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 538 (1993).

¹² Ann Oakley, *Who Cares for Women? Science Versus Love in Midwifery Today*, in MIDWIFERY AND MEDICALIZATION, *supra* note 18, at 319, 323.

¹³ Carol Sakala & Maureen P. Corry, *Evidence-Based Maternity Care: What It Is and What It Can Achieve*, MILBANK MEMORIAL FUND REPORT, at 12 (2008).

charge for uncomplicated vaginal birth that year.”¹⁴ The report also noted that “[i]n 2005, fully 27 percent of hospital charges (or \$34,164,460,561 to Medicaid and 15 percent of hospital charges (or \$39,726,164,301) to private insurers were for birthing women and newborns.”¹⁵

These numbers reflect the staggering financial costs of a system in which “common [medical] interventions disrupt and preclude the physiologic capacities of the childbirth process and incur a cascade of secondary interventions used to monitor, prevent, and treat the side effects of the initial interventions.”¹⁶ Thus, the view that pregnancy and childbirth are illnesses to be treated has imposed significant costs on the healthcare system, costs which are disproportionately borne by low-income pregnant women or passed on to the overburdened Medicaid system.

In contrast to the medical model of pregnancy and childbirth, feminist scholars and advocates for pregnant women “argue that these processes and the wide variation in women’s experience of them are normal”¹⁷ These activists support lay midwifery, which uses trained professionals to assist women to give birth at home or in low-intervention hospital settings, as a superior alternative to medicalized childbirth.¹⁸ Scholars have noted, however, that one consequence of the rise of medicalized childbirth in the United States “is that midwives have almost been eliminated as viable childbirth competitors with medical doctors.”¹⁹ This process has cost

¹⁴ *Id.* at 12-13.

¹⁵ *Id.* at 11.

¹⁶ *Id.* at 28.

¹⁷ Rose Weitz & Deborah A. Sullivan, *The Politics of Childbirth: The Re-Emergency of Midwifery in Arizona*, 33 *SOCIAL PROBLEMS* 163, 163 (1986).

¹⁸ *See id.*; *see also* Judith P. Rooks, *The Context of Nurse-Midwifery in the 1980s: Our Relationships with Medicine, Nursing, Lay-Midwives, Consumers and Health-Care Economists*, in *MIDWIFERY AND THE MEDICALIZATION OF CHILDBIRTH: COMPARATIVE PERSPECTIVES* 301, 304 (Edwin van Teijlingen et al., eds., 2004) [hereinafter *MIDWIFERY AND MEDICALIZATION*] (drawing a distinction between African lay midwives, who are “traditional birth attendants or village midwives with relatively brief training limited essentially to pregnancy and childbirth” and nurse-midwives, who are “fully prepared nurses with additional midwifery education and training”).

¹⁹ Edwin van Teijlingen et al., *General Introduction to Midwifery and the Medicalization of Childbirth: Comparative Perspectives*, in *MIDWIFERY AND MEDICALIZATION*, *supra* note 18, at 1, 2.

women considerably more than simply a wide variety of childbirth options. Indeed, the loss to women is one of constitutional dimensions, as explored later in this paper.

b. The Rise of the “Maternal-Fetal Conflict”

Traditionally, an obstetrician owed a duty of care only to his pregnant patient, and not to her potential child. The fetus his patent carried “under common law had no legal persona unless and until born alive.”²⁰ However, in recent years “a breathtaking array of civil suits and statutory and regulatory initiatives has sought to treat fetuses as entirely separate from the pregnant women whose bodies sustain them.”²¹ This is in large part a result of “[t]he development of techniques for imaging, testing, and treating the [fetus],” which “has now yielded a medical view of the [fetus] as a separate entity, and of pregnancy as involving two ‘patients’ in one body – a viewpoint that encourages physicians to see pregnancy as inherently involving a conflict of interests between the woman and the [fetus] she is carrying.”²²

The legal status of the fetus is a highly politically charged issue in the current American legal landscape. As the idea of the fetus as a separate entity has become more prevalent in Western society, a number of “fetal protection” policies and laws have taken shape, in both the employment and medical realms.²³ Scholars have “argued that the often unarticulated bases of these fetal protection policies assume that women should not make decisions concerning their own bodies and that fetal interests are superior to those of women.”²⁴ Some conservative

²⁰ *Id.* at 12.

²¹ Linda C. Fentiman, *The New “Fetal Protection”*: *The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children*, 84 DENV. U.L. REV. 537, 544 (2006).

²² MEREDITH, *supra* note 6, at 2 (footnotes omitted).

²³ See Pamala Harris, Note, *Compelled Medical Treatment of Pregnant Women: The Balancing of Maternal and Fetal Rights*, 49 CLEV. ST. L. REV. 133, 138-39 (2001) (discussing *United Auto Workers v. Johnson Controls*, 499 U.S. 187 (1991), in which the Supreme Court held that an employer policy excluding women of child-bearing age from certain jobs violated the Pregnancy Discrimination Act).

²⁴ Harris, *supra* note 23, at 139.

scholars have made this prioritization explicit, arguing that once a woman “conceives and chooses not to abort,” her “viable fetus acquires rights to have the mother conduct her life in ways that will not injure it.”²⁵ Legally speaking, a number of lower court decisions have “extend[ed] the doctor’s duty of care to the [fetus] while it is *in utero*, and not only once it has been born alive – creating potential conflicts if this duty is at variance with that owed to the pregnant woman, or with her expressed wishes that go against medical advice.”²⁶

Merging with this increasing characterization of the fetus as a separate medical and sometimes legal entity is a dramatic trend towards the treatment of pregnancy as something “pathological.”²⁷ If pregnancy is deemed a disease to be treated, rather than a natural process that can be completed with little to no non-emergency medical intervention, then doctors’ ideas of proper treatments come to have considerably more weight than women’s desires to govern the course of their pregnancies, labors, and deliveries. As a result, we have come to accept “the idea and practice of controlling women with regard to gestation and childbirth . . . Women who do not conform to these expectations are considered to be bad mothers and their noncompliance is assumed to be willful and immoral.”²⁸ These devaluations of women’s choices are especially harmful to women of color, who are assumed by many doctors to be particularly noncompliant and “litigious” and are thus subjected to even greater scrutiny for their choices in the childbirth process.²⁹

²⁵ John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 438 (1983). It seems self-evident that this would be a slippery slope with no end in sight—could a fetus sue its mother for harm done in utero? Could a child born with any type of birth defect have a claim in tort for its mother’s failure to take a full array of prenatal vitamins? At any rate, this view of fetal rights as superior to those of a pregnant woman has not been widely adopted in either the medical or legal communities.

²⁶ MEREDITH, *supra* note 6, at 12.

²⁷ *Id.* at 29.

²⁸ Harris, *supra* note 23, at 136-37.

²⁹ Ehrenreich, *supra* note 11, at 523.

Thus, a woman who does not heed her doctors' advice during the conduct of her pregnancy is viewed as acting in her interest to the exclusion of her fetus's best interests, a problem often labeled "maternal-fetal conflict."³⁰ Justice Ruth Bader Ginsburg has noted that this conflict has much larger ramifications than the scope of one pregnancy:

The conflict, however, is not simply one between a fetus' interests and a woman's interests, narrowly conceived, nor is the overriding issue state versus private control of a woman's body. Also in the balance is a woman's autonomous charge of her full life's course . . . her ability to stand in relation to man, society, and the state as an independent, self-sustaining, equal citizen.³¹

Other scholars have noted that the issue is more accurately termed "obstetric conflict," as pregnant women who act against their doctors' wishes are acting to oppose their doctors, and there is no evidence of an active ill-will against the interests of the fetus.³² Indeed, in several well-publicized cases women have violated court orders to compel compliance with medical directives, and have gone on to deliver healthy children.³³ Issues of obstetric conflict come to the fore, and occasionally enter the courts, in cases where a pregnant woman desires to have a labor and delivery with limited-to-no medical intervention, directly conflicting with a medical establishment that generally prefers to conduct deliveries with a high degree of such intervention.³⁴

³⁰ See, e.g., Alicia Ouellette, *New Medical Technology: A Chance to Reexamine Court-Ordered Medical Procedures During Pregnancy*, 57 ALB. L. REV. 927 (1994) ("In most cases, a pregnant woman will do anything to ensure the health and safety of her fetus. In some cases, however, a pregnant woman may refuse treatment . . . for reasons such as religion, fear of surgery, and concern for her health or the welfare of her other children.").

³¹ Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C.L. REV. 375, 383 (1985) (footnote omitted).

³² See generally MEREDITH, *supra* note 6.

³³ See, e.g., *Jefferson v. Griffin Spalding County Hosp.*, 274 S.E.2d 457 (Ga. 1981) (infant was born healthy through natural childbirth even after the Georgia Supreme Court granted an order compelling a cesarean section); *In Re Baby Boy Doe*, 632 N.E.2d 326, 332 (Ill. App. Ct. 1st Dist. 1994) (infant born healthy after doctor fought unsuccessfully to compel cesarean section).

³⁴ The modern medicalization of childbirth has been discussed in a wide variety of popular books, magazines, and even a theatrical documentary. See, e.g., PAUL STARR, *THE SOCIAL TRANSFORMATION OF MEDICINE* (1983); Paul, *supra* note 4, at 36; *THE BUSINESS OF BEING BORN* (Barranca Productions 2007).

c. VBAC Bans: The Current Medical Landscape

Scholarly discussions of the medicalization of childbirth often cite to the ever-increasing rate of cesarean sections as an example of the new norm of childbirth as a sterile, surgical, hospitalized experience.³⁵ Research shows that “[f]or a host of reasons, including legal defensiveness, an excessive commitment to technological solutions, the seeking of higher profits by physicians and hospitals, and misunderstandings about the true need for cesarean sections, there are many unnecessary cesarean procedures performed in this country.”³⁶ This increase is accompanied by significant risks of increased medical complications and even potentially life-threatening effects, as “the mortality rate for women undergoing cesarean surgery is significantly higher than the mortality rate for women who deliver vaginally.”³⁷ Nevertheless, when women refuse a cesarean section, doctors have sometimes resorted to the courts to compel compliance with their directives.³⁸

One instance where women’s desires for a natural childbirth frequently comes into conflict with her doctors’ treatment preferences is when a woman who has previously delivered an infant via cesarean section desires to deliver a second or later child through a natural vaginal

³⁵ See, e.g., Lisa Ikemoto, *Furthering the Inquiry: Race, Class, and Culture in the Forced Medical Treatment of Pregnant Women*, 59 TENN. L. REV. 487, 505-06 (“The understanding of childbirth as a pathology, a set of risks to be controlled, developed during the twentieth century as doctors became participants in caring for pregnant women. Medical intervention has steadily increased through the past few decades. Cesarean sections, in particular, have risen in number . . .”).

³⁶ Joel Jay Finer, *Toward Guidelines for Compelling Cesarean Surgery: Of Rights, Responsibilities, and Decisional Authority*, 76 MINN. L. REV. 239, 240 n.1 (1991).

³⁷ Ikemoto, *supra* note 35, at 506.

³⁸ See, e.g., *In Re A.C.*, 573 A.2d 1235 (D.C. Cir. 1990) (holding that the trial court had erred when it allowed a cesarean section to be performed on a woman who was twenty-six weeks pregnant and dying of cancer, resulting in the death of both mother and infant); *Jefferson*, 274 S.E.2d 457 (Ga. 1981) (granting the state temporary custody of a fetus in order to compel a cesarean section where doctors felt that the mother’s medical condition would almost guarantee fetal death in a vaginal delivery); *Doe*, 632 N.E.2d 326 (upholding a woman’s decision to refuse a cesarean section even where her doctors claimed that a vaginal delivery would result in the death of her nearly-full-term fetus); Another context in which women are frequently brought to court to compel compliance with obstetricians’ desires is where pregnant women refuse blood transfusions. See Finer, *supra* note 36, at 250-52 (noting that courts in blood transfusion cases generally allow the infringement of “the autonomy and bodily integrity of mothers . . . to serve a traditional state value, the prevention of harm to third parties”).

birth. This procedure, called a VBAC (vaginal birth after cesarean), is discouraged and flatly banned by many hospitals.³⁹ When a woman who has previously had a cesarean section desires to attempt a vaginal birth in a subsequent delivery, and is told that her hospital refuses to allow such an attempt, she has a number of choices. If she has a portable health insurance plan (and if her insurance will cover a VBAC attempt), time to seek another hospital, and happens to reside in an area where other hospitals are available, she may go elsewhere for treatment.⁴⁰ She may decide to labor at home, and hope that she is able to find midwifery assistance. Of course, not all women who decide to labor at home after being denied VBAC assistance are left to do in piece, as in one Florida case where a woman who sought to deliver a child vaginally after a previous cesarean section was forcibly returned to the hospital in active labor by county police and given a cesarean section.⁴¹ A court later ruled that neither the hospital's nor the county's actions had violated her constitutional rights.⁴² And the travel-elsewhere and birth-at-home options are unlikely to be readily available to lower-income or rural women, who may find themselves with only one realistic option, that of undergoing a compelled repeat cesarean section at the only available hospital.

Why are VBACs viewed so dimly by the medical community, and why might a pregnant woman wish to attempt one against her doctor's advice? The dominant view in the obstetrical community is that cesarean sections are preferred in many circumstances, and "[p]hysicians may have a low tolerance for many patients' refusals of medical treatment for what [are] considered

³⁹ See International Cesarean Awareness Network, *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 May 15, 2009) (noting that "over 300 hospitals across the U.S." have instituted VBAC bans).

⁴⁰ See Paul, *supra* note 4 (telling the story of a woman who plans to travel 100 miles to a hospital that will allow a VBAC delivery).

⁴¹ See *Pemberton v. Tallahassee Mem. Regional Med. Ctr.*, 66 F. Supp. 2d 1247 (1999).

⁴² See *id.*

to be low-risk invasive procedures, such as cesarean sections.”⁴³ A patient who has previously had a cesarean section is considered to be at greater risk for catastrophic uterine rupture—endangering lives of both mother and child—if she later attempts a vaginal delivery of a subsequent child, although The American College of Obstetricians and Gynecologists (ACOG) recognizes this risk to be “generally less than 1%.”⁴⁴ This gynecological emergency poses a risk to the life of both the pregnant woman and the fetus.⁴⁵ On the other hand, “successful VBAC is associated with shorter maternal hospitalizations, less blood loss and fewer transfusions, fewer infections, and fewer [blood clots] than cesarean delivery.”⁴⁶

On the other side of the VBAC debate are those who point out that VBACs bear no greater risk of potentially life-threatening emergency than any vaginal delivery, and that any hospital that is not equipped to handle a possible uterine rupture is not equipped to deal with any of a range of mother-and-infant endangering catastrophes.⁴⁷ Blanket VBAC bans do not serve to encourage a case-by-case consideration of the clinical need for a repeat cesarean section, which can vary widely depending on factors such as the number of previous cesarean births, whether labor has been artificially induced, and whether the woman has previously had a successful

⁴³ Harris, *supra* note 23, at 138. *Contra* Ehrenreich, *supra* note 11, at 523 (“When a laboring woman is defined as a good girl, the physician is likely to have concern for the well-being of her child and to offer the surgery to her as valuable medical technology. In the event that she refuses it, however, her motivations are not as likely to be questioned, her autonomy is likely to be valued, and she is unlikely to be ordered to comply with the doctor’s advice.”).

⁴⁴ Vaginal Birth After Previous Cesarean Delivery, ACOG Practice Bulletin (The American College of Obstetricians and Gynecologists), July 2004, at 4 [hereinafter ACOG Bulletin], *available at* http://www.acog.org/acog_districts/dist9/pb054.pdf; *see also* Richard P. Porreco et al., *The Changing Specter of Uterine Rupture*, 200 AM. J. OBSTETRICS & GYNECOLOGY 269 (2009) (indicating that the risk of true uterine rupture is even lower than popularly believed).

⁴⁵ *Id.*

⁴⁶ *Id.* at 3.

⁴⁷ *See* Paul, *supra* note 4, at 37 (“Some doctors, however, argue that any facility ill equipped for VBACs shouldn’t do labor and delivery at all.”).

vaginal delivery.⁴⁸ Moreover, advocates for pregnant women note the serious health ramifications of even a single cesarean section, consequences made far greater by repeat surgeries. Far from a “low-risk invasive procedure,” a cesarean section is a major abdominal surgery that “can lead to a variety of postpartum complications, including wound infection, hemorrhage, severe complications from anesthesia, and even death.”⁴⁹ Indeed, the pregnancy-related mortality rate among cesarean section patients is about 3.5 times higher than that for women who deliver vaginally (35.9 per 100,000 live births as opposed to 9.2 per 100,000 live births).⁵⁰ These consequences should more than encourage doctors to avoid repeated cesareans where not medically necessary, they should require such avoidance.

No state, as of yet, has a statute requiring that women who have had previous cesarean sections report to hospitals for surgical delivery of subsequent infants; there are no state statutes making it a crime under any theory of negligence or child abuse to refuse a cesarean section even when such refusal results in the death of an otherwise viable fetus.⁵¹ Thus, the challenge envisioned in this paper is not to a prosecution of a woman who has flouted a VBAC ban and caused harm to her fetus; rather, it is a challenge brought against a hospital or an insurance company that imposes such a ban, perhaps seeking a declaratory judgment that the woman must be allowed to attempt a VBAC if she so desired.

⁴⁸ See Aaron B. Caughey, *Informed Consent for a Vaginal Birth After Previous Cesarean Delivery*, 54 J. MIDWIFERY & WOMEN’S HEALTH 249, 251 (2009).

⁴⁹ Daniel R. Levy, *The Maternal-Fetal Conflict: The Right of a Woman to Refuse a Cesarean Section Versus the State’s Interest in Saving the Life of the Fetus*, 108 W. VA. L. REV. 97, 99 (2005).

⁵⁰ *Id.*

⁵¹ Monica Miller, *Refusal to Undergo a Cesarean Section: A Woman’s Right or a Criminal Act?*, 15 HEALTH MATRIX 383, 395 (2006).

III. Potential Legal Challenges to VBAC Bans: Tort and Informed Consent Claims

Legal scholars have observed that the ethical and legal quandaries imposed upon physicians and judges in cases of compelled medical treatment are “formidable and serious”.⁵² They argue that “[w]hen mothers [refuse] treatment, the most appropriate response of physicians, nurses, and hospitals is to honor their wishes. Correspondingly, judges also should honor a mother’s refusal and refrain from issuing orders that would compel her to receive treatment that she has decided, for her own reasons, to forego.”⁵³ What claims are available to women when doctors and judges do not respect their desire to refuse a cesarean section? This Part discusses the possible legal claims, sounding in tort and in informed consent doctrine, that can be brought by a pregnant woman who is subjected to a cesarean section against her wishes.

These challenges will likely be infrequently available, as it is the rare hospital that will actually perform a surgery upon a non-consenting patient without first seeking judicial approval: “Since nonconsensual medical treatment may subject physicians and hospitals to liability for assault and battery . . . the issue of an individual’s refusal to consent to lifesaving medical treatment is invariably taken to the courts for resolution.”⁵⁴ Nevertheless, the threat of tort liability may suffice to persuade hospital and insurance company administrators that blanket VBAC bans invite more legal trouble than they prevent.

a. Tort Law Claims

It is a hornbook principle of tort law that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who

⁵² Lawrence J. Nelson et al., *Forced Medical Treatment of Pregnant Women: ‘Compelling Each to Live As Seems Good to the Rest’*, 37 HASTINGS L.J. 703, 704 (1986).

⁵³ *Id.* at 762.

⁵⁴ John Alan Cohan, *Judicial Enforcement of Lifesaving Treatment for Unwilling Patients*, 39 CREIGHTON L. REV. 849, 850 (2006).

performs an operation without his patient's consent, commits an assault, for which he is liable in damages.”⁵⁵ Thus, a suit brought by a pregnant woman who has been subjected to a cesarean section against her will (and without prior judicial approval) should have a high probability of success, regardless of the underlying medical merits—or lack of merit—of the doctor’s conduct. However, this cause of action would probably not allow a pregnant woman to bring a preemptive suit alleging that her hospital planned to assault her by performing a VBAC against her will; rather, she would have to wait until the forced surgery was completed in order to seek redress in tort (for battery, rather than assault, per modern principles of tort law). As this paper seeks to develop challenges that can be brought before such an occurrence, the obvious principle of tort liability is not of much assistance.

b. Informed Consent Claims

Common law and statutory principles of informed consent “require[] that not only must a patient freely and voluntarily consent to any proposed medical procedure, but also that this consent be given with an appropriate understanding of the circumstances, based on sufficient knowledge of the risks, benefits, burdens[,] and reasonable alternatives.”⁵⁶ In the case of compelled medical treatment of a pregnant woman, the question of consent “becomes more complicated . . . because The American College of Obstetricians and Gynecologists recognizes the fetus as a separate patient even though the woman is the only patient able to give informed consent.”⁵⁷ Although in the case of VBAC bans, the interest of the pregnant woman and the fetus will normally coincide, rather than conflict—since uterine rupture poses as great a harm to the pregnant woman as to the fetus—obstetricians analyze the available treatment options, and

⁵⁵ *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.).

⁵⁶ MEREDITH, *supra* note 6, at 7.

⁵⁷ Harris, *supra* note 23, at 134 (footnotes omitted).

determine whether to request judicial intervention, as if there were two conflicting patients in one body.

Courts have divided on the question of whether a pregnant woman's withholding of consent to a particular obstetric treatment should represent the final word on the matter. In cases involving a physician's determination that a blood transfusion or other procedure is necessary to preserve the life of the fetus, and where there is little to no concomitant risk to the mother, courts have usually found the intrusion minor enough, and the state interest great enough, to justify medical treatment even in the absence of informed consent.⁵⁸ These courts, and commentators who cite to them, often point to the range of other cases in which minor bodily intrusions are allowed in the service of significant state interests.⁵⁹ In cases involving compelled cesarean sections, however, courts have been more cognizant of the significant medical risk to the mother, and at least one court has held "that a competent woman's choice to refuse to undergo a cesarean section must be honored, even where her choice may be harmful to her fetus."⁶⁰ Thus, pregnant women do not surrender their right to refuse medical treatment when they become pregnant.⁶¹

In those cases where courts must consider overriding the decision of a competent patient to give consent, there are four state interests that must be considered: "the preservation of life, the prevention of suicide, the protection of third parties, and the ethical integrity of the medical profession."⁶² The first factor may have more weight in the VBAC context than in a usual case involving a compelled cesarean section where the pregnant woman's own life would be at risk,

⁵⁸ See *In Re Jamaica Hospital*, 491 N.Y.S.2d 898, 900 (N.Y. Sup. Ct. 1985) (holding that "the State has a highly significant interest in protecting the life of a mid-term fetus, which outweighs the patient's right to refuse a blood transfusion on religious grounds" and appointing a special guardian to make medical decisions for the fetus).

⁵⁹ See *Finer*, *supra* note 36, at 279 n.218 (collecting cases in which prisoners and criminal suspects were ordered to comply with physically-invasive searches after ex parte proceedings).

⁶⁰ *Harris*, *supra* note 23, at 144 (citing *In Re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1st Dist. 1994)).

⁶¹ *Doe*, 632 N.E.2d at 332.

⁶² *Cohan*, *supra* note 54, at 900-01.

but it does not seem that the risk is so substantial as to merit the extraordinary state intrusion into a competent woman's medical decision-making.⁶³ A determination of whether the attempted VBAC represented an attempted suicide would be a fact-specific inquiry in a particular court, but there is no evidence of such an occurrence in the literature. The third factor could weigh heavily in favor of upholding a VBAC ban if the risk to the fetus were substantial and supported by the weight of medical opinion in a given case, but ACOG's own report seems to indicate that the risk is small if the hospital is properly prepared should an emergency arise.⁶⁴

With respect to the fourth factor, "the ethical integrity of the medical profession," leading medical organizations dictate that doctors should respect a pregnant woman's right to informed consent, notwithstanding potential harm to the fetus. ACOG has made it "clear that in balancing maternal-fetal conflict, the physician should put more weight on the autonomy of the pregnant woman and honor her refusal of treatment."⁶⁵ As a policy matter, the College requires doctors to respect the traditional rights of pregnant women to grant or withhold consent, and cautions that concern for the fetus should not lead doctors to coerce their pregnant patients into undesired interventions through legal or other means.⁶⁶ The American Medical Association notes that a physician who resorts to the courts in order to enforce a desired course of action "interferes with the physician-patient relationship" and "creates an adversarial relationship [that] may discourage women from seeking medical care."⁶⁷ Thus, none of the four traditional state interests that would allow a court to override a pregnant woman's refusal to undergo a repeat cesarean section

⁶³ See ACOG Bulletin, *supra* note 44, at 3 (noting a risk of perinatal death of less than 1%).

⁶⁴ *Id.* at 6.

⁶⁵ Harris, *supra* note 23, at 141.

⁶⁶ *Id.*

⁶⁷ *Id.* at 142-43.

in deference to a hospital VBAC ban seem to carry sufficient merit to outweigh the law's usual respect for the key importance of informed consent to surgery.

However, scholars have argued that there are two major areas in which states have limited the absolute right to give informed consent to medical treatment, and that these areas may be relevant to the question of whether a pregnant woman may refuse a cesarean section. The first of these is that “the living will statute of virtually every state contains a pregnancy exception” that invalidates the pregnant woman’s previously expressed wishes regarding life-saving measures for the duration of her pregnancy.⁶⁸ This is argued to imply a determination that “the state’s interest in protecting the fetus outweighs the patient’s right to determine whether to forgo medical treatment.”⁶⁹ One could argue, on the other hand, that such exceptions are merely a symptom of the larger problem: it is assumed that the rational pregnant woman will subsume her beliefs and desires to the interest of her fetus, even where she has expressly stated a desire to the contrary.⁷⁰

The second context in which the right to give informed consent is not absolute is “the situation where a parent refuses medical treatment for his or her minor child.”⁷¹ Courts generally override parental wishes for their children in cases where the parents’ refusal to consent is based on religious beliefs. Such holdings are generally based on a Supreme Court decision that “a state may infringe upon religious freedom if it protects a child against some clear and present

⁶⁸ Levy, *supra* note 49, at 105-06.

⁶⁹ *Id.* at 106.

⁷⁰ See Fentiman, *supra* note 21, at 564-65 (“Women have regularly been denied the right to self-determination and bodily integrity by state laws that, in the name of ‘fetal protection,’ automatically invalidate advance health care directives when a woman is pregnant . . . [this] enshrines a normative view of women – that any ‘reasonable’ woman would choose to continue on life-support if it meant that her fetus would survive until birth.”). Challenges to these laws brought by healthy, non-pregnant women are usually dismissed for lack of justiciability, rendering them nearly unchallengeable. *Id.* at 565-566.

⁷¹ Levy, *supra* note 49, at 106.

danger.”⁷² The fallacy of this argument should be clear to anyone who is able to distinguish between a fetus, which may or may not achieve viability and a full panoply of legal rights; and a child, which has such rights. Arguing that a fetus’s interests can always override its mother’s religious beliefs and bodily autonomy where a living child’s interests could only trump the former gives the fetus greater legal rights than the living child (no one is arguing that a mother should be forced to donate her bone marrow to save her child’s life), a legally untenable position.

c. A Potential Legal Argument in Support of VBAC Bans: The Duty to Rescue

Some commentators have argued that pregnant women may be compelled to have cesarean sections in a variety of contexts, including in the VBAC case, as a result of the common law duty to rescue. These writers recognize that “[a]n individual generally has no duty to donate an organ or bone marrow to another, even if it will save another’s life,”⁷³ but then claim that because “the fetus is completely dependant on the mother” there is “a duty for the mother to undergo a [c]esarean section.”⁷⁴ The argument is that “the special relationship forms once the fetus reaches viability[,] since the woman has refused to exercise her right to abort the pregnancy and therefore assumes the risk of reasonably caring for the fetus in order to safely deliver her baby.”⁷⁵

However, a case that is often cited in the duty-to-rescue context stated:

For our law to compel [an individual] to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the

⁷² *Id.* at 107 (citing *Prince v. Massachusetts*, 321 U.S. 158, 167 (1944)).

⁷³ *Id.* at 108.

⁷⁴ *Id.* at 103.

⁷⁵ *Id.* at 121. This claim is almost offensive in its assumption that a woman who has not secured an abortion prior to the point of fetal viability has affirmatively refused to do so, given the volume of commentary concerning the many difficulties women, particularly rural and low-income women, have in securing access to abortion services. This is a problem recognized even by the Supreme Court, as Justice Ginsburg noted in the 2006 term: “Adolescents and indigent women, research suggests, are more likely than other women to have difficulty obtaining an abortion during the first trimester of pregnancy. Minors may be unaware they are pregnant until relatively late in pregnancy, while poor women’s financial constraints are an obstacle to timely receipt of services.” *Gonzales v. Carhart*, 127 S. Ct. 1610, 1642 n.3 (2007) (Ginsburg, J., dissenting).

sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.⁷⁶

This is particularly true in the case of pregnant women. If women have an affirmative duty to submit to surgery for the benefit of their fetus, there is no line that can be drawn to protect any conduct during pregnancy. Women could be held liable for failure to rescue their fetuses if they do not flee abusive relationships, or if they undertake potentially risky plane flights, or if they do not take adequate prenatal vitamins. Imposing a prenatal duty to rescue upon pregnant women would represent a serious and boundless infringement on their rights to autonomy and privacy, which cannot be justified by the state's arguable interest in the protection of viable fetuses.

IV. Potential Constitutional Challenges to VBAC Bans: The Bans Violate Women's Rights to Privacy and Bodily Autonomy

The Supreme Court has observed that there is a protected "'liberty interest' under the Due Process Clause" implicated in the right to refusal medical treatment, but that "whether [an individual's] constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests."⁷⁷ A survey of cases involving informed consent in the pregnancy context reveals that:

[T]here are two approaches the courts use when deciding to honor a woman's refusal to submit to compelled medical treatment. One is an "absolute approach" that gives the pregnant woman an absolute right to refuse treatment. The other is a "balancing approach" or test, where the court weighs the interests of the woman and the fetus and concludes that the woman's interest outweighs that of her fetus.⁷⁸

Just as doctors must consider both the short and long-term effects of the cesarean section when determining whether it is appropriate in a particular case, courts must consider the

⁷⁶ McFall v. Shrimp, 10 Pa. D. & C.3d 90, 91 (Pa. Ct. Comm. Pleas 1978).

⁷⁷ Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 278-79 (1990) (citing Youngberg v. Romeo, 457 U.S. 307, 321 (1982)).

⁷⁸ Harris, *supra* note 23, at 145.

woman's interest not only in terms of the birth itself but also in terms of the life-long effects of a compelled surgery.⁷⁹ The consideration of these effects must be balanced with a determination of the pregnant women's constitutionally protected rights to privacy, bodily integrity, and decisional autonomy.

A consideration of potential constitutional challenges in the reproductive rights arena necessarily begins with a consideration of the framework established by the Supreme Court in *Roe v. Wade*,⁸⁰ *Planned Parenthood of Southeastern Pennsylvania v. Casey*,⁸¹ and subsequent abortion-related cases. These cases generally hold that "at the point of viability and thereafter, states may impose various regulations to protect fetal life Prior to viability, however, states may enact such legislation only if it does not present an undue interference with the woman's constitutional right" to terminate the pregnancy.⁸² The Supreme Court has consistently recognized that "there is a substantial state interest in potential life throughout pregnancy."⁸³

However, it is not clear that the *Roe-Casey* abortion framework should even govern the issue under consideration here. In the VBAC-ban context, the question is not whether the state may compel a woman to give birth at all, but whether the state may compel a woman to give birth in her doctors' preferred manner. This is because "[w]hile reproductive privacy may not receive the maximum protections available under our federal Constitution, bodily integrity may not be abridged absent a compelling state interest implemented via the least restrictive alternative."⁸⁴

⁷⁹ See Levy, *supra* note 49, at 99-100.

⁸⁰ 410 U.S. 113 (1973) (establishing a trimester-based framework balancing the mother's health and safety and the state's interest in the preservation of potential human life).

⁸¹ 505 U.S. 833 (1992) (rejecting *Roe*'s trimester structure and allowing restrictions on abortion access as long as such restrictions did not pose an "undue burden" on the right to abortion).

⁸² Amy Kay Boatright, Comment, *State Control Over the Bodies of Pregnant Women*, 11 J. CONTEMP. LEGAL ISSUES 903, 910 (2001).

⁸³ *Casey*, 505 U.S. at 876.

⁸⁴ Boatright, *supra* note 82, at 911 (footnotes omitted).

Thus, the nature of a pregnant woman’s constitutionally protected privacy interest in the labor and delivery context is somewhat different from her interest in the abortion context. Indeed, scholars have argued “that because *Roe* does not address situations outside of the abortion context, it leaves intact women’s common law and constitutional liberty rights to direct their medical care.”⁸⁵

Some courts, in addressing the issue of whether a court may compel a woman to undergo a cesarean section, have reflexively cited to the abortion-rights cases, assuming that the state’s recognized interest in the life of a viable fetus suffices to override a pregnant woman’s privacy rights without further consideration. For example, the court in the Florida case discussed above reasoned that “a third-trimester mother can be forced against her will to bear a child she does not want; this is in fact a substantially greater imposition of the mother’s constitutional interests that requiring a mother to give birth by one method rather than another.”⁸⁶ However, scholars have queried: “If the State cannot insist that a woman ‘makes the sacrifice’ of carrying a [fetus] to term, is it entitled to demand the arguably more onerous sacrifice of submitting to major abdominal surgery should her physicians deem a [cesarean] desirable?”⁸⁷

The Supreme Court has recognized that even in the context of abortion rights and even after the point of fetal viability, “women have the constitutional right to put their own lives and health before that of their fetuses”⁸⁸ The Court’s decision in *Thornburgh* was specifically predicated upon a finding that the law at issue, which required doctors to prefer a certain type of late-pregnancy abortion because it increased the odds of fetal survival, “created an unacceptable

⁸⁵ April L. Cherry, *Roe’s Legacy: The Nonconsensual Medical Treatment of Pregnant Women and Implications for Female Citizenship*, 6 U. PA. J. CONST. LAW. 723, 725 (2004).

⁸⁶ *Pemberton v. Tallahassee Mem. Regional Med. Ctr.*, 66 F. Supp. 2d 1247, 1252 n.9 (1999).

⁸⁷ MEREDITH, *supra* note 6, at 27 (citing *Casey*, 505 U.S. at 852).

⁸⁸ Cherry, *supra* note 85, at 727 (citing *Thornburgh v. Am. Coll. of Obstetricians and Gynecologists*, 476 U.S. 747 (1986)).

risk to the mother in order to protect the fetus.”⁸⁹ While more recent decisions have cast doubt upon the argument that the Court will always respect women’s health over fetal life,⁹⁰ it is still the case that “nowhere does *Roe* or its progeny suggest that the state’s interest in the fetus empowers the state to ‘choose between treatment options for the pregnant woman when abortion is not an issue,’ and by so doing, disregard the woman’s decisional authority and hence, her autonomy.”⁹¹

Thus, when lower federal courts rely upon *Roe*’s finding of a state interest in fetal life to support compelled medical treatment against a pregnant woman’s wishes, they are importing standards developed in the abortion-rights context into the greater medical context, an application that the Supreme Court has not recognized as constitutionally valid. Instead, the Court has specifically ruled that “a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment”⁹²

Scholars have argued that “[s]ince the right to bodily integrity is a fundamental right,” proposed infringements of the right in the form of forced cesarean sections “necessitate[] a strict scrutiny analysis.”⁹³ This means that the state must demonstrate a compelling interest in the protection of the fetus’s life, and that requiring a cesarean section is the least restrictive, or least invasive, means of realizing the state interest.⁹⁴ In the case of VBAC bans, the state could argue that it has an interest in protecting not only the fetus’s life but that of the pregnant woman as

⁸⁹ Miller, *supra* note 51, at 397 (citing *Thornburgh*, 476 U.S. at 768-69).

⁹⁰ *Gonzales v. Carhart*, 127 S. Ct. 1610 (upholding a challenged federal statute barring so-called partial-birth abortions even where the statute did not contain an exception allowing the procedure in circumstances where the mother’s health, but not her life, was at risk).

⁹¹ Cherry, *supra* note 85, at 732 (footnotes omitted).

⁹² *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 278 (1990)

⁹³ Boatright, *supra* note 82, at 912.

⁹⁴ *Id.*

well. However, it is clear from the Supreme Court’s jurisprudence that a competent patient may refuse even life-sustaining medical treatment;⁹⁵ it would be difficult for a physician to argue that a woman who wishes to attempt a VBAC is by definition incompetent to make her own decisions. Further, it is unclear that the risk to the life of the pregnant woman and fetus is so substantial as to merit a highly invasive state-mandated abdominal surgery, particularly in light of ACOG’s stated position favoring VBAC attempts in many circumstances.⁹⁶

A counter-argument to this line of reasoning is that women who face a risk of serious harm not only to themselves but to their viable fetus as a fetus of a VBAC should not have the right to refuse the surgery, as “the right to harm oneself is not an absolute right” and “hardly qualifies as a principle worthy of protection no matter what the cost to others.”⁹⁷ This argument ignores the nature of the compelled medical treatment: the state is not acting to prevent the pregnant woman from affirmatively harming herself or her viable fetus; rather, it is forcing her to undergo major surgery, admittedly on the advice of her physician, but in flagrant violation of her right to bodily autonomy, a right that she does not surrender merely because she is pregnant.

On a final constitutional note, scholars have argued that compelling pregnant women to undergo medical treatment without their consent violates the rights of women in general to equal protection of the laws,⁹⁸ because “[w]omen as a class are harmed by their resulting subordination to their reproductive capacities and state-sanctioned gender roles.”⁹⁹ The argument is that physicians and courts unconstitutionally discriminate against women when, in the interest of

⁹⁵ *Cruzan*, 497 U.S. at 281 (“It cannot be disputed that the Due Process Clause protects an interest in life *as well as* an interest in refusing life-sustaining medical treatment.”) (emphasis added).

⁹⁶ ACOG Bulletin, *supra* note 44, at 4.

⁹⁷ Finter, *supra* note 36, at 283-84.

⁹⁸ U.S. CONST. amend. XIV § 1 (“[N]or shall any State . . . deny to any person within its jurisdiction the equal protection of the laws.”).

⁹⁹ Cherry, *supra* note 85, at 740.

protecting fetal rights, they act to restrict “women’s autonomy by compelling unwanted, nonconsensual treatment on behalf of the fetus.”¹⁰⁰ In so doing, the state acts to enforce specific gender norms and ideals of motherhood, and “consign[s] women to something less than full citizenship, which is forbidden by our current constitutional norms.”¹⁰¹ Thus, it can be argued that VBAC bans violate women’s constitutional rights under the Fourteenth Amendment, because they are predicated upon discriminatory opinions of the worth of a woman’s consent and rights when balanced against those of her potential child.

V. Potential Challenges to VBAC Bans: The Human Rights Argument

In addition to the domestic legal and constitutional arguments that can be made to challenge VBAC bans in the courts, appeals to international human rights standards may also allow policy advocates to argue against VBAC bans in order to shape public and legislative opinion. This paper argues that existing human rights frameworks can be understood to ensure that women’s rights to control over childbirth are protected human rights, as described below. This Part first provides a general overview of extant international frameworks that address the issue of women’s healthcare rights, and then argues that these standards establish international law norms that VBAC bans limiting women’s choices clearly violate.

a. Established Frameworks

A survey of established international human rights frameworks dealing with women’s access to medical care reveals a common theme encouraging the constant participation of women

¹⁰⁰ *Id.*; see also Nora Christie Sandstad, *Pregnant Women and the Fourteenth Amendment: A Feminist Examination of the Trend to Eliminate Women’s Rights During Pregnancy*, 26 *LAW & INEQUALITY* 171, 195 (2008) (“The recognition of separate rights in the fetus necessarily diminishes the pregnant woman’s rights, which are guaranteed by the Fourteenth Amendment. The idea of one individual’s exercise of her or his rights being allowed to reduce another’s guaranteed rights is anathema to the idea of equal protection.”).

¹⁰¹ *Id.* at 742.

in the development and implementation of healthcare systems. Moreover, there is a clear emphasis on the importance of protecting women's autonomy and control over their own medical decisions. The four key frameworks, discussed here in chronological order, are the Convention on the Elimination of All Forms of Discrimination Against Women, the Cairo Programme, the Beijing Platform, and the comments of the United Nations Committee on Economic, Social and Cultural Rights.

i. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

CEDAW was adopted by the United Nations General Assembly in 1979, and sets forth global principles of women's rights and gender equality. The Convention defines the parameters of what will be internationally recognized as discrimination against women, and sets out a multi-pronged program to combat and eliminate such discrimination. The United States has signed but not ratified the Convention.¹⁰²

CEDAW Article 12 describes a right to “appropriate services in connection with pregnancy, confinement, and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”¹⁰³ The same Article mandates that “States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services” CEDAW does not describe the precise nature of either the pregnancy-related “appropriate services” or the general “health care services” that are to be ensured.¹⁰⁴

¹⁰² For general background information on the Convention, see Convention on the Elimination of All Forms of Discrimination Against Women, Introduction, <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>.

¹⁰³ Convention on the Elimination of All Forms of Discrimination Against Women art. 12, *entry into force* Sept. 3, 1981, <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>.

¹⁰⁴ A 1999 Recommendation noted that “[m]easures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women” and otherwise detailed potential restrictions on access to health care services, but did not express an explicit preference

More specification is given in the general recommendations that have been developed by the Committee in the years since CEDAW's entry into force. For example, General Recommendation 15 exhorts states parties to "ensure the active participation of women in primary health care" ¹⁰⁵ CEDAW's emphasis on equal access and active participation implies a focus on gender equality in healthcare decisionmaking, which VBAC bans undermine to the extent that they limit women's healthcare options and decisional autonomy.

ii. Cairo Programme (1994)

The Cairo Programme, presented in 1994 in the report of the International Conference on Population and Development, aims to "collectively address the critical challenges and interrelationships between population and sustained economic growth in the context of sustainable development." ¹⁰⁶ Its principles recognize the central importance of "ensuring women's ability to control their own fertility" ¹⁰⁷ and mandate that "[s]tates should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care" ¹⁰⁸ The Programme also emphasizes "the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant." ¹⁰⁹

for medical, as opposed to traditional and community-based, health providers. CEDAW Recommendations no. 24 (twentieth session, 1999).

¹⁰⁵ General Recommendations Made by the Committee on the Elimination of Discrimination Against Women [hereinafter CEDAW Recommendations], no. 15 (ninth session, 1990), <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm>.

¹⁰⁶ Programme of Action of the International Conference on Population and Development [hereinafter Cairo Programme] ¶ 1.9 (1994), available at <http://www.unfpa.org/icpd/icpd-programme.cfm>.

¹⁰⁷ *Id.* princ. 4.

¹⁰⁸ *Id.* princ. 8.

¹⁰⁹ *Id.* ¶ 7.2.

Other key facets of the Cairo Programme include its recognition of the importance of protecting and improving women’s decisional autonomy, and of the fact that “improving the status of women also enhances their decision-making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction.”¹¹⁰ It exhorts states parties to take actions towards the end of “[e]liminating all practices that discriminate against women; assisting women to establish and realize their rights, including those that relate to reproductive and sexual health.”¹¹¹ The Cairo Programme, thus, specifically advocates for the protection of women’s access to a wide range of healthcare services, particularly in the reproductive arena, and cautions against limitations imposed by healthcare practitioners (such as VBAC bans) that would limit women’s ability to exercise their human rights.

iii. Beijing Platform (1995)

The Beijing Platform stems from the Fourth World Conference on Women, hosted in 1995 in Beijing, China. The Platform is self-described as “an agenda for women’s empowerment” and aims to “remov[e] all the obstacles to women's active participation in all spheres of public and private life through a full and equal share in economic, social, cultural and political decision-making.”¹¹² As with the Cairo Programme, the Beijing Platform emphasizes women’s decisional autonomy and implicitly cautions against de facto policies that limit women’s control over their own decisions, in the medical realm and otherwise. While it does not have the same focus on medical care as do the other frameworks discussed in this Part, it is nevertheless relevant to the VBAC discussion. VBAC bans are arguably an instrument through

¹¹⁰ *Id.* ¶ 4.1.

¹¹¹ *Id.* ¶ 4.4(c).

¹¹² The United Nations Fourth World Conference on Women: Action for Equality, Development, and Peace, Platform for Action [hereinafter Beijing Platform], Mission Statement (Sept. 1995), *available at* <http://www.un.org/womenwatch/daw/beijing/platform/plat1.htm#statement>.

which women are deprived of an opportunity to fully participate in an important sphere of human life, namely, the chance to exercise full control over their own medical treatment.

iv. The Committee on Economic, Social and Cultural Rights

Finally, the United Nations Committee on Economic, Social and Cultural Rights (CESCR) “publishes its interpretation of the content of human rights provisions, in the form of general comments on thematic issues.”¹¹³ The mandate for women’s and community involvement in health-care decisionmaking is implied in CESCR General Comment 14, which explains that “acceptable health care must be provided through a system that is ‘respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals . . . and communities [and] sensitive to gender and lifestyle requirements.’”¹¹⁴ CESCR also “prohibits interference with ‘the right to control one’s health and body, including sexual and reproductive freedom . . . and the right to be free from . . . non-consensual medical treatment.’”¹¹⁵ CESCR, thus, provides the most explicit international human rights language that can be used to challenge VBAC bans. CESCR explicitly forbids policies that impede women’s control over their medical decisions and invade their rights to be free from forced medical treatment. While the other frameworks provide a theoretical background against which VBAC bans can be juxtaposed, the CESCR commentaries are a clear statement of international human rights standards that are violated by the bans.

¹¹³ Comm. on Econ., Social and Cultural Rights [CESCR], General Comments, <http://www2.ohchr.org/english/bodies/cescr/comments.htm>.

¹¹⁴ Mehlika Hoodbhoy et al., *Exporting Despair: The Human Rights Implications of U.S. Restrictions on Foreign Health Care Funding in Kenya*, 29 FORDHAM INT’L L.J. 1, 14 (2005) (citing CESCR General Comment 14, available at <http://www.fao.org/righttofood/KC/downloads/vl/docs/AH354.pdf>).

¹¹⁵ *Id.* at 18.

b. A New Standard for Women's Control over Childbirth

The various existing human rights schemas implicitly acknowledge the threat to women's rights that can arise when their own choices are replaced with healthcare solutions that cede control of decisional autonomy to third parties, and recognize that women have always, and should continue to be, intimately involved with proposals related to the improvement of reproductive rights and family life. Reflecting these ethical demands and considering present international standards, this paper argues that women's control over childbirth, including the manner by which they deliver, is a protected human right envisioned by extant human rights treaties. Advocates for pregnant women who seek to challenge VBAC bans can harness these existing frameworks to argue that such bans not only violate domestic legal and constitutional standards, but also conflict with the United States's obligations under international law. These arguments can also be used to demonstrate the flaws of VBAC bans as a matter of policy, as they demonstrate that there are implications far beyond the impact that such bans will have on the childbirth options of individual American women.

VI. Conclusion

Women who wish to attempt to deliver a child via vaginal birth after having had a previous cesarean section have a legal and constitutional right to do so. Hospital bans on VBAC delivery may be challenged on a variety of grounds, with the legal argument of informed consent and the constitutional argument of protected bodily privacy the most likely routes to success. While women should, and in the vast majority of cases do, heed the advice of their physicians throughout the course of their pregnancies, a woman does not lose her usual rights merely because she carries a potentially viable fetus. To rule otherwise would be to establish legal

precedent for the proposition that the conduct of women throughout their pregnancies can be governed by their doctors and by the state, and would render pregnant women powerless to exert control over their own bodies and lives. The United States Constitution and laws, as well as international law and human rights standards, do not, and cannot, allow such a conclusion.