Nature Versus Suture: Why VBAC Should Still Be in Vogue
By Paul Christopher Estaris Torio

Introduction

In 1995, Laura Pemberton of Tallahassee, Florida, diagnosed with placenta previa,[1] delivered a baby via cesarean section.[2] Unlike conventional C-sections performed using a low horizontal incision, hers involved an uncommon vertical incision that extended well beyond a traditional low vertical incision up into the myometrium,[3] resembling the shape of an upside-down letter T.[4] Shortly afterward, Mrs. Pemberton became pregnant once again and attempted to find a doctor who would assist her in having a normal childbirth.[5] None was willing to accommodate her request for a vaginal birth after cesarean ("VBAC") due to a purported 3% to 6% risk that her type of cesarean scar would rupture during a subsequent vaginal delivery.[6] However, based on months of her own research of medical literature, Mrs. Pemberton decided that a vaginal birth would be a safer option for herself and her fetus than a repeat C-section.[7] As a result, she and her husband made arrangements to deliver their baby at home, to be attended only by a midwife.[8]

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[1] Placenta previa occurs when any part of the placenta implants in the lower uterine segment, covering all or some of the internal cervical opening, in advance of the fetal presenting part. ARTHUR T. EVANS, MANUAL OF OBSTETRICS 154 (7th ed. 2007). This condition is associated with risk of serious maternal hemorrhage. *Id.*
[2] JENNIFER BLOCK, PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH & MODERN MATERNITY CARE 249, 251 (2007).
[3] *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr.*, 66 F. Supp. 2d 1247, 1249 (N.D. Fla. 1999). The myometrium is the thickest subcompartment of the wall of the uterus formed by interlacing bundles of smooth muscle. RAY C. HENRIKSON ET AL., NAT'L MED. SERIES FOR INDEP. STUDY, HISTOLOGY 382 (1997)
[4] BLOCK, *supra* note 2, at 249.
[5] *See Pemberton*, 66 F. Supp. at 1249. Another term frequently used to describe a post-cesarean vaginal delivery is TOLAC, which stands for "trial of labor after cesarean." *See, e.g.*, AM. ACAD. FAM. PHYSICIANS, TRIAL OF LABOR AFTER CESAREAN (TOLAC), FORMERLY TRIAL OF LABOR VERSUS ELECTIVE REPEAT CESAREAN SECTION FOR THE WOMAN WITH A PREVIOUS CESAREAN SECTION (2005) (hereinafter "TRIAL OF LABOR"), *available at* http://www.aafp.org/online/etc/medialib/aafp_org/documents/clinical/clin_recs/tolacpolicy.Par.0001.File.dat/clinicalrec_tolac.pdf. For simplicity, this paper will only use the VBAC acronym.
[6] BLOCK, *supra* note 2, at 249.
[7] *Id.*
[8] *Pemberton*, 66 F. Supp. at 1249; BLOCK, *supra* note 2, at 249.

On January 13, 1996, after two days of labor, Mrs. Pemberton, dehydrated and having difficulty holding down nourishment, went with her husband to the emergency room of the Tallahassee Memorial Regional Medical Center to request an intravenous infusion of fluids.[9] Upon arriving, however, the couple was confronted by the attending physician, several obstetricians, and the hospital administrator, each of whom insisted that Mrs. Pemberton sign a consent form for a cesarean.[10] "I was given an ultimatum: no signature, no IV," she recalls.[11] When reassured by nurses that her uterus showed no signs of rupturing, Mrs. Pemberton and her husband fled through a back door and returned home to proceed with a trial of labor.[12] Before long, William Meggs, the State Attorney for Florida's Second Judicial District, accompanied by law enforcement and paramedics, arrived at the Pemberton residence with a court order requiring Mrs. Pemberton to return to the hospital and submit to a C-section.[13] Wearing only a robe, she was strapped by paramedics onto a stretcher by her wrists and ankles, wheeled into the ambulance in front of her neighbors, and driven back to the hospital.[14]

Inside the exam room, Second Circuit Chief Judge Phillip J. Padovano conducted a hearing while a still-dehydrated Mrs. Pemberton was lying on the exam table.[15] Offered no legal representation, she argued on her own behalf in the middle of her contractions, namely that she made an informed decision to pursue VBAC, she and her baby were in perfect health, and the C-section was not medically necessary.[16] Unconvinced, Judge Padovano deferred to the hospital's doctors, who testified that vaginal birth would pose a substantial risk of uterine rupture and result

[9] *Pemberton*, 66 F. Supp. at 1249; BLOCK, *supra* note 2, at 249.
[10] BLOCK, *supra* note 2, at 249-250.
[11] *Id.* at 250.
[12] *Id.* at 250-251.
[13] *Pemberton*, 66 F. Supp. at 1250; BLOCK, *supra* note 2, at 250.
[14] BLOCK, *supra* note 2, at 251.
[15] *Pemberton*, 66 F. Supp. at 1250; BLOCK, *supra* note 2, at 251.
[16] BLOCK, *supra* note 2, at 251.

in the baby's death, and ordered Mrs. Pemberton to submit to a C-section.[17] Despite the fact that Mrs. Pemberton's cervix had dilated nine centimeters,[18] her baby was surgically removed.[19] Fortunately, both mother and child did not suffer complications from the cesarean delivery.[20] Three years later, in 1999, Mrs. Pemberton avoided any chance of a similar ordeal and delivered twins in hiding.[21]

Laura Pemberton's court-ordered operation appears to be a radical case, but the situation is actually far from unprecedented.[22] The relative obscurity of her narrative ironically illustrates the disturbing lack of coverage given to a matter directly concerning reproductive choice, a subject that normally provokes contentious debate. For instance, use of birth control measures such as over-the-counter contraceptives,[23] sterilization,[24] and especially abortion,[25] are among the most controversial and divisive topics in the United States.[26] Yet, once the decision is made to carry a fetus to term, the dialogue fades away. Because Americans seem less troubled about reproductive choices relating to *how* a baby will be delivered into this world, even alarming cases such as *Pemberton v. Tallahassee Memorial Regional Medical Center* tend to transpire unnoticed.

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[17] *Pemberton*, 66 F. Supp. at 1250; BLOCK, *supra* note 2, at 251.
[18] Once the cervix is fully dilated ten centimeters, a baby's head can descend through the vagina and the mother can start pushing. PETER M. DOUBILET ET AL., YOUR DEVELOPING BABY: CONCEPTION TO BIRTH 171-72 (2008)
[19] BLOCK, *supra* note 2, at 251.
[20] *Pemberton*, 66 F. Supp. at 1250.
[21] BLOCK, *supra* note 2, at 249.
[22] *See, e.g.*, Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951 (1986). For accounts of pregnant women who were threatened with compulsory cesareans, but escaped surgical intervention, see BLOCK, *supra* note 2, at 251-53.
[23] *See generally* LESLIE WOODCOCK TENTLER, CATHOLICS AND CONTRACEPTION: AN AMERICAN HISTORY (2004); LINDA GORDON, THE MORAL PROPERTY OF WOMEN: A HISTORY OF BIRTH CONTROL POLITICS IN AMERICA (2002).
[24] *See generally* PAUL A. LOMBARDO, THREE GENERATIONS, NO IMBECILES: EUGENICS, THE SUPREME COURT, AND BUCK V. BELL (2008).
[25] A recent Gallup poll indicates that 50% of Americans are more likely to identify themselves as pro-choice while 44% are likely to call themselves as pro-life. Lydia Saad, *Abortion Issue Laying Low in 2008 Campaign*, GALLUP, May 22, 2008, *available at* http://www.gallup.com/poll/107458/Abortion-Issue-Laying-Low-2008-Campaign.aspx. In fact, since 1998, the percentage gap separating these sides has remained small and relatively constant. *Id.*
[26] *See* sources cited *supra* notes 23-25.

This apparent public indifference is all the more astonishing in light of widespread recognition that the birthing process is "a major physical and psychosocial experience" that is "dangerous, overwhelming, and unique . . . ."[27] Moreover, control of parturition[28] implicates issues such as "procreative and bodily autonomy, the limits of professional expertise, and protection of the fetus."[29] Thus, government intrusion upon a woman's decision to engage in a vaginal birth after undergoing a primary cesarean[30] warrants closer scrutiny. Such an analysis reveals that those advocating against VBAC—whose justifications often form the basis for court-ordered C-sections—unfairly distort the risks of vaginal birth and effectively deprive many women of a viable option.[31] In other words, women who have had prior C-sections "are commonly denied the freedom to choose vaginal delivery for subsequent births, *even though the medical evidence suggests that the choice is complex, but reasonable*."[32] Until the data convincingly shows otherwise, as a rule, pregnant women should be free to choose VBAC and, if rebuffed, to pursue a cause of action for relief in a court of law.

The remainder of this article is divided into three major sections. Part I provides a basic comparison between cesareans and VBAC as well as an overview of their respective developments in the United States in recent decades. Next, Part II highlights the irrationality and adverse consequences of banning VBAC as a sensible option. Finally, Part III identifies possible

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[27] John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 450 (1983) (citation omitted).
[28] Parturition is simply "the expulsion of a viable baby from the uterus at the end of pregnancy . . . ." H. MAURICE GOODMAN, BASIC MEDICAL ENDOCRINOLOGY 440 (3d ed. 2003) (citation omitted).
[29] Robertson, *supra* note 27, at 451.
[30] The first cesarean section performed on a patient is known as primary cesarean section. ALAN H. DECHERNEY ET AL., CURRENT OBSTETRIC & GYNECOLOGIC DIAGNOSIS & TREATMENT 518 (9th ed. 2002). Subsequent procedures are referred to as secondary, tertiary, and so on, or simply as repeat cesarean section. *Id.*
[31] *See infra* Parts I-II.
[32] Sylvia A. Law, *Childbirth: An Opportunity for Choice that Should Be Supported*, 32 N.Y.U. REV. L. & SOC. CHANGE 345, 359 (2008) (emphasis added).

legal and social mechanisms through which pregnant women can better exercise their choice to deliver vaginally.

I. An Erratic (Double) Standard of Care: "Once a C-Section, Always a C-Section" in the 21st Century

Vaginal birth is associated with fewer risks, requires less anesthesia, poses a lower potential for postpartum morbidity, involves a shorter hospital stay, saves money, and encourages earlier and often smoother interaction between mother and infant.[33] Accordingly, it is generally accepted as the preferred method of delivery.[34] Only when complications exist—such as when labor is protracted, the fetus is in an upside-down breech position, or the expectant mother has a serious health problem—is a cesarean section even considered.[35] Yet, nowadays, if a pregnant woman has had a prior C-section, a repeat C-section becomes the ideal procedure.[36] Whether this reversal in the standard of care is justifiable requires a look at the inherent risks of having a repeat cesarean versus VBAC.

A. Cesarean Superiority

A C-section is a surgical procedure in which an incision is made in the mother's abdominal and uterine walls to deliver the fetus, placenta, and membranes.[37] There are three categories of cesareans, based on the kind of uterine incision received: (1) low transverse, the conventional procedure in which a horizontal cut is made across the lower, thinner part of the uterus; (2) low vertical, in which a longitudinal cut is made, also in the lower part of the uterus;

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[33] DECHERNEY, *supra* note 30, at 528-29.
[34] *See, e.g.*, PAMELA J. CARTER, LIPPINCOTT'S TEXTBOOK FOR NURSING ASSISTANTS: A HUMANISTIC APPROACH TO CAREGIVING 785 (2d ed. 2007).
[35] *See id.*
[36] *See infra* Part II.A-B.
[37] *See* AM. C. OBSTETRICIANS & GYNECOLOGISTS, LABOR, DELIVERY, AND POSTPARTUM CARE: VAGINAL BIRTH AFTER CESAREAN DELIVERY (2009) (hereinafter "ACOG LABOR"); DECHERNEY, *supra* note 30, at 518 (9th ed. 2002).

and (3) high vertical, also known as the "classic" cesarean section, in which the cut is made in the upper uterus.[38] Multiple complications may arise from this surgery, including increased postpartum risks of cardiac arrest, wound hematoma, hysterectomy, hemorrhage requiring hysterectomy, anesthetic complications, venous thromboembolism, and major puerperal infection.[39] Maternal fatality rates also significantly increase: one article cites the pregnancy-related mortality rate among women with C-section delivery to be approximately thirty-six deaths per 100,000 live births, about four times the rate found among women who delivered vaginally.[40] Given these inherent dangers, birth by cesarean is compulsory only "whenever labor is unsafe for either the mother or the fetus, when labor cannot be induced, when dystocia or fetal problems represent significant risks with vaginal delivery, or when an emergency mandates immediate delivery."[41]

Since 1996, however, the number of C-section births in the United States has proliferated by more than 50%.[42] In 2007, the cesarean delivery rate rose to a record-high 31.8% of all births,

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[38] ACOG LABOR, *supra* note 37. *See also* DECHERNEY, *supra* note 30, at 523-26. Although the simplest to perform and the quickest in terms of delivery, the high vertical C-section is also associated with the greatest loss of blood and the type of scar most susceptible to uterine rupture in subsequent pregnancies. *See id.* at 523. This is the type of cesarean that Laura Pemberton had in 1995. *See supra* Introduction.

[39] Shiliang Liu et al., *Maternal Mortality and Severe Morbidity Associated with Low-Risk Planned Cesarean Delivery Versus Planned Vaginal Delivery at Term*, 176 CAN. MED. ASS'N J. 455 (2007). Venous thromboembolism, or VTE, is one of the most common cardiovascular disorders in the United States and results from thrombus, or blood clot, formation in the venous circulation. MARIE A. CHISHOLM-BURNS ET AL., PHARMACOTHERAPY: PRINCIPLES & PRACTICE 162 (2007). Puerperal infection refers to the infection of the reproductive tract. ADELE PILLITTERI, MATERNAL & CHILD HEALTH NURSING: CARE OF THE CHILDBEARING & CHILDREARING FAMILY 663 (5th ed. 2006). Interestingly, the Centers for Disease Control and Prevention ("CDC") considers the C-section to be a morbidity in and of itself. BLOCK, *supra* note 2, at 115.

[40] 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) (citing Margaret A. Harper & Robert P. Byington, *Pregnancy-Related Death and Health Care Services*, 102 OBSTETRICS & GYNECOLOGY 273, 275 (2003)). Levy emphasizes that the C-section mortality rate may be inflated because patients having cesareans are usually those with maternal or fetal complications and are already more susceptible to death even prior to the C-section. *Id.* n.13.

[41] Levy, *supra* note 40, at 99 (2005) (citing JAMES R. SCOTT ET AL., DANFORTH'S OBSTETRICS & GYNECOLOGY 449 (9th ed. 2003)). *See also* Law, *supra* note 32, at 347 ("Historically, C-sections were a sad necessity to save the life of [the] woman or baby, and far more dangerous than vaginal birth for both mother and child."). Dystocia includes any "mechanical problems of the uterus, fetus, or birth canal or ineffective uterine contractions that result in unsuccessful progress of labor and vaginal delivery . . . ." SCOTT, *supra* note 41, at 450 (citation omitted).

[42] Brady E. Hamilton et al., *Births: Preliminary Data for 2007*, 57 NAT'L VITAL STATS. REPS. 1, 3 (2009).

a 2% increase from the previous year and the eleventh consecutive year of increase.[43] By contrast, the World Health Organization established the optimal cesarean delivery rate should be between 5% and 10%.[44] In the absence of evidence that this substantial increase in cesarean sections is due to a correlating increase in the number of medical emergencies necessitating the procedure, a number of reasons are passed around in an attempt to explain both the propensity of physicians to recommend major abdominal surgery and the apparent willingness of American women to submit to it. These include the overall population growth of childbearing females, an increase in the number of healthy women who voluntarily opt for cesareans, an increase of pregnancies among older women with preexisting medical conditions, limited public awareness about C-section complications, casual medical and societal attitudes about surgery, the financial incentive for hospitals to pursue the costlier surgical alternative, the perceived belief among providers that performing cesareans reduces the risk of malpractice lawsuits, and the failure of medical professionals to offer women the informed choice of VBAC.[45]

There is little to no evidence that a repeat cesarean is safer than a primary cesarean. In fact, a repeat surgery retains the same risks,[46] perhaps even aggravates them.[47] Preference for surgery when a post-cesarean pregnancy is involved may nonetheless be justifiable upon a convincing showing that VBAC is significantly more harmful to women. Whether or not this premise can be proven would certainly influence the landscape of a cesarean-friendly United

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[43] *Id.* "With more than a million performed annually, C-section is the country's most common operation." Rita Rubin, *Moms' Cesarean Complications Examined; Researchers: More Tracking Needed*, USA TODAY, Jan. 21, 2009, at 3A.

[44] CHILDBIRTH CONNECTION, WHY DOES THE CESAREAN RATE KEEP GOING UP? (2007), *available at* http://www.childbirthconnection.org/pdfs/rising-cesarean-section-rate.pdf.

[45] *See id.* Regarding the health care costs of C-sections, Bhat highlights that a reduction in the national cesarean rate, from 23.6% to 15.4%, would net a savings of about $1.5 million per annum. VASANTHAKUMAR N. BHAT, MEDICAL MALPRACTICE: A COMPREHENSIVE ANALYSIS 180 (2001). Considering that the cesarean rate is higher, the calculated savings in reducing the frequency to an acceptable level would certainly higher today.

[46] *See* HELEN VARNEY ET AL., VARNEY'S MIDWIFERY 854 (4th ed. 2004).

[47] *See* ROGER W. HARMS ET AL., MAYO CLINIC GUIDE TO A HEALTHY PREGNANCY 352 (2004).

States, where approximately 40% of C-sections are performed solely because the woman has had one before.[48]

B. Vanishing VBAC

At least through 1916, obstetricians and gynecologists followed the "once a cesarean, always a cesarean" mantra.[49] Between 1970 and 1988, the C-section rate in the United States increased dramatically from 5% to nearly 25%.[50] Recognizing this troubling increase in abdominal surgeries, organizations such as the National Institutes of Health ("NIH") and the American College of Obstetricians & Gynecologists ("ACOG") began to welcome VBAC as a way to impede this escalation.[51] Enthusiasm for post-cesarean natural birth led to a gradual but steady reduction in the C-section delivery rate, which dropped to 20.7% by 1996.[52] Simultaneously, the percentage of VBAC ascended from less than 18.9% in 1989 to a high of 28.3% seven years later.[53]

Like primary and repeat cesareans, VBAC carries its own set of potential complications if the trial of labor fails, including hysterectomy, operative injury, increased maternal infection, increased neonatal morbidity, and uterine rupture, which is associated with fetal death and severe neonatal neurologic injury.[54] Due primarily to concerns about uterine rupture, physicians are inclined to discourage women from resorting to VBAC if they have had a classical, high-vertical

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[48] John Zweifler et al., *Vaginal Birth After Cesarean in California: Before and After a Change in Guidelines*, 4 ANNALS FAM. MED. 228, 228 (2006).
[49] *See* BLOCK, *supra* note 2, at 87 (citing Edwin B. Craigin, *Conservatism in Obstetrics*, 104 N.Y. MED. J. 1 (1916)).
[50] Am. C. Obstetricians & Gynecologists, *Vaginal Birth After Previous Cesarean Delivery*, ACOG PRACTICE BULLETIN: CLINICAL MANAGEMENT GUIDELINES FOR OBSTETRICIAN-GYNECOLOGISTS (hereinafter "ACOG Bulletin"), July 2004, at 1.
[51] *Id.* at 1-2.
[52] *Id.*
[53] *Id.* at 2.
[54] *Id.* at 3-4.

cesarean, previous ruptures, or multiple cesareans with no vaginal deliveries.[55] Nevertheless, most published studies indicate that between 60% and 80% of women attempting VBAC end up having births without complications.[56] The vast majority of these women, therefore, benefit from a shorter maternal hospitalization, less blood loss, fewer transfusions, fewer infections, and fewer thromboembolic events.[57]

Despite this remarkable degree of success, the VBAC surge during the 1980s and 1990s was curtailed by negative publicity and subsequent backpedalling. Two 1996 studies found that women who attempted labor but ended up with an unplanned repeat cesarean suffered twice the rate of surgical injury and blood loss as women who elected repeat cesareans[58] and that women who would labor are more likely to suffer major maternal complications than women who would plan a C-section.[59] Other opinion pieces and articles followed, including a medical case study about the cardiovascular collapse and death of a woman who elected vaginal birth, bringing about an upsurge in medical malpractice lawsuits.[60] In 1999, ACOG rescinded its initial support of VBAC and adopted new, more rigorous preconditions for medical facilities offering it, such as requiring the immediate availability of obstetric, anesthesia, nursing, and surgical personnel to

[55] *See id*. at 5.
[56] ACOG Bulletin, *supra* note 50, at 3. In California, the success rate goes as high as high as 83%. Zweifler, *supra* note 48, at 232.
[57] ACOG Bulletin, *supra* note 50, at 3.
[58] BLOCK, *supra* note 2, at 87 (citing M.J. McMahon et al., *Comparison of a Trial of Labor with an Elective Second Cesarean Section*, 335 N.Y. MED. J. 689 (1996)). Block recognizes that the risks of unplanned surgery are the same for women without uterine scars. *Id.*
[59] *See* HENCI GOER, THE THINKING WOMAN'S GUIDE TO A BETTER BIRTH 164 (1999). Goer points out, however, that the researchers of this study coded wound infections and hemorrhages requiring transfusions, both of which occur more often in planned cesarean delivers, as "minor complications." *Id.*
[60] BLOCK, *supra* note 2, at 87; GOER, *supra* note 59, at 164. Because VBAC was performed indiscriminately by many hospitals that forced pregnant women to give birth vaginally despite contra-indications, major complications did occur that justified some of these suits. *See* RITA RUBIN, WHAT IF I HAVE A C-SECTION? 162 (2004) (California hospital that mandated VBAC paid $24 million to settle forty-nine claims related to VBAC). Because of these highly-publicized lawsuits, medical malpractice insurers raised their annual premiums, sometimes by tens of thousands of dollars. *Id*.

perform emergency C-sections.[61] In essence, the new ACOG criteria "confine[d] VBAC to university and tertiary-level medical centers . . . ."[62] As the final nail in the coffin, in 2001, the New England Journal of Medicine published both an article on the danger of uterine rupture during VBAC and a commentary urging physicians to select elective repeat C-sections instead.[63] As a result of these damaging reports, expensive settlements, and ACOG's revised standard, more than 1,000 hospitals in the United States now deprive women of the VBAC choice.[64] Predictably, the VBAC rate plummeted, falling to 9.2% of all post-cesarean births by 2004.[65]

II. Drawbacks of the VBAC-lash: An Absurd Argument Leads to Ridiculous Results [66]

"Thirty years ago obstetricians said VBAC was dangerous. Then they said it was safe. Now they've gone back to saying it's dangerous."[67] The pendulum-like shifts in opinion by the medical community at large seem to suggest that VBAC is now incontrovertibly more harmful to

[61] Law, *supra* note 32, at 357-58. ACOG maintains this position today. *See generally* ACOG Bulletin, *supra* note 50. Marsden Wagner observes that while ACOG stresses the need to counsel patients regarding the risks and benefits of VBAC, the group does not place such emphasis on the risks and benefits of cesarean section. MARSDEN WAGNER, BORN IN THE USA: HOW A BROKEN MATERNITY SYSTEM MUST BE FIXED TO PUT WOMEN AND CHILDREN FIRST 29 (2008).

[62] Law, *supra* note 32, at 358. *See generally* Zweifler, *supra* note 48 (impact of ACOG guidelines on rural hospitals).

[63] Law, *supra* note 32, at 358 (citing Mona Lydon-Rochelle et al., *Risk of Uterine Rupture During Labor Among Women with a Prior Cesarean Delivery*, 345 NEW ENG. J. MED. 3 (2001) and Michael F. Greene, *Vaginal Delivery After Caesarean Section – Is the Risk Acceptable?*, 345 NEW ENG. J. MED. 54 (2001)). Law notes that many criticized the article as offering no new data and Dr. Greene's editorial comment as inflammatory. *Id.* ("Misinterpretation of study findings leading to diminished options for women seeking VBAC is not in the best interests of mothers and babies." (quoting Bruce L. Flamm, *Vaginal Birth After Cesarean and the New England Journal of Medicine: A Strange Controversy*, 28 BIRTH 276, 287 (2001))).

[64] This information is provided by the International Cesarean Awareness Network ("ICAN") via an online data base. Int'l Cesarean Awareness Network, VBAC Policies in U.S. Hospitals, http://www.ican-online.org/vbac-ban-info (choose and submit "De Facto Ban" and "Banned" from dropdown menu at the bottom of the page) (last visited May 4, 2009). Over 800 hospitals have official policies against VBAC. *Id.* In addition, nearly 400 facilities have de facto bans: while these hospitals do not have an official policy against VBAC, ICAN determined that none of their doctors will agree to attend one. *Id.* Tallahassee Memorial HealthCare—once known as Tallahassee Memorial Regional Medical Center, the same place that denied Laura Pemberton's request for VBAC—now gives patients that opportunity. Int'l Cesarean Awareness Network, VBAC Policies in U.S. Hospitals, Tallahassee Memorial HealthCare, http://www.ican-online.org/vbac-bans/tallahassee-memorial-healthcare (last visited May 4, 2009). For background on the hospital's name change, see Tallahassee Memorial HealthCare, About Us – History, http://www.tmh.org/body.cfm?id=19 (last visited May ,4, 2009)

[65] BLOCK, *supra* note 2, at 88.

[66] This article borrows the term "VBAC-lash" from author Henci Goer. *See* GOER, *supra* note 59, at 164.

[67] BLOCK, *supra* note 2, at 270.

women than a repeat cesarean. While C-sections are safer than ever, they are not necessarily safer than a vaginal birth.[68] Thus far, high-quality data about the relative risks and benefits of VBAC versus repeat cesareans is absent.[69] Nonetheless, judging by the ever-growing divergence between C-section and VBAC rates in the United States, this unsubstantiated premise has somehow become the rule.

Neither elective repeat cesarean delivery nor VBAC is without some risk.[70] Yet, actions taken by medical institutions give the impression that VBAC is quantifiably and significantly more hazardous. The one potential complication of a failed trial of labor that has dominated the debate and developed into the war cry for the anti-VBAC movement is the risk of uterine rupture.[71] While conceding that uterine rupture is life-threatening and more likely to occur in women undergoing VBAC instead of repeat C-section,[72] the actual incidence of rupture during attempted VBAC is roughly one in 200, or less than 1 %, even in women with multiple cesarean scars.[73] Moreover, the rate of neonatal brain damage or death resulting from this rupture is even less: about one in 2,000.[74] Of course, these statistics should be put into perspective. The risk of

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[68] *See* Law, *supra* note 32, at 349 n.20 (citing Marsden Wagner, Choosing Caesarean Section, 356 THE LANCET 1677, 1677 (2000)).

[69] Paul Crawford & Leonora Kaufmann, *How Safe is Vaginal Birth After Cesarean Section for the Mother and Fetus?*, 55 J. FAM. PRAC. 149, 149-50 (2006). *See also* TRIAL OF LABOR, *supra* note 5, at 1; Law, *supra* note 32, at 345, 349 n.14.

[70] ACOG Bulletin, *supra* note 50, at 3. *See infra* Part I.

[71] Block descriptively labels this the "exploding uterus" card. *See generally* BLOCK, *supra* note 2, at 91-97.

[72] ACOG Bulletin, *supra* note 50, at 4. It should be noted that there is still a slight risk of uterine rupture during a planned repeat C-section. *See* BLOCK, *supra* note 2, at 90 (approximately 0.2%). There may also be "ample evidence . . . that many uterine scars are indeed firm and that many patients who have had a prior uncomplicated cesarean section can be delivered easily and with less hazard vaginally than by repeat cesarean section." DECHERNEY, *supra* note 30, at 520 (citation omitted).

[73] BLOCK, *supra* note 2, at 88 (citing Lydon-Rochelle, *supra* note 63); Mark B. Landon et al., *Risk of Uterine Rupture with a Trial of Labor in Women with Multiple and Single Prior Cesarean Delivery*, 108 OBSTETRICS & GYNECOLOGY 12 (2006). One study proposes that the uterine rupture rate may be even less than 1 in 200 if active management, or induced labor, is abandoned. Ron Gonen et al., *Results of a Well-Defined Protocol for a Trial of Labor after Prior Cesarean Delivery*, 107 OBSTETRICS & GYNECOLOGY 240 (2006). *See also* TRIAL OF LABOR, *supra* note 5, at 1 ("Prostaglandins should not be used for cervical ripening or induction as their use is associated with higher rates of uterine rupture and decreased rates of successful vaginal delivery.").

[74] BLOCK, *supra* note 2, at 88 (citing Lydon-Rochelle, *supra* note 63).

miscarriage following amniocentesis,[75] a widespread practice, is 1 in 200.[76] Abruptio placenta[77] occurs between 0.4% and 3.5% of all deliveries and accounts for 15% of all perinatal deaths.[78] In fact, the risk of a U.S.-born baby not surviving labor in a low-risk pregnancy is about 1 in 1000.[79] By comparison, the lifetime odds of dying in a motor vehicle accident are 1 in 84 as calculated in 2005.[80] If the minuscule risk of uterine rupture and damage is sufficient to prohibit VBAC and likewise compel cesareans, a similar argument can be made to forbid not only amniocentesis but also childbirth and, to a greater extent, driving.[81] Author and critic Jennifer Block sums up the absurdity best:

> The risk-benefit analysis of VBAC versus repeat cesarean breaks down something like this: If you are a woman attempting a VBAC, you have around a 75% chance of delivering vaginally and avoiding another major surgery and at least a 99.5% chance of not suffering a uterine rupture. If you choose a repeat cesarean, you have a 99.8% chance of not suffering a uterine rupture (it can still happen) and a 100% chance of having another major surgery, with all the risks and drawbacks that entails. These include longer hospital stay; longer and more painful recovery; higher risk of infection, organ damage, adhesions, hemorrhage, embolism, and hysterectomy; more blood loss; higher chance of rehospitalization; higher chance of a complication with the next pregnancy; less initial contact with the baby; less success breastfeeding; higher risk of respiratory problems for the

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[75] Amniocentesis is "a prenatal screening procedure in which a small quantity of amniotic fluid surrounding the fetus is removed from the uterus of a pregnant woman to allow the chromosomes of the fetus to be examined." KAREN J. CARLSON ET AL., THE NEW HARVARD GUIDE TO WOMEN'S HEALTH 34 (2d ed. 2004).

[76] BLOCK, *supra* note 2, at 93 (citing Bridget M. Kuehn, *Study Downgrades Amniocentesis Risk*, 296 J. AM. MED. ASS'N 2663 (2006)).

[77] "Abruptio placenta, or premature separation of the placenta, is the detachment of part or all of the placenta from its implantation site, typically occurring after the 20th week of pregnancy." KATHLEEN RICE SIMPSON ET AL., PERINATAL NURSING 154 (3d ed. 2007).

[78] RAE LANGFORD & JUNE D. THOMPSON, MOSBY'S HANDBOOK OF DISEASES 1 (3d ed. 2004). Perinatal mortality looks at deaths occurring during the period just before, during, and just after parturition. JACOB S. SIEGEL ET AL., THE METHODS AND MATERIALS OF DEMOGRAPHY 296 (2d ed. 2004). One common formula combines fetal and neonatal deaths. *Id.*

[79] BLOCK, *supra* note 2, at 88 (citing Marian F. McDorman et al., *Infant and Neonatal Mortality for Primary Cesarean and Vaginal Births to Women with "No Indicated Risk," United States, 1998-2001 Birth Cohorts*, 33 BIRTH 175 (2006)).

[80] Nat'l Safety Council, Resources – The Odds of Dying From…, http://www.nsc.org/research/odds.aspx (last visited May 5, 2009).

[81] *Cf.* Nat'l Advocs. for Pregnant Women, Writing Contest to Advance Feminist Legal Scholarship on the Subject of Pregnant Women's Civil and Human Rights (Aug. 28, 2008) ("[E]very 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." (alteration added)), *available at* http://advocatesforpregnantwomen.org/VBACContest.pdf.

> baby; and twice the risk of the most catastrophic complication of all: maternal death.[82]

Furthermore, at least one 2006 study revealed that a particular state's neonatal and maternal mortality rates failed to improve in the years following ACOG's 1999 guideline revisions, even though the VBAC rate plunged.[83] Given the marginal probability of uterine rupture in the first place, the risk of its occurrence "should no longer underpin the clinical practice guidelines on VBAC."[84]

Still, the "exploding uterus card"[85] receives such a disproportionate amount of attention that VBAC seems categorically worse for the fetus—and sometimes the mother—than repeat C-sections.[86] This distortion has led to at least three interrelated consequences. First, as long as physicians and the courts believe that cesareans are preferable to VBAC, they diminish the maternal autonomy of women with preexisting uterine scars.[87] Second, for those women who are unable to proceed with VBAC and are pressured to submit to an unwanted surgery, they suffer not only physical harm but also intense emotional and psychological injuries.[88] Last, for those women who cannot find an accommodating facility but are committed to vaginal birth, they find ways to circumvent intervention, such as avoiding standard medical care altogether and going into hiding.[89]

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[82] BLOCK, *supra* note 2, at 90.
[83] Zweifler, *supra* note 48.
[84] Jennifer Fenwick et al., *Women's Experiences of Caesarean Section and Vaginal Birth After Caesarian: A Birthrites Initiative*, 9 INT'L J. NURSING PRAC. 10, 16 (2003).
[85] *See supra* text accompanying note 71.
[86] Many courts have been swayed by the exploding uterus card, as manifested in their rulings to compel C-sections. *See, e.g.*, *Pemberton*, 66 F. Supp. 2d at 1253 ("[T]he risk the baby would die if there was a rupture was 50 percent.") (alteration added).
[87] *See infra* Part II.A.
[88] *See infra* Part II.B.
[89] *See infra* Part II.C.

A. In the Name of the Fetus: Compromising Maternal Autonomy

The general principle that a competent adult patient—not the hospital or the government—has ultimate authority over her own body is of constitutional import here in the United States.[90] Maternal autonomy, in fact, encompasses decision-making as to issues pertaining not only to a woman's physical body but also to subsequent childrearing and custody.[91] Because control over parturition via VBAC or compulsory C-section directly affects the mother's bodily integrity, maternal autonomy is clearly implicated. Taking into account the fundamental value assigned to this principle,[92] common sense dictates that doctors and judges should defer to maternal autonomy if no extenuating circumstances are present.

VBAC antagonists profess that such a circumstance customarily exists if women choose vaginal birth instead of a repeat cesarean: uterine rupture leading to certain death of the fetus.[93] In light of the studies and reports that fetal death ensuing from a failed trail of labor is far from

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[90] *See, e.g.*, *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) ("If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."). *See also Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("Every 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 performs an operation without his patient's consent, commits an assault, for which he is liable in damages." (citing *Pratt v. Davis*, 79 N.E. 562 (Ill. 1906); *Mohr v. Williams*, 104 N.W. 12 (Minn. 1905))). Moreover, a majority of states today recognize the maternal autonomy of minors to obtain confidential prenatal care. *See generally* GUTTMACHER INST., STATE POLICIES IN BRIEF – IINORS' ACCESS TO PRENATAL CARE (2009), *available at* http://www.guttmacher.org/statecenter/spibs/spib_MAPC.pdf.

[91] *See, e.g.*, *Troxel v. Granville*, 50 U.S. 57, 66 (2000) ("[W]e have recognized the fundamental right of parents to make decisions concerning the care, custody, and control of their children.") (alteration added); *Santosky v. Kramer*, 455 U.S. 745, 753 (1982) ("The fundamental liberty interest of natural parents in the care, custody, and management of their child does not evaporate simply because they have not been model parents or have lost temporary custody of their child to the State."); *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 535 ("The child is not the mere creature of the State; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations."); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923) ("[Liberty] denotes not merely freedom from bodily restraint but also the right of the individual to . . . marry, establish a home and bring up children . . . .") (alteration added) (citation omitted).

[92] *See, e.g.*, *Roe v. Wade*, 410 U.S. 113, 153 (1973) ("[O]nly personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty,' are included in this guarantee of personal privacy. They also make it clear that the right has some extension to activities relating to . . . *procreation*, contraception, family relationships, and child rearing and education.") (alteration added) (citation omitted) (emphasis added).

[93] BLOCK, *supra* note 2, at 2 ("[The] exploding uterus card . . . is usually followed by the 'dead baby card.'") (alteration added) (citation omitted). The U.S. Supreme Court does identify the post-viability protection of fetal life as a legitimate state interest in the context of abortion regulation. *Planned Parenthood v. Casey*, 505 U.S. 833 (1992); *Roe*, 410 U.S. 113.

guaranteed,[94] this rationale should not be evoked to usurp a pregnant woman's discretion. Aside from lacking empirical corroboration, the fetal mortality claim surreptitiously fashions an ostensibly one-sided conflict between the expecting mother and her physicians, the state, and the fetus.[95] This maternal-fetal tension, which would tip the legal scale in favor of extra-maternal intervention, is nonetheless contrived. Unlike women who exercise their legal right to abort, women who are weighing their options with regard to delivery method have already decided to carry the fetus to term and desire a safe birthing experience for the fetus as well as themselves. In addition, focusing on the welfare of the fetus tends to "ignore [] the fact that a surgical intrusion upon the woman's body is also at issue."[96]

Thus, by arguing viscerally, VBAC opponents effectively insist that the autonomy of a pregnant women, who considers multiple factors when considering either VBAC or repeat C-section such as the pros and cons on fetal health, economic costs, and her own well-being, should be subjugated in favor of doctors and even judges who will first and foremost guard the interests of the unborn fetus. Neither advocates nor adversaries of VBAC want harm to befall either the mother or the potential newborn. Yet, those against VBAC believe that the ideal manner by which to achieve an optimal birth after a prior cesarean is one that infringes upon the longstanding principle of maternal autonomy as well as involves another major abdominal surgery. Moreover, the implicit proposition that a fetus "has achieved the status of a second

[94] *See supra* Part I.
[95] "[T]he leap from acknowledging the fetus's presence to limiting the pregnant woman's autonomy is a reflection of the medical community's response to technological advances such as ultrasound, which permits obstetricians to visualize the fetus within the mother's uterus." Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 471-72 (2000).
[96] April L. Cherry, *The Free Exercise Rights of Pregnant Women Who Refuse Medical Treatment*, 69 TENN. L. REV. 563, 599 (2002) (hereinafter "Cherry (Exercise)") (quoting Rhoden, *supra* note 22, at 1968 (alteration added)).

patient who faces greater risks of serious morbidity and mortality than does the mother"[97] remains controversial.[98]

Even so, hundreds of hospitals have withdrawn VBAC entirely, placing an irreconcilable gulf right in the middle of the maternal choice continuum. While "most jurisdictions [maintain] that a woman has the unfettered right to abort a fetus in the first trimester, the right to make most medical decisions for a child moments after birth, and the right to refuse medical treatment for herself in any other situation, . . . she does not have the right to choose among safe childbirth alternatives for herself and her child."[99] Another odd discrepancy emerges when one considers that the majority of U.S. states allow pregnant minors to obtain prenatal care, including regular medical visits and routine services for labor and delivery, without informing their parents,[100] whereas pregnant adults like Laura Pemberton, who have greater life experience and familiarity with delivery and childrearing, are treated like criminals for refusing to take the doctor's advice without hesitance.[101] Difficult situations will undoubtedly arise in which a repeat C-section may well be the optimal mode of delivery and the pregnant woman adamantly refuses the procedure.[102] Outside of these scenarios, in which the woman's motivations for avoiding surgery

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[97] Oberman, *supra* note 95, at 472 (quoting F. GARY CUNNINGHAM ET AL., WILLIAMS OBSTETRICS 1031 (19th ed. 1993)).

[98] In contrast to courts like that in *Pemberton*, other jurisdictions do not readily accept the notion that fetuses have rights equal to or superior to those of people who are already born. *See, e.g.*, Monica K. Miller, Refusal to Undergo a Cesarean Section: A Woman's Right or a Criminal Act?, 15 HEALTH MATRIX 383, 397 (2005) (discussing *In re A.C.*, 573 A.2d 1235 (D.C. 1990)). Recently, some states have tried to bestow such rights on the unborn, but these attempts have been soundly rejected so far. Charles Lewis, *North Dakota Senate Rejects Embryo Bill*, NAT'L POST, Apr. 4, 2009, http://www.nationalpost.com/related/links/story.html?id=1463074 (proposed legislation defining personhood as occurring at the moment of conception); David Montero, *Voters Reject Amendment 48 'Personhood' Issue*, ROCKY MOUNTAIN NEWS, Nov. 5, 2008, http://www.rockymountainnews.com/news/2008/nov/05/voters-reject-amendment-48-personhood-issue/ (proposed amendment granting constitutional rights such as due process to fertilized eggs).

[99] Amy F. Cohen, *The Midwifery Stalemate and Childbirth Choice: Recognizing Mothers-to-Be as the Best Late Pregnancy Decisionmakers*, 80 IND. L.J. 849, 852-53 (2005) (alterations added) (citation omitted).

[100] *See* GUTTMACHER INST., *supra* note 90.

[101] *Cf.* Miller, *supra* note 98, at 399 (disapproving criminal prosecutions of women who refuse to submit to a C-section).

[102] *Compare Pemberton*, 66 F. Supp. 1247, *with Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981) (court-ordered cesarean issued because defendant has complete placenta previa that cannot be corrected

should be taken into account anyway, VBAC should be available. Furthermore, if the woman desires VBAC, consistent with the principle of autonomy, her preference should be respected.

B. Rejected & Dejected: The Emotional & Psychological Side Effects of Nonconsensual Cesareans

Limiting maternal autonomy with respect to childbirth choice is not simply a wrong in itself. In addition to violating privacy and bodily integrity, nonconsensual surgery on behalf of the fetus impairs women's dignitary interests.[103] Refusing to honor elective VBAC sends the message that women somehow forfeit control over parturition by having an earlier C-section and that their input, no matter well-informed, is irrelevant. This presumption of maternal incapacity predictably generates negative reactions.[104] Patients are simultaneously angered, distressed, and made helpless by the lack of conscientious discussion about their birthing options, the condescending remarks by health-care professionals about their foolishness and selfishness for wanting VBAC, and the absence of a nurturing and supportive birth environment.[105] They also become disillusioned,[106] suspicious of a medical establishment that heartily values a woman's right to have a repeat C-section but not VBAC.[107] Research even links the disparaging treatment

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prior to delivery and both mother and fetus likely to perish in the course of natural childbirth). In contrast, Laura Pemberton willingly elected cesarean delivery when informed that she had placenta previa. *See supra* Introduction. This condition did not exist when she sought VBAC for a subsequent pregnancy.

[103] *See* April L. Cherry, Roe*'s Legacy: The Nonconsensual Medical Treatment of Pregnant Women and Implications for Female Citizenship*, 6 U. PA. J. CONST L. 723, 736-37 (2004) (hereinafter "Cherry (Legacy)").

[104] *See generally* Fenwick, *supra* note 84. Although the fifty-nine-person sample size of this Australian-based survey is relatively small, the anecdotes of these women, who overwhelmingly condemned their C-section experience, nonetheless demonstrate that the wounds of the surgery go beyond the uterine incision and should be recognized as a serious problem. *See generally id.*

[105] *See id.* at 12-15. The idea that women are greedy for seeking VBAC is partially explained by Cherry as a product of an American culture in which women are expected to be altruistic and "sacrifice their own lives for their children or fetuses." Cherry (Legacy), *supra* 103, at 740-41.

[106] *See, e.g.*, BLOCK, *supra* note 2, at 147 ("I'll never, ever place my children or myself under the risks of walking into a hospital without reason again.").

[107] *See id.* at 93 (chair of ACOG's obstetric practice committee supporting a patient's right to choose cesarean delivery but condemning VBAC as unsafe medicine); News Release, New ACOG Opinion Addresses Elective Cesarean Controversy (Oct. 31, 2003) ("[I]f they physician believes that cesarean delivery promotes the overall health and welfare of the woman and fetus more than does vaginal birth, then he or she is ethically justified in

of pregnant women with post-traumatic stress disorder ("PTSD"), akin to the "flashbacks, avoidance, and paranoia that plague survivors of rape and war."[108] Women who underwent nonconsensual surgery in lieu of VBAC fitting described the ordeal as "birthrape":

> I felt raped. Lying naked on a cold table, strangers sticking tubes up my body, pulling my innermost organs out to fondle. I could not even pull myself out of bed for the first 3 weeks. My life was hell for months. . . . This is not birth. I went in pregnant, and I came out a bleeding, empty woman.[109]

In addition to engendering cynicism towards hospital staffs, VBAC bans potentially mar the pregnant woman's transition into motherhood. Cesarean delivery is often seen as clinical and abnormal.[110] One woman, for instance, felt that she was "gutted like a fish while in a crucified position on the table."[111] The birth trauma caused by the operation can overshadow the elation of the baby's arrival.[112] The maternal-fetal bond is further jeopardized when patients are made apathetic by epidural anesthesia and other labor-inducing drugs and—because they need to recover physically and mentally from major surgery—are unable to hold, touch, see, or breastfeed the newborn.[113] Many C-section recipients also allude to feelings of feminine inadequacy caused by "their bodies' inability to birth their baby . . . ."[114] These side effects of nonconsensual surgeries seem all-the-more unnecessary by the fact the data in favor of repeat cesareans is nowhere near conclusive.

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performing a cesarean delivery."), *available at* http://www.acog.org/from_home/publications/press_releases/nr10-31-03-1.cfm

[108] BLOCK, *supra* note 2, at 145 (citing Cheryl T. Beck, Post-*Traumatic Stress Disorder Due to Childbirth*, 53 NURSING RES. 216 (2004)). Beck found that between 1.5% and 6% of mothers suffer from PTSD as a result of their birth experience. *Id. See also* Fenwick, *supra* note 84, at 12 (78% of women surveyed reported that their cesarean section was both physically and emotionally traumatic).

[109] BLOCK, *supra* note 2, at 146.

[110] *See* Fenwick, *supra* note 84, at 14.

[111] *Id.*

[112] *See, e.g.*, BLOCK, *supra* note 2, at 144 ("[W]hen you're lying there gutted like a fish, you can't really relate.").

[113] *See id.* at 142-148; Fenwick, *supra* note 84, at 14.

[114] Fenwick, *supra* note 84, at 13. *See also* Robertson, *supra* note 27, at 454. In contrast, women who underwent VBAC achieved a sense of empowerment. *See* Fenwick, *supra* note 84, at 14 ("Support [for VBAC] led to active decision-making, which ultimately facilitated a woman's sense of control over labour and confidence in her body's ability to birth. For many women birthing vaginally was a way to heal." (alteration added)).

C. Anywhere But the Hospital: VBAC Goes Underground

There is no state or federal law that illegalizes VBAC.[115] "In theory, a woman who strongly desires a vaginal birth after a C-section can travel to an urban center and give birth at a tertiary care hospital" that complies with ACOG's standard.[116] Some have shown the willingness to journey hundreds of miles to a VBAC-friendly hospital.[117] For many, however, this theoretical autonomy does not take into consideration a myriad of costs that they cannot bear.[118] As a result of remaining stationary, however, these women are faced with a birthing dilemma: go to the nearby, anti-VBAC hospital and undergo a C-section or resort to a type of "back alley birth."[119]

So as to not completely abandon modern obstetric care, a number of women have employed a "showing up pushing" strategy.[120] In order for this approach to succeed, the pregnant woman must calculate the distance between her initial birthing location and the hospital and then painstakingly time her labor so that she arrives at the labor and delivery floor practically crowning.[121] The initial birthing location may be her home or, to minimize timing error, the hospital's adjacent parking lot.[122] Physicians, however, have caught on to this tactic. Instead of conceding that it is too late to operate, they obstinately force surgery through deceptive practices

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[115] *See* Miller, *supra* note 98, at 395.
[116] Law, *supra* note 32, at 359.
[117] *See, e.g.*, BLOCK, *supra* note 2, at 96 ("A woman in Alaska recalled traveling 280 miles from her home of Homer to Anchorage to give birth in a hospital that would allow a VBAC.").
[118] Law, *supra* note 32, at 359 ("[I]t is difficult to predict when natural labor will begin and an extended stay in a distant city is costly in both financial and human terms.").
[119] *See* Shel Lyons, *Back Alley Births: Research Supports Birth Choices as Insurance and Hospitals Limit Them*, WOMEN'S RTS., Jan. 14, 2009, http://womensrights.change.org/blog/view/back_alley_births. This phrase is a play on the well-known phrase "back alley abortions" used as a rallying cry by pro-choice advocates prior to *Roe*. *See id.* *See generally* ANDREA TONE, CONTROLLING REPRODUCTION: AN AMERICAN HISTORY (2d ed. 1997). For the purposes of this paper, a back alley birth includes any tactical attempts by pregnant women to obtain VBAC when VBAC is unavailable, whether or not labor and delivery ultimately occurs inside a hospital.
[120] *See* BLOCK, *supra* note 2, at 94.
[121] *See id.*
[122] *Id.*

such as anesthetizing under the pretense of administering oxygen[123] or police and judicial strong-arming.[124]

Others skeptical of conventional health care institutions have avoided them altogether, whether or not they incur out-of-pocket expenses for doing so.[125] Some have opted for home births after cesarean ("HBAC"),[126] hiring a midwife or doula to attend or proceeding into labor alone.[127] Those who have the financial means have stayed at VBAC-friendly birthing centers.[128] These sites, which more closely resemble an intimate and comfortable home setting,[129] have yielded positive results: one study recognizes a trial of labor success rate of 87% in these centers, compared to 70% in typical hospital venues, as well as a uterine rupture rate of 0.4%.[130] One communal birthing center in Tennessee that has hosted 124 VBACs has an unparalleled record: no maternal deaths in its forty-year history and a neonatal morbidity rate of 0.39%.[131] Even assuming for the sake of argument that hospitals are the most secure places to attempt VBAC,[132]

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[123] *See id.*
[124] *See, e.g.*, *Pemberton*, 66 F. Supp. 1247.
[125] Hospital care is about three times more expensive than midwifery service. *See* CostHelper.com, Baby Delivery Cost – How Much Does Baby Delivery Cost?, http://www.costhelper.com/cost/child/baby-delivery.html (last visited May 6, 2009). However, savings received by pursuing the latter may be offset. For example, women insured by Kaiser, Aetna, and Blue Cross Blue Shield will find that their coverage does not always extend to births occurring outside of hospitals. *See* Lyons, *supra* note 119. In addition, insurance companies have withheld coverage from women who have had prior C-sections. *Id.*
[126] BLOCK, *supra* note 2, at 95. HBAC need not occur at the pregnant woman's own home. *See id.* at 96 (women offering up their bedrooms to host someone else's birth).
[127] *Id.* at 95-97; Law, *supra* note 32, at 368. A doula, or paramanadoula, provides emotional support to the birthing family whereas a midwife provides clinical skills akin to a care provider. JANET SCHWEGEL & PAM ENGLAND, ADVENTURES IN NATURAL CHILDBIRTH: TALES FROM WOMEN ON THE JOYS, FEARS, PLEASURES, AND PAINS OF GIVING BIRTH NATURALLY 177-78 (2005).
[128] BLOCK, *supra* note 2, at 96. Such "havens" are also located abroad. *Id.*
[129] AM. ASS'N BIRTH CTRS., How are Birth Centers Different?, http://www.birthcenters.org/birth-center-faq/bc-difference.php (last visited May 6, 2009).
[130] Rory Windrim, *Vaginal Delivery in Birth Center After Previous Caesarean Section*, 365 THE LANCET 106, 106 (2005).
[131] BLOCK, *supra* note 2, at 96. For more information about The Farm in Summertown, Tennessee, go to http://www.thefarm.org.
[132] *See, e.g.*, *id.* Windrim, *supra* note 130, at 106 (citing 2004 U.S. study concluding that attempted VBAC in a birth centre associated with higher perinatal mortality). Windrim, however, questions this finding. *See generally id.*

prohibiting VBAC would only undermine this policy by deterring post-cesarean mothers from visiting such facilities.

III. Safeguarding Choice of Delivery

Given the lack of irrefutable support that VBAC is considerably worse than a repeat C-section and the detrimental effects that VBAC prohibitions have on maternal autonomy, it is imperative to protect women's choice to deliver vaginally post-cesarean. This article recommends a two-pronged, conjunctive approach. The first component is to apply external pressure:[133] to cast the refusal to allow VBAC as a violation of a legal right and establish via litigation a logical, appropriate, and uniform analytical framework for the courts to apply. The second is to apply internal pressure: to solicit the at-large medical community's compliance with the informed consent doctrine, the disregard of which has helped cultivate the cesarean-first complex. It is through this joint effort that short- and long-term gains can be made to restore the once-reputable standing of VBAC.

A. Conjuring *Cruzan*

At first glance, the assertion that pregnant women are legally entitled to attempt VBAC looks frail. After all, no court or legislature has recognized that there is a constitutional or statutory right to control over parturition or that the established right to privacy encompasses that control.[134] Lack of acknowledgment is not necessarily fatal, though, especially when the rights to

[133] *Cf.* Oberman, *supra* note 95, at 495 ("[E]thics and practice guidelines may be more readily adopted by physicians when they provide clear rules with a 'credible threat of enforcement from outside of the profession . . .'" (quoting David Orentlicher, *The Influence of a Professional Organization on Physician Behavior*, 57 ALB. L. REV. 583, 596 (1994)).

[134] *See* Cohen, *supra* note 99, at 852. In contrast, some states have sought to entirely eliminate maternal control over the fetus. *See supra* text accompanying note 98.

privacy[135] and abortion[136] are not themselves explicit in the federal constitution. In fact, a feasible argument can be made for an implied right of childbirth choice based on the U.S. Supreme Court's unearthing of the right to terminate a pregnancy. Such a right is more accurately viewed as a bifurcated one: (1) the freedom to exercise the choice to abort before the fetus reaches the state of viability, or (2) the freedom *not* to exercise that choice.[137] Along these lines, *Roe* stands for the proposition that women have full procreative freedom: "[t]he freedom *not* to reproduce and the freedom *to* reproduce when, with whom, and by what means one chooses."[138] Full procreative freedom also logically extends to every aspect of reproduction, including conception, childrearing, gestation, and labor.[139] Since fundamental rights have already been deemed to exist with respect to both conception and childrearing,[140] it would only be sensible to recognize maternal autonomy with regard to method of delivery.[141] However, due to the ongoing criticism of judicial activism,[142] the Supreme Court may be overly conscious about expanding the "menu of unwritten fundamental rights"[143] and avoid such an interpretation to preserve its legitimacy.

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[135] *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965) ("[S]pecific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance. Various guarantees create zones of privacy.") (alteration added).

[136] *Roe*, 410 U.S. at 153 ("This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action . . . [or] in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.") (citation omitted) (alteration added).

[137] *See* Robertson, *supra* note 27, at 416.

[138] *Id.* at 406 (alteration added).

[139] *Id.* at 408.

[140] *See* cases cited *supra* notes 90-92.

[141] "Because parturition is an intensely intimate emotional and physical experience, a woman's interest in controlling the conditions of her confinement should, as a matter of ethics and policy, be recognized." Robertson, *supra* note 27, at 452.

[142] For works censuring the judicial activism of either liberal or conservative courts, see generally MARK R. LEVIN, MEN IN BLACK: HOW THE SUPREME COURT IS DESTROYING AMERICA (2005); THOMAS MOYLAN KECK, THE MOST ACTIVIST SUPREME COURT IN HISTORY: THE ROAD TO MODERN JUDICIAL CONSERVATISM (2004).

[143] Robertson, *supra* note 27, at 452.

Nevertheless, even without this type of contention, there is a preexisting, standalone legal cause of action available that easily implicates the issues of bodily integrity, self-determination, and privacy that go together with childbirth choice: the federal constitutional right to refuse medical treatment.[144] As explained in *Cruzan v. Director, Missouri Department of Health*, "the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment" is guaranteed by the Due Process Clause the Fourteenth Amendment as well as rooted in traditional common law.[145] This right, which protects even "an interest in refusing *life-sustaining* medical treatment,"[146] should certainly apply to women who want to decline an invasive abdominal surgery that in no way ensures her or the fetus's health and safety.[147]

It is unclear from *Cruzan* whether refusing medical treatment is a fundamental right that warrants strict scrutiny of government regulation, although the case did not establish whether rational basis review—the most deferential standard to government intervention—was proper either.[148] Traditionally, however, a state can intervene if its own interests outweigh the interests of the patient.[149] Four government interests are generally considered in deciding whether to

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[144] *See Miller*, *supra* note 98, at 387. *See generally Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).
[145] *Cruzan*, 497 U.S. at 278. *See also* Cherry (Exercise), *supra* note 96, at 590 ("This right is a component of the common law right to bodily integrity and self-determination and is maintained in large part through the doctrine of informed consent, which prohibits physicians from performing any medical procedure on a patient without explaining all relevant information and obtaining the patient's consent."). Although the fitness of the woman as decision-maker is a threshold issue, this paper assumes maternal competency because a woman who was capable enough to consent to a primary C-section does not suddenly become incapable of rebuffing the exact same surgery and alternatively requesting VBAC. In those extreme cases in which competency is lacking, the state may then have compelling cause to intervene. *See, e.g.*, *In re A.C.*, 573 A.2d at 1246 (*parens patriae* doctrine).
[146] *Cruzan*, 497 U.S. at 281 (emphasis added).
[147] For many, forced cesarean delivery is sufficiently egregious to constitute a due process violation. *Cf. Rochin v. California*, 342 U.S. 165, 166, 172 (1965) ("At the direction of one of the officers a doctor forced an emetic solution through a tube into Rochin's stomach against his will. This 'stomach pumping' produced vomiting. . . . This is conduct that shocks the conscience. Illegally breaking into the privacy of the petitioner, the struggle to pen his mouth and remove what was there, the forcible extraction of his stomach's contents -- this course of proceeding by agents of the government to obtain evidence is bound to offend even hardened sensibilities. They are methods too close to the rack and the screw to permit of constitutional differentiation") (citation omitted).
[148] *See* ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 850 (3d ed. 2006).
[149] *See, e.g.*, *In re Fetus Brown*, 689 N.E. 2d 397, 402 (Ill. App. Ct. 1997).

override competent treatment decisions: (1) preservation of life; (2) prevention of suicide; (3) ethical integrity of the medical profession; and (4) protection of third parties.[150] None of these would usually be present in the VBAC context. First, notwithstanding the potential complications of a failed VBAC, the maternal mortality rate is still significantly greater for patients who deliver surgically than for patients who deliver naturally.[151] Second, if a patient intends to commit suicide, she would not do so via VBAC—which has no complications whatsoever in four out of five cases[152]—when easier, quicker methods can be executed without physicians' oversight. Third, the government's interest in the ethical integrity of the medical profession would actually be subverted by ignoring maternal autonomy,[153] seeking court intervention to compel C-sections,[154] and actively increasing the rate of cesarean deliveries above and beyond the recommended percentage.[155] Fourth, the protection of third parties exception evolved from cases involving compulsory vaccination statutes and child abandonment.[156] In contrast to vaccination, compulsory C-sections perpetuate a public health

[150] *Id. See also* Cherry (Exercise), *supra* note 96, at 592.
[151] *See* sources cited *supra* note 40. Moreover, even if the government has a compelling interest to preserve the life of the fetus in an abortion case, preservation of the mother's life takes precedence even post-viability. *See, e.g.*, *Casey*, 505 U.S. at 846 ("[We confirm] the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health.") (alteration added); *Thornburgh v. Am. C. Obstetricians & Gynecologists*, 476 U.S. 747, 768-69 (1986) (provision of Pennsylvania abortion statute facially invalid as requiring a trade-off between the mother' health and fetal survival).
[152] *See* sources cited *supra* note 56.
[153] *See, e.g.*, *In re Baby Boy Doe*, 632 N.E.2d 326, 334-35 (Ill. App. Ct. 1994) ("In the ethical opinions and recommendations it has issued, the medical profession strongly supports upholding the pregnant woman's autonomy in medical decisionmaking. The American Medical Association's Board of Trustees cautions that the physician's duty is not to dictate the pregnant woman's decision, but to ensure that she is provided with the appropriate information to make an informed decision. If the woman rejects the doctor's recommendation, the appropriate response is not to attempt to force the recommended procedure upon her, but to urge her to seek consultation and counseling from a variety of sources.").
[154] Not only are physicians under no legal duty to seek a court order, but professional medical organizations recommend against using such orders. *See* Cherry (Exercise), *supra* note 96, at 591 n.161 (citing Joelyn K. Levy, *Jehovah's Witnesses, Pregnancy, and Blood Transfusions: A Paradigm for the Autonomy Rights of All Pregnant Women*, 27 J.L. MED. & ETHICS 171, 182 (1999)).
[155] *See* source *supra* note 44.
[156] *See* Cherry (Exercise), *supra* note 96, at 592 n.164 (citing *Jacobson v. Massachusetts*, 197 U.S. 11 (1905); *In re Dubreuil*, 629 So. 2d 819 (Fla. 1993)).

epidemic in the form of unnecessary recourse to major surgery.[157] Also, [i]n reaching the point of parturition . . ., a woman has already chosen to procreate."[158] By not exercising her constitutional right to abort, she manifests the intent to carry the fetus to term, not to abandon it.[159] Her decision to attempt VBAC is influenced in part by the welfare of the fetus, among numerous factors.

Fetal protection remains the principal legal rationale that courts articulate in affirming compulsory C-sections. However, the majority of these courts—including that in *Pemberton*—have curiously relied on *Roe*.[160] This ground-breaking case never addressed situations outside of the narrow abortion context, leaving undisturbed the common law and constitutional liberty rights to direct medical care:

> By protecting women's decisional and physical autonomy in health care decision making outside of the context of abortion, like in Cruzan, the Court's opinions seem to support women's right to autonomy over the state's interest in the life and health of the fetus, except in the narrow case of the abortion of a viable fetus when the pregnant woman's life and health are not compromised by continuing the pregnancy.[161]

Holdings in favor of prohibiting VBAC based on this misinterpretation of *Roe* should therefore be invalidated. Had *Pemberton* been viewed properly through *Cruzan* and its progeny and

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[157] *See supra* note 44 (optimal national C-section rate between 5% and 10%).
[158] Robertson, *supra* note 27, at 451 (alteration added) (citation omitted).
[159] Furthermore, a separate argument can be made that, because the fetus is not a child, there can be no child abandonment. *See Casey*, 505 U.S. at 913 (Stevens, J., concurring in part and dissenting in part) ("The Court in *Roe* carefully considered and rejected, the State's argument that the fetus is a person within the language and meaning of the Fourteenth Amendment. After analyzing the usage of 'person' in the Constitution, the Court concluded that the word has application only postnatally. . . . Perfection of the interests involved . . . has generally been contingent upon live birth. In short, the unborn have never been recognized in the law as persons in the whole sense. . . . [N]o Member of the Court has ever questioned this fundamental proposition. Thus, as a matter of federal constitutional law, a developing organism that is not yet a 'person' does not have what is sometimes described as a right to life.") (internal citation marks omitted) (citation omitted) (alteration added).
[160] Cherry (Legacy), *supra* note 103, at 732. *See, e.g.*, *Pemberton*, 66 F. Supp. at 1251-52; *Jefferson*, 274 S.E.2d at 460.
[161] Cherry (Legacy), *supra* note 103, at 731. *See also* Levy, *supra* note 40, at 102 ("In most Cesarean refusal cases, the potential mother does not intend to abort the pregnancy. . . . Therefore, the issue of Cesarean section refusal must be analyzed under whether the procedure is generally one included under the constitutional right to refuse medical treatment.") (citation omitted).

balanced all of the appropriate factors, instead of concentrating excessively on the fetus, Laura Pemberton would not have been the victim of a nonconsensual C-section. In fact, had she serendipitously attempted VBAC in another jurisdiction, Mrs. Pemberton would have received a sympathetic, legally-coherent judgment holding that her right to refuse compulsory surgery could not be overridden by the fetal protection rationale considerations on either one of two grounds: (1) because, while the courts recognize a public health policy rationalizing vaccination legislation, common law does not otherwise compel a person to permit a significant intrusion upon his or her bodily integrity, such as an operation, for the benefit of another person's health;[162] or (2) because a fetus is not a child and cannot be covered by the child abandonment facet of the third-party protection exception.[163] In order to resolve the inconsistencies in legal authority, a uniform analysis should be implemented. Given the obvious impropriety of applying *Roe*, courts that erroneously do so should reverse course and follow the VBAC-friendly framework of *Cruzan*.

B. Incentivizing Adherence to Informed Consent

While litigation may be a powerful instrument to empower mothers and the pro-VBAC movement, it suffers its share of shortcomings. Many conflicts between women and their physicians arise at or near the time that she is beginning labor, "when she is unlikely to be in a position to confront her doctor or to hire an advocate to assert her rights for her."[164] In addition,

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[162] *See In re A.C.*, 573 A.2d at 1243-44 (citing *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941) (skin graft); *McFall v. Shimp*, 10 Pa. D. & C. 3d 90 (Allegheny County Ct. 1978) (bone marrow transplant).

[163] *See In re Baby Boy Doe*, 632 N.E.2d at 330, 334 ("[A] woman's competent choice in refusing medical treatment as invasive as a cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus. . . . The 'third parties' referred to in this context are the family members, particularly the children, of the person refusing treatment. Where an individual's decision to refuse treatment will result in orphaning an *already-born* child, courts have indicated that this is one factor they might consider.") (alteration added) (citation omitted) (emphasis added). *See also* In re A.C., 573 A.2d at 1244 ("Surely, however, a fetus cannot have rights in this respect superior to those of a person who has already been born.").

[164] Oberman, *supra* note 95, at 481.

by themselves, lawsuits may do more harm than good, such as cause further enmity between the parties.[165] Instead, the VBAC campaign in the courtroom should be paired with a crusade for change in medical culture. As laid out by Professor John Robertson, "One cannot overemphasize the importance of social conditions in determining women's childbearing choices, however. Legal rules are important, but external social constraints on a woman's decisions whether and when to have children may be even more important. . . ."[166] Increasing stigmatization of VBAC is manifested through the synchronized descent in VBAC and ascent in C-sections this past decade.[167] To offset this stigma, a transformation in thought must occur at the basic social level where anti-VBAC sentiments first originate: the doctor-patient relationship.[168]

Women routinely identify the nature of their interactions with doctors as making the greatest difference between a positive and negative gestational experience.[169] Specifically, these women value a doctor-patient relationship built upon mutual respect and partnership, a reciprocal relationship in which doctors share accurate and appropriate information that increases women's sense of participation in and control over parturition.[170] This notion, also known as the informed consent doctrine,[171] is crucial in light of the inherent imbalance of power that exists between

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[165] *Cf.* STEPHEN K. ERICKSON & MARILYN S. MCKNIGHT, THE PRACTITIONER'S GUIDE TO MEDIATION: A CLIENT-CENTERED APPROACH 6 (2000) ("Many come to realize that the litigation system is responsible for breeding much of the ill will and fall-out that contaminates postdivorce families and postdivorce functioning.").
[166] Robertson, *supra* note 27, at 408 n.7.
[167] *See supra* Part I.
[168] *See* Cherry (Exercise), *supra* note 96, at 599 n.205. Some may argue that state licensing boards, professional disciplinary boards and the like should issue guidelines and impose sanctions in order to force compliance, but such measures are hindered by "a general reluctance of physicians to police their colleagues' behavior," "the poor funding of professional disciplinary boards," and doctors' disinclination to follow ethics and practice guidelines that appear bounded by "personal, subjective prerogatives." Oberman, *supra* note 95, at 495, 496. The author of this article is optimistic, however, that a rational appeal to doctors' common sense, as well as the external threat of litigation, is sufficiently persuasive.
[169] Fenwick, *supra* note 84, at 16.
[170] *Id."* Poor staff-client relationships in which women's experiences were seemingly dismissed only heightened feelings of grief and failure." *Id. See supra* Part II.B.
[171] *See generally Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972). "Caveat emptor is not the norm for the consumer of medical services. Duty to disclose is more than a call to speak merely on the patient's request, or merely to answer the patient's questions; it is a duty to volunteer, if necessary, the information the patient needs for

physicians who have specialized knowledge and expertise and patients who are ill or anxious about their health and vulnerable.[172] Yet, in order for many of these patients to receive the information they need to make an intelligent decision between VBAC or repeat cesarean, the physicians—those in the position to abuse their power—must make the initial disclosures.[173]

Medical professional guidelines facially embrace patients' informed consent.[174] This, combined with the empirical uncertainty surrounding the VBAC versus repeat cesarean debate, should call for widespread acknowledgement that neither childbirth choice is decisively superior, not that C-section is preeminent. At least one organization, the American Academy of Family Physicians ("AAFP"), understands that no such evidence-based recommendation can be made.[175] Unfortunately, other data indicates not only that many practitioners fail to share information on birthing options in an uncomplicated and unbiased way,[176] but also that they are more than willing to override a patient's choice if she does not follow their preferred treatment.[177] To make matters worse, doctors who introduce their own personal philosophies into the equation are left unchecked by professional codes incorporating informed consent, which are non-binding,[178] but simultaneously encouraged by others that place doctors' discretion on a pedestal.[179]

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intelligent decision." *Id.* at 783 n.36. Informed consent is also an essential feature of the right to refuse medical treatment. *See supra* text accompanying note 145.

[172] *See* Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 245-46 (1995).

[173] Alternatively, women may follow Laura Pemberton's example and conduct their own independent research. This may be futile in light of *Pemberton*, in which the court deferred to the physicians' judgment. 66 F. Supp. at 1250. This only accentuates the importance of changing medical opinion toward VBAC.

[174] *See supra* text accompanying note 153 (referring to American Medical Association)

[175] TRIAL OF LABOR, *supra* note 5, at 1. *See also* Zweifler, *supra* note 48, at 234 ("We recommend that a balanced presentation of risks and the encouraging outcomes [regarding VBAC] found in this analysis be included in discussions with pregnant patients who have had a previous cesarean section." (alteration added)).

[176] Fenwick, *supra* note 84, at 16.

[177] Cherry (Exercise), *supra* note 96, at 590 n.151 (quoting Leslie G. Espinoza, Dissecting Women, Dissecting Law: *The Court-Ordering of Caesarean Section Operations and the Failure of Informed Consent to Protect Women of Color*, 13 NAT'L BLACK L.J. 211, 231 (1994)).

[178] Oberman, *supra* note 95, at 491.

[179] *See* sources cited *supra* note 107.

At least two key transformations in viewpoint must occur at the doctor-patient relationship level so that such behavior no longer runs rampant. First, in keeping with the autonomy aspect of the informed consent doctrine, physicians must realize that their interactions with patients are not supposed to be unilateral and paternalistic. Patients are ultimately consumers who are free to accept or reject a particular product or service.[180] If a normal salesperson attempted to foist an unwanted product or service on a customer, the salesperson would risk alienating that customer and losing business. Alternatively, if that salesperson sold a product or service that the customer eventually discovered was unnecessary, the customer would probably feel deceived and lose trust for that salesperson. Likewise, doctors adhering to a subjective, cesarean-first complex should be conscious of possibly severing their relationships with pregnant patients, with whom they share common goals of a healthy mother and child. They must promote trust and a collaborative spirit and "distance [themselves] as much as possible form [sic] [their] personal preferences and values and . . . present information in a manner that reflects an objective assessment of the interests at stake for the patient."[181] When an irreconcilable conflict arises between physician and patient, the former must refer the latter to an alternate provider instead of imposing his or her own will.[182]

Second, the at-large medical community must come to realize that adherence to informed consent actually enhances a defense against allegations of negligence, one of the factors that convince physicians to perform "defensive"[183] repeat C-sections.[184] A medical malpractice claim

[180] *See Canterbury*, 464 F.2d at 783 n.36.
[181] Cherry (Exercise), *supra* note 96, at 599 n.205 (alterations added) (citation omitted). As a corollary, physicians should even discuss possibilities of using midwives or birth centers. *See, e.g.*, BLOCK, *supra* note 2, at 65 ("My personal feeling is that physicians should work with midwives."); Windrim, *supra* note 130.
[182] *See* Oberman, *supra* note 95, at 497 n.192 (citing *Ascher v. Gutierrez*, 533 F.2d 1235 (D.C. Cir. 1976)).
[183] *See* BHAT, *supra* note 45, at 177 ("Defensive medicine occurs when doctors order tests, procedures or visits, or avoid high-risk patients or procedures, primarily but not necessarily solely to reduce their exposure to malpractice liability.") (internal parenthesis omitted).

must, as a threshold matter, establish both a duty and a breach of duty.[185] The former is easily proven by virtue of the doctor-patient relationship while the latter occurs when the doctor does not adhere to the appropriate standard of care.[186] Due to the VBAC uterine rupture lawsuits and settlements in the mid- to late-1990s, the medical community decided that the appropriate standard for these women was to generally avoid VBAC and rely on surgery.[187] The problem with this new standard is that the objective, scientific evidence does not justify the sudden, wholesale departure from the pro-VBAC stance of the 1980s and 1990s. Even ACOG, which has played a major role in the current restriction of VBAC practice, concedes the soundness of considering VBAC if the chance of success is 50% or greater and the desire for future pregnancy after cesarean delivery is at least 10-20%.[188] A claimant has a stronger argument for breach of duty—and malpractice—when the standard of care is ambiguous or inappropriate.[189] Thus, rather than curb litigation, this questionable anti-VBAC standard may encourage legal claims of a different nature: nonconsensual performance of an unnecessary cesarean. Furthermore, the incidents of uterine rupture that formed the centerpiece of early VBAC litigation were most likely caused by haphazard, across-the-board VBAC attempts by hospitals, which chose natural childbirth for reasons other than patients' benefit, facilitating a mistaken perception that a retreat from VBAC was the needed response.[190]

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[184] *See, e.g.*, BHAT, *supra* note 45, at 184. ("In malpractice cases, plaintiffs claim that failure to perform the cesarean section in a timely fashion is the cause of cerebral palsy and . . . this is the major reason for physician's need to perform cesarean sections.") (citation omitted). Limited studies conflict as to the precise effect of the malpractice system on cesarean rates. *Id.* at 182-83.

[185] *See, e.g., Cortes-Irizarry v. Corporacion Insular De Deguros, 111 F.3d 184, 189 (1st Cir. 1997)*; DECHERNEY, *supra* note 30, at 1118.

[186] DECHERNEY, *supra* note 30, at 1118.

[187] GOER, *supra* note 59, at 164.

[188] ACOG Bulletin, *supra* note 50, at 3.

[189] *See* DECHERNEY, *supra* note 30, at 1120.

[190] *See, e.g.*, RUBIN, *supra* note 60, at 162 (hospital mandating VBAC on grounds that VBAC costs $2,300 less than elective repeat C-section). As Rubin plausibly summarizes, "Just as forcing all pregnant women with a prior C-

As previously discussed, the full disclosure exhibits respect for patients' autonomy— and their right to refuse medical treatment—by giving them the necessary information needed to make an educated decision. Adherence to the informed consent doctrine, especially when there is no clear-cut "correct" standard of care, also safeguards hospitals from malpractice liability. By openly divulging the risks and benefits of both VBAC and repeat cesarean as presently known, as well as concurring with the patient's choice, a doctor easily and reasonably discharges his or her legal duty.[191] The patient cannot then successfully sue the doctor for not forcing her to select the alternative birthing method; otherwise, the doctor would be required to violate informed consent which, in turn, breaches his or her duty towards patients.[192] In addition, reliance on full disclosure rather than an inflexible, questionable standard of care signals to society and the courts, both of which rely upon medical expertise in health care-related matter, that VBAC is as viable an option as ever for many pregnant women,

Conclusion

Every individual on the planet has once lived inside the womb before coming into the world as a newborn. In this sense, everyone has taken part in childbirth. Only pregnant women, however, can fully comprehend this unique phenomenon and the physical, mental, emotional, and social sacrifices it entails. Because they alone fully grasp this experience, these women are the definitive authorities over their bodies. Compared to past history, maternal autonomy is more validated today, legally and socially. Disappointingly, the scope of maternal autonomy is compromised in situations when a mother becomes pregnant once again and wishes for a natural

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section to attempt a VBAC is misguided, so is forcing all of them to have a repeat cesarean. The appropriate approach is somewhere in between." *Id.* at 164.

[191] Vanessa Merton, *The Exclusion of Pregnant, Pregnable, and Once-Pregnable People (a.k.a. Women) from Biomedical Research*, 19 AM. J.L. & MED. 369, 412 n.184 (1993).

[192] *See id.*

childbirth, only to discover that her uterine scar from a previous cesarean delivery demands that she undergo that same surgery once again. That mother, who has legal rights to forego her pregnancy and to rear her children postnatally, somehow loses her bodily authority in the middle of the procreative process.

Once upon a time, the adage "once a cesarean, always a cesarean" was considered an antiquated remnant of a bygone generation. Yet, despite increased incidents of maternal morbidity and mortality, C-sections now account for approximately one-third of all births in the United States, a good proportion of which could have been delivered vaginally. VBAC, though, has been defamed in recent years as a risky, irresponsible course of action that would endanger the mother and fetus, a marked deviation from the optimism that initially accompanied VBAC starting two decades ago. While attempted VBAC has intermittently resulted in death, such risks are also present in repeat cesareans. Empirical evidence offers little in the way of determining the superiority between VBAC and repeat C-sections. The answer is simply that there is none.

Because they choose to carry a fetus to term, pregnant women will account for the safety of the future child, as well as themselves, in deciding whether to deliver vaginally or surgically. In an ever-increasing number of hospitals, maternal control over parturition has been taken away by physicians—and even the courts—who believe that women disregard fetal health by opting for VBAC, even though compulsory cesareans do not guarantee a better result. In order to preserve the maternal choice of VBAC, advocates must effectively draw attention to these distortions and absurdities of the current anti-VBAC stance through litigious and non-litigious means and reaffirm that VBAC is still in vogue.