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Misinformed Consent: Non-medical Bases For American Birth Recommendations as a Human Rights Issue

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What we see [in obstetrics units] resembles childbirth as much as artificial insemination resembles sexual intercourse.[1]

A significant number of American women receive clinical birthing-option advice from obstetrician-gynecologists ("ob-gyns") without being informed of the non-medical considerations that influence the recommendations they receive. This professional custom may cause various adverse consequences to the women who receive such recommendations. These adverse consequences include: (a) impairment of a woman's ability to consent to or refuse surgery or other treatment in an informed manner; (b) reduction of available birthing services; and (c) restraint of qualified non-obstetricians—including nurses, midwives, and family practice physicians—from providing birthing services. By introducing undisclosed, non-medical considerations into the formulation of birthing recommendations, ob-gyns also subvert established American policies in favor of reducing the surgical delivery of babies[2] and against the restraint of trade in the healthcare field.[3]

The key premise of this paper is that the provision of medical advice in this manner constitutes a human rights violation under both international and American human rights norms. Part I of this paper first discusses the international and domestic human rights norms that counsel respect for women's rights to select the birthing and healthcare options of their choice. Part II then examines the decline of midwifery in the United States and the corresponding rise of professionalized medicine. Part III discusses how professionalized medicine has resulted in a surge of ob-gyn-attended cesarean sections and laid the groundwork for the undisclosed, non-medical considerations that influence (and limit) a woman's birthing options today. Such considerations include financial rewards and disincentives for individual healthcare providers, the potential for legal liability flowing from a given clinical decision, and political and social pressures that arise, not from the clinical presentation of any one individual, but from a broader environment of social conflict.

After these premises are examined generally, Part IV explores the formalized, but non-governmental encouragement of delivery of babies by cesarean section (also referred to as "C-section") due, in part, to a restriction of available medical services that support vaginal birth by women who have previously delivered by C-section

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1. Marsden Wagner, Born In the USA: How A Broken Maternity System Must Be Fixed To Put Women And Children First 1 (University of California Press 2006) (quoting Ronald Laing).

2. *See, e.g.*, U.S. Dep't of Health & Human Serv., Pub. Health Serv., Pub. No. 91-50213, Healthy People 2000: National Health Promotion and Disease Prevention Objectives (1991) [hereinafter Healthy People 2000] (establishing C-section reduction goal of 15%); U.S. Dep't of Health & Human Serv., Pub. Health Serv., National Institutes of Health, Pub. No. 82-2067, Cesarean Childbirth (1981), *available at* http://consensus.nih.gov/1980/1980Cesarean027html.htm [hereinafter Cesarean Childbirth] (the Consensus Development Conference on Cesarean Childbirth of the National Institutes of Child Health and Human Development convened in 1980 to sound the alarm over the then record high American cesarean birth rate of 15%). *See, e.g.*, Francis C. Notzon, *International Differences in the Use of Obstetric Interventions*, 263 JAMA 3286, 3287 (1990).

3. *See generally* Sherman Antitrust Act, 15 U.S.C. §§ 1–11 (2006).

(known as "VBAC," or vaginal birth after cesarean).[4] This section, in turn, argues that by preventing access to VBACs, professional standards adopted by many American ob-gyns not only violate women's human rights as patients, but also resemble anti-trade practices that violate women's rights as consumers of medical goods and services in a free market.

Part V suggests a remedy for these violations through greater transparency in the delivery of medical services—particularly with respect to the establishment of clinical practice standards by the American College of Obstetricians and Gynecologists (hereinafter "ACOG"), and through litigation to increase ob-gyn accountability. Part VI concludes with a summary of this paper's arguments.

I. THE HUMAN RIGHTS CONTEXT FOR WOMEN'S ACCESS TO HEALTHCARE

A. International Norms

The United States is one of the most dangerous places in the industrialized world to give birth.[5]

Many prescriptive or proscriptive human rights norms relate specifically to the provision of healthcare. The Universal Declaration of Human Rights provides: "Everyone has the right to a standard of living adequate for . . . health and well-being."[6] Various international documents shed light on the evolving "right" to health, which has been recognized to various degrees by the international community, and in many different formulations from country to country.

The United States often refrains from becoming a party signatory to a treaty that provides for so-called "social and economic rights," as opposed to the "civil and political rights" on which the U.S. was historically founded. This results in the denial of direct enforcement power to American courts of law. Nonetheless, evolving international norms—as reflected in treaties, international custom, and pronouncements from respected international organizations such as the United Nations, the World Health Organization, the World Court, and the European Court of Human Rights—are powerful, persuasive authority on the appropriate treatment of human beings.[7]

4. Comparative assessment of the clinical risks and benefits of various birthing methods, locations, and care providers is beyond the scope of this paper (and beyond the qualifications of the author). Health factors specific to a particular woman or baby, i.e., maternal age at first birth, confirmed parental genetic risks, individual history of illness or surgery, and other patient-specific medical issues are not evaluated.

5. Michael J. Myers, *ACOG's Vaginal Birth After Cesarean Standard: A Market Restraint Without Remedy?*, 49 S.D. L. Rev. 526, 527 (2003).

6. Universal Declaration of Human Rights, Article 25, G.A. Res. 217A (III), U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 10, 1948).

7. The history and sources of international human rights are beyond the scope of this paper. For purposes of the instant discussion, international human rights norms are presumed to have at least persuasive force. Often, they also carry enforcement authority in various national fora.

International standards are evidence of what the U.S. Supreme Court has called "values we share with a wider civilization."[8] Any individual in any country may cite to these norms in defense of his or her rights, as they reflect the expectations of relevant actors in the international arena; that is, individual human beings are the subjects of both national and international law.[9]

Human rights refer to the basic rights and freedoms to which all humans are entitled. There is a general international consensus that these rights include the right to life, as well as the right to participate in culture, the right to food, the right to work, and the right to education. The International Covenant on Civil and Political Rights provides that each party to the Covenant "undertakes to respect and to ensure to all individuals within its territory . . . the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political, or other opinion . . . birth, or other status."[10]

A right to health is specifically identified in the International Covenant on Economic, Social, and Cultural Rights (the "Covenant"), which states that its subscribing countries (which number more than 150) "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[11] At the international level, compliance with the Covenant is tracked by the Committee on Economic, Social, and Cultural Rights. In the year 2000, this committee issued a General Comment elucidating the right to health.[12]

The General Comment is accorded substantial respect as an authoritative statement of the Covenant by those charged with its implementation.[13] The Comment interprets the right to health as a web of related freedoms and entitlements, which

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8. Lawrence v. Texas, 539 U.S. 558, 576 (2003).

9. *See, e.g.*, Harold D. Lasswell & Myres S. McDougal, Jurisprudence for a Free Society: Studies in Law, Science and Policy (New Haven Press 1992); Myres S. McDougal & W. Michael Reisman, Power and Policy in Quest of Law (Martinus Nijhoff Publishers 1985); W. Michael Reisman & Eisuke Suzuki, *Recognition and Social Change in International Law: A Prologue for Decisionmaking*, *in* Toward World Order and Human Dignity: Essays in Honor of Myres S. McDougal 403 (W. Michael Reisman & Burns H. Weston eds., 1976); Myres S. McDougal et al., *The World Constitutive Process of Authoritative Decision*, 19 J. Legal Educ. 253 (1967); Myres S. McDougal et al., *The World Community: A Planetary Social Process*, 21 U.C. Davis L. Rev. 807 (1988); Siegfried Wiessner & Andrew R. Willard, *Policy-Oriented Jurisprudence and Human Rights Abuses in Internal Conflict: Toward a World Public Order of Human Dignity*, 93 AM. J. Int'l L. 316 (1999); W. Michael Reisman, The Harold D. Lasswell Memorial Lecture at the Proceedings of the 75th Convocation of the American Society of International Law, International Lawmaking: A Process of Communication (Apr. 24, 1981) *in* 74 Am. Soc'y Int'l L. Proc. 101 (1981).

10. International Covenant on Civil and Political Rights, art. 2, Feb. 23, 1967, 6 I.L.M. 360, 369.

11. International Covenant on Economic, Social and Cultural Rights, art. 12, Feb. 23, 1967, 6 I.L.M. 363.

12. U.S. Econ. & Soc. Council, Comm. on Econ., Soc. & Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter *General Comment No. 14*].

13. *See generally* Amnesty Int'l, *Caring for Human Rights: Challenges and Opportunities for Nurses and Midwives* AI Index: ACT 75/003/2006, June 15, 2006.

include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, including torture, non-consensual medical treatment, and experimentation. These entitlements also include the right to a system of health protection that provides equal opportunity for people to enjoy the "highest attainable standard of health."[14]

The World Health Organization ("WHO"), which is affiliated with the United Nations, defines health as a "state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."[15] In addition, "the right to health should be understood as extending beyond health care to . . . 'access to health-related education and information, including on sexual and reproductive health.'"[16] The Preamble to the Constitution of WHO provides: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[17] The Committee on Economic, Social, and Cultural Rights has developed a set of criteria for assessing whether health facilities and services are compatible with these human rights principles. One criterion is "accessibility of information, including the right to seek, receive, and impart information, consistent with confidentiality of personal data."[18]

Certain international norms relate specifically to women's health issues. For example, the Convention on the Elimination of All Forms of Discrimination against Women requires those countries that are parties to its treaty to "take all appropriate measures to eliminate discrimination against women . . . in particular to ensure . . . [a]ccess to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."[19] Children are accorded similar recognition in the international Convention on the Rights of the Child, which requires subscribing countries to "take appropriate measures . . . to ensure appropriate pre-natal and post-natal health care for mothers."[20]

As briefly illustrated herein—and as noted by Amnesty International—there is an increasing body of international human rights law and commentary that sets out the requirements of states to protect women's sexual and reproductive rights in authoritative terms.[21]

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14. *General Comment No. 14*, *supra* note 12, ¶ 1.

15. WHO Const. pmbl.

16. Amnesty Int'l, *supra* note 13, at 49–50 (quoting *General Comment No. 14*, *supra* note 12, ¶ 11).

17. WHO Const., *supra* note 15.

18. *See* Amnesty Int'l, *supra* note 13, at 50.

19. Convention on the Elimination of All Forms of Discrimination against Women, G.A. Res. 34/180, art. 10, ¶ (h), U.N. GAOR, 34th Sess., Supp. No. 46, U.N. Doc. A/34/46 (Dec. 18, 1979).

20. Convention on the Rights of the Child, G.A. Res. 44/25, art. 24, ¶ 2, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (Nov. 20, 1989).

21. *See* Amnesty Int'l, *supra* note 13.

B. American Norms

In the United States, women often encounter gender bias in medical diagnosis and treatment.[22] The quality of care received by women is also influenced by "general cultural and societal bias."[23] A pervasive societal bias in the United States is "the fantasy of omniscience and omnipotence, as embodied in the doctor who commands the wondrous apparatus of modern science, [and] the fantasy of ignorance and weakness, as embodied in the uncertain, dependent patient."[24]

Nonetheless, there are many pertinent enforceable legal norms. The U.S. Constitution is generally perceived as the acme of our legal authority. Many judicial cases inform federal constitutional protection as it relates to giving birth. Although rooted in other settings, broader doctrines premised on bodily autonomy may be invoked in relation to pregnancy, labor, and delivery.

The right to refuse treatment is illustrative. Absent imposition of a court-ordered medical guardian, the individual patient herself must be consulted for her informed consent regarding surgical procedures and other treatment. In the context of administration of psychotropic drugs, federal courts have acknowledged what they call the "intuitively obvious proposition" that "a person has a constitutionally protected interest in being left free by the state to decide for himself whether to submit to . . . serious and potentially harmful medical treatment . . . ."[25]

Even persons subject to a guardianship are entitled to legal review prior to being subjected to unwanted treatment and surgical intervention. A burden of proof must be carried by the proponent of the treatment, who must show that: (1) the affected individual would, if mentally competent, accept the treatment, or (2) that there is a sufficiently important state interest that would override the individual's refusal.[26] The U.S. Supreme Court has rooted the basis of these requirements in the due process protection afforded by the Fifth Amendment to the U.S. Constitution.[27]

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22. *See, e.g.*, Bruce A. Bergelson & Carl L. Tommaso, *Gender Differences in Clinical Evaluation and Triage in Coronary Artery Disease*, 108 CHEST 1510, 1510 (1995) (concluding that a gender-based selection bias exists in choosing patients to undergo cardiac procedures); Michelle Oberman & Margie Schaps, *Women's Health and Managed Care*, 65 Tenn. L. Rev. 555, 580 (1998) (noting that "the mere increased representation of women in clinical trials and the handful of federally-funded studies on health issues specific to women will not 'cure' the problems emanating from a research structure that is accustomed to treating men as the norm and women as the exception."); Tiffany F. Theodos, *The Patient's Bill of Rights: Women's Rights Under Managed Care and ERISA Preemption*, 26 AM. J. L. & Med. 89 (2000) (detailing the need for increased patient protections for women); Mary Lake Polan, *Medical Researchers, Heal Thyselves of Gender Bias*, L.A. Times, Feb. 24, 1991, at M2.

23. Theodos, *supra* note 22, at 93; *see also* Oberman & Schaps, *supra* note 22.

24. Harold J. Bursztain, Medical Choices, Medical Chances: How Patients, Families, and Physicians Can Cope with Uncertainty, xxix (University Press 2001).

25. *See, e.g.*, Rogers v. Okin, 634 F.2d 650, 653 (1st Cir. 1980), *vacated and remanded on other grounds sub nom*. Mills v. Rogers, 457 U.S. 291 (1982).

26. *See, e.g.*, Guardianship of Roe, 383 Mass. 415 (1981) (interpreting constitutional liberty interest pertaining to the autonomy of the body).

27. *See, e.g.*, *Mills,* 457 U.S. at 303.

Failing to observe these requirements in the administration of unwanted medical treatment has been described as a "massive curtailment of liberty."[28] These fundamental constitutional principles have been invoked to analyze the propriety of surgical and other medical interventions during pregnancy, labor, and delivery.[29] In one example, a pregnant woman named Angela Carder refused to consent to a C-section despite having cancer. Hospital officials sought and obtained a court order approving surgical delivery of the fetus before administering cancer treatment. The attending physicians subjected Ms. Carder—who had not been adjudicated mentally incompetent (nor was she alleged to be)—to the unwanted surgery. Both Ms. Carder and her baby died. In a rare posthumous ruling, a federal appeals court held on constitutional grounds that a pregnant woman has the right to make all medical decisions on behalf of herself and her fetus, noting that parents of born children could not, by law, be forced to donate organs to their children or otherwise undergo surgery to benefit existing children.[30] The court also ruled that the state's interest in the viability of the fetus and in preventing any potential harm the mother might cause to it by refusing treatment does not override her fundamental right to bodily integrity and to refuse treatment.[31]

In another example, a pregnant woman refused a blood transfusion, prompting hospital officials to seek and obtain a court order for a forced transfusion. This time, the presiding federal court declined the healthcare provider's request, and instead upheld the woman's right to refuse the treatment in question despite the fact that she was pregnant.[32]

In addition to protections afforded at common law, various federal and state statutes may provide or recognize additional rights or entitlements for women. For example, at the federal level, the Emergency Medical Treatment and Active Labor Act[33] prohibits hospitals and doctors from turning away a woman in active labor who has come to a hospital building. In some circumstances a patient en route to a hospital may satisfy the "has come to" requirement of the statute.[34] At the state level, state

28. *In re* W.H., 144 Vt. 595, 597, 599 (1984).

29. The legal and social controversy surrounding abortion is outside the scope of this paper. For instant purposes, it should be noted that legal challenges to abortion or restrictions on abortion typically involve criminalizing the actions of a woman who willingly undergoes a medical procedure that is the subject of condemnation by certain parts of society. Forcible cesarean section, on the other hand, involves subjection of a woman to a medical intervention to which she is opposed, thereby invoking autonomy and privacy interests not present in the case of abortion. This distinction has important legal ramifications within constitutional jurisprudence.

30. *In re* A.C., 573 A.2d 1235 (D.C. 1990).

31. The constitutional jurisprudence of pregnancy termination is distinct. *See supra* note 29.

32. *In re* Baby Boy Doe v. Mother Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994).

33. Emergency Medical Treatment and Active Labor Act of 2009, 42 U.S.C. §§ 1395dd(a)–(c) (2006).

34. *See* Morales v. Sociedad Espanola de Auxilio Mutuo y Beneficencia, 524 F.3d 54, 60–62 (1st Cir. 2008).

constitutions may recognize more extensive liberty interests for women than those independently protected by the federal constitution.[35]

Finally, state common law may afford some protections to pregnant women in the form of civil malpractice lawsuits, complaints to medical boards, or both. For instance, in 2005, a Massachusetts woman sued her healthcare providers for performing an unwanted C-section, contrary to her previously stated preference for a vaginal birth. The jury found that the surgery was not medically necessary, and that it resulted in physical injuries that left the woman largely bedridden and unable to perform normal life tasks for several years. The woman was awarded $1.5 million for the violation of her rights, plus the costs associated with her injuries and home-care needs.[36]

II. THE HISTORY OF BIRTHING OPTIONS IN AMERICA: AN EMERGING HUMAN RIGHTS ISSUE

A woman is a uterus surrounded by a supporting organism.[37]

The human rights aspect of some birthing issues is palpable at a glance—for example, the penal practice of shackling detainees during labor and delivery.[38] Other birthing practices, however, require some analysis to reveal their questionable nature in relation to human rights. In the United States, most births occur in hospitals with obstetricians attending. However, in many other highly developed countries—including the United Kingdom, Sweden, Denmark, and Japan—midwives attend most births and far outnumber obstetricians. A brief historical look is illuminating.[39]

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35. *See e.g.*, Best v. Dep't of Health and Human Serv., 563 S.E.2d 573 (N.C. Ct. App. 2002); Bethea v. Springhill Memorial Hosp., 833 So.2d 1 (Ala. 2002). A survey of relevant state jurisprudence is beyond the scope of this article. Suffice it to say, for instant purposes, that no state is at liberty to provide lesser protections than those afforded at the federal level.

36. Meador v. Stahler & Gheridian (Middlesex Superior Court C.A. No. 88-6450, Mass. 1993). A discussion of this case by the plaintiff's expert witness can be found at http://www.forensic-psych.com/articles/artAskexp02.php (last visited Oct. 8, 2009).

37. Kate Maloy, Birth or Abortion? Private Struggles in a Political World 47 (Perseus Publishing 1992) (quoting Iago Gladstone).

38. In 2006, the United Nations Committee Against Torture issued a report condemning this continuing American practice as a form of torture. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, United Nations Committee Against Torture, *Conclusions and Recommendations of the Committee Against Torture*, ¶ 33, U.N. Doc. CAT/C/USA/CO/2 (July 25, 2006).

39. *See* Judith Rooks, *The History of Childbearing Choices in the United States*, Our Bodies Ourselves, http://www.ourbodiesourselves.org/book/companion.asp?id=22&compID=75 (last visited Oct. 8, 2009); *see also* Ina May Gaskin, Ina May's Guide to Natural Childbirth (Bantam Books 2003); Judith Rooks, Midwifery and Childbirth in America (Temple University Press 1997).

A. Midwifery in the United States

Throughout most of history, the primary care providers at births were midwives. Midwives attended almost all births in the American colonies, relying on and then disseminating the skills learned in their British homeland.[40] Slavery effectively imported midwives from West Africa, who attended deliveries by both black and white women in certain southern states. This engendered a post-Civil War legacy of African-American midwives in most rural parts of the South. Such midwives were referred to as "granny midwives" and tended laboring poor women of various races.[41] American Indian tribes had their own midwives and midwifery traditions, now mainly limited to work on reservations.[42]

With its fragmented and rural character, significant variation in midwifery practices and laws predictably developed in the United States. There were few midwifery schools, and virtually no legal regulation of the practice of midwifery (or medicine, for that matter) throughout much of American history. With midwives tending primarily to poor, rural women who lacked ready access to doctors willing or able to attend them, there was little motivation to outlaw midwives, who thus practiced in most states without government control or physician resentment until the 1900s.[43]

B. The Rise of Professionalized Medicine

In the latter half of the nineteenth century, American medicine started to become professionalized, as practitioners seeking financial reward gladly incorporated burgeoning technology and the nineteenth-century spirit of innovation into their practices. At roughly the same time, large segments of the American population shifted from rural to urban settings, placing more and more pregnant women physically within reach of doctors and hospitals. This set the stage for the ongoing, often bitter conflict between physicians and midwives that we observe in this country to the present day.[44]

By the beginning of the twentieth century, midwives attended only about half of all births in the U.S., with physicians attending the other half. Scholars have consistently identified economic competition, professional and institutional needs to hospitalize birth, and gender discrimination as factors contributing to this profound shift in maternity-care service providers.[45]

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40. Rooks, *supra* note 39.

41. *Id.*

42. *Id.*

43. *Id.*

44. *Id.*

45. *See, e.g.*, Mainstreaming Midwives: The Politics of Change (Robbie Davis-Floyd & Christine Barbara Johnson eds., 2006); Barbara Bridgman Perkins, The Medical Delivery Business: Health Reform, Childbirth, and the Economic Order (Rutgers University Press, 2004); Wagner, *supra* note 1.

This shift to physician-dominated birthing attendance became ever more extreme as the twentieth century progressed, culminating in an almost complete usurpation of the traditional role of the midwife by doctors, and giving rise to the "pathology-oriented medical model of childbirth" that permeates the U.S. to the present day. Major events in this historical paradigm shift include two reports on medical education, published in 1910 and 1912, which identified significant deficiencies in American obstetrical training and, ironically, recommended remedying the situation with the gradual abolition of midwifery, and hospitalization for all deliveries. Rather than propose birth at home in the company of a midwife, the reports argued that poor women should attend charity hospitals so as to provide training opportunities for doctors.[46]

These influential reports—issued in a country in the throes of a love affair with progress, technology, science, and chemistry—were followed a few years later by the introduction of "twilight sleep" in 1914. "Twilight sleep was induced through a combination of morphine, for relief of pain, and scopolamine, an amnesiac that caused women to have no memories of giving birth. Upper-class women initially welcomed twilight sleep as a symbol of medical progress, although its negative effects were later publicized."[47] The opinion of lower-class women, recently imported into charity hospitals as training subjects for the new medical specialty of obstetrics, appears not to have been recorded.

Thus, the seeds for bitter conflict were sown early in the twentieth century between obstetricians—virtually all of them male and eager to ply their ever-growing surgical and technological skills—and midwives, virtually all of them female, already being marginalized by exclusion from the scientific fraternity.[48]

With the simultaneous destruction of traditional competition, the burgeoning of medical technology, and the urbanization of the American population, the die was cast for American birthing practices for the next century. The new philosophy was articulated most famously in 1915 by noted author Dr. Joseph DeLee. In the premier issue of the *American Journal of Obstetrics and Gynecology*, Dr. DeLee proposed a sequence of interventions designed to save women from the "evils natural to labor." The interventions included the routine use of sedatives, ether, episiotomies, and forceps.[49]

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46. *See e.g.*, Rooks, *supra* note 39.

47. *Id.*

48. According to Robbie Davis-Floyd, a leading commentator on the subject:

> Starting in the early 1900s, physicians [who were] determined to take charge of childbirth . . . waged systematic and virulent propaganda campaigns against the thousands of immigrant midwives practicing in the north-eastern cities, as they were seen to be the greatest threat to physician's [sic] attempts to take control of birth. These campaigns employed stereo-types of midwives as dirty, illiterate, ignorant, and irresponsible, in contrast to hospitals and physicians, which were portrayed as clean, educated, and the epitome of responsibility in health care . . . .

MAINSTREAMING MIDWIVES, *supra* note 45, at 32–33.

49. Rooks, *supra* note 39. Judith Rooks, author of *The History of Childbearing Choices in the United States,* described Dr. DeLee as very influential:

By 1935, midwife attendance had dropped to less than 15% of all births, as compared to approximately half of all births in 1900. By the 1930s, midwives mostly served black or poor, white manual laborers in the rural south. The increase in physician attendance of births between 1915 and 1929 was accompanied by a 41% *increase* in infant mortality due to birth injuries attributable to obstetrical interference.[50]

Even as American midwifery was sliding rapidly into decline due to a multitude of pressures, nurses began a resuscitation of non-physician professionalism in American birthing. A form of practice known as nurse-midwifery evolved in the rural south, in part due to the work of the Frontier Nursing Service ("FNS"), an organization founded in 1925 by Mary Breckinridge, a former public health nurse for the Red Cross in France at the end of World War I. Ms. Breckinridge brought back from overseas the knowledge and skills she acquired from British nurse-midwives.[51]

In the mid-1950s, obstetric leaders of several inner-city teaching hospitals recognized the potential value of nurse-midwifery in dealing with the post-war baby boom, thus transferring the situs of most nurse-midwifery care from the home to the hospital, and under the supervision of physicians. Nurse-midwives were influential, in part, because they won the respect of the physician community through a required educational process sufficiently similar to the medical-school model recognized by doctors. Yale University School of Nursing was a leader in the field, benefiting from the contributions of many distinguished and precedent-setting midwives. These included Helen Varney-Burst, who not only advanced the practice of nurse-midwifery and helped professionalize and standardize the educational requirements, but also served as a chronicler of the profession itself.[52]

Due in significant part to the increasing "medicalization" of birth, along with the modernization of obstetrics as a lucrative medical specialty for physicians, many new labor and delivery practices developed—many of which were "delivered in a manner

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> [Dr. DeLee] changed the focus of health care during labor and delivery from responding to problems as they arose to preventing problems through routine use of interventions to control the course of labor. This change led to medical interventions being applied not just to the relatively small number of women who had a diagnosed problem, but instead to every woman in labor . . . . American obstetrics is still functioning under the medical paradigm of childbirth it inherited from Dr. DeLee.
>
> *Id.*

50. Many sources document these trends. *See* Rooks, *supra* note 39. This apparent dichotomy is echoed in present-day America, when some 95% of births are physician attended, yet the U.S. experiences one of the highest rates of maternal and infant mortality and morbility in the industrialized world. *See, e.g.*, Michael McCarthy, *US Maternal Death Rates Are on the Rise*, 348 Lancet 394 (1996). *See generally* Wagner, *supra* note 1.

51. Wagner, *supra* note 1. Though commencing in rural Kentucky, Ms. Breckinridge actively exported her vision of care elsewhere, for example, to New York City, where she helped found the Lobenstine Clinic (1930) and Lobenstine Midwifery School (1931), to formalize and professionalize nurse-midwifery training. *See, e.g.*, Rooks, *supra* note 39.

52. *See, e.g.*, Helen Varney Burst & Joyce E. Thompson, *Genealogic Origins of Nurse-Midwifery Education Programs in the United States*, 48 J. Of Midwifery & Women's Health 464, 464–72 (2003).

that suited the convenience of medical professionals (mostly men)."[53] In the 1950s, "women were expected to be passive in child birth . . . . [M]others were often denied information, restrained while in labor, and sometimes drugged and strapped. To fit the schedules of doctors, births were often induced when not necessary; other times they were delayed by holding patients' legs together."[54]

Coinciding with these new birthing practices, the resuscitation of American midwifery in the nursing/hospital context faced a challenging setting in which the contributions of nurse-midwives were especially valuable to mothers—now viewed as "patients." Nurse-midwives were important innovators and "humanizers" in American obstetrics units. They re-introduced the concept of family-centered maternity care (such as allowing fathers in the delivery room and retaining the newborn baby in the mother's room, rather than segregating the baby in a nursery with other newborns), promoted childbirth education, and encouraged mothers to breastfeed in an age of formula and sterilized bottles.[55] Of course, the advent of nurse-midwifery did not end birthing issues. The physician sub-culture of condescension toward women as passive recipients of forced wisdom proved remarkably persistent.[56]

The general (albeit not universal) limitations faced by certified nurse-midwives in the obstetric departments of hospitals left in limbo those women who wished to resist the routine use of medical interventions utilized in hospitals.[57] Non-nurse midwives—the so-called "direct-entry midwives"—gradually filled this gap by providing pre-natal, labor, and delivery care outside of hospitals. These services took place either in free-standing birth centers or at-home births, typically without supervision by ob-gyns or other physicians. This lay-midwifery/home-birth movement developed during the 1960s and 1970s as part of "a grassroots effort by women to reclaim power over their own bodies and births."[58] It involved primarily a small number of well-educated, middle-class, white women opting for home births, as well as even smaller numbers of limited populations of women with specific religious or sub-cultural reasons for selecting home-delivery, such as Mormons and certain Native American groups.

In 2003, direct-entry midwives attended four of every thousand U.S. births and almost five of every thousand vaginal births (non-cesarean). Today, the majority of women who choose home birth are professional, white, and middle class, along with

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53. Marc A. Rodwin, *Patient Accountability and Quality of Care: Lessons From Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movements*, 20 Am. J. L. & Med. 147, 158 (1994).

54. *Id.*

55. Rooks, *supra* note 39.

56. According to a 1979 medical textbook on obstetrics and gynecology: "The evaluation of the patient's personality need not be a lengthy matter . . . . Character traits are expressed in her walk, her dress, her makeup . . . . The observant physician can quickly make a judgment as to whether she is overcompliant, overdemanding, aggressive, passive, erotic, or infantile." J. Robert Willson et al., Obstetrics and Gynecology 51 (6th ed. 1979).

57. *See generally* Rooks, *supra* note 39. *See also* Wagner, *supra* note 1, at 99–125.

58. Rooks, *supra* note 39.

a significant minority of poor and working-class women who consistently choose home birth.[59] Even so, the vast majority of women in the United States give birth in hospitals, attended by ob-gyns; that is, by *surgeons*, whose training necessarily encompasses surgery as a standard weapon in the arsenal against the "pathology" of birth.[60]

Many people assume that doctor-provided care is safer than that provided by other practitioners. In reality, the U.S. consistently displays one of the highest medical-error rates in the industrialized world. A study conducted in 2000 concluded that medical error in the United States results in between 44,000–98,000 unnecessary deaths in hospitals each year and 1,000,000 excess injuries.[61]

Though nearly all American women deliver their babies in hospitals with surgeon-physicians in attendance, twenty-eight countries have a lower maternal mortality rate. And for more than twenty-five years, the number of American women dying around the time of childbirth has been increasing—by one thousand per year—and half of these deaths are believed to have been preventable.[62] If this reality is merely a reflection of the informed choice of individuals, no human rights issue is presented, even if medically guided births are no safer than others. On the other hand, if the majority of women choose physician-attended hospital births due to misinformation about the clinical situation and birthing options, as well as an undue restriction of alternative services, their rights are violated and a remedy is necessary.

III. THE RISE AND RISK OF SURGICAL BIRTH

The surgical removal of a baby from the womb of its mother is an act that exudes deep philosophical and cultural conflict.[63]

A. A Brief History of the C-section

Although the matter is not entirely without dispute, it is generally believed that an edict of the Caesars of Imperial Rome (*Lex Caesarea*) gave rise to the term "cesarean section." This ancient law provided that "any pregnant woman dying at or near term was to be delivered by C-section," that is, the surgical delivery of a fetus. Mothers expected to survive the delivery were not, however, to be sacrificed for the

59. Mainstreaming Midwives, *supra* note 45, at 22.

60. *See, e.g.*, Gary H. Lipscomb et al., *Senior Obstetric-Gynecologic Residents' Perceptions of Their Surgical Training, Experiences and Skill*, 38 J. Reprod. Med. 871 (1993) (discussing senior obstetric and gynecologic residents' self-perceptions of surgical skill and arguing a need for comprehensive reevaluation of the components of gynecologic surgical curricula).

61. Saul N. Weingart et al., *Epidemiology of Medical Error*, Brit. Med. J., Mar. 18, 2000, at 774–77, *available at* http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1117772.

62. Wagner, *supra* note 1, at 9. Dr. Wagner also notes that forty-one countries have lower infant-mortality rates than the U.S. *Id.*

63. Myers, *supra* note 5, at 535.

welfare of the fetus.[64] Thus, the legal origins of modern cesarean section are rooted in surgical removal of a fetus from a *dying* mother only.[65]

Ironically, in twentieth-century America, where increasingly sophisticated medical technology was within grasp of the surgeons who came to dominate maternity care, this surgical procedure came to be used—and aggressively promoted—in regard to *healthy* mothers. The C-section was transformed from an effort to salvage a living infant from a dying mother to a routine procedure to surgically remove a fetus from a woman with a future.

A cesarean section constitutes major surgery.[66] The doctor—a surgeon—administers an anesthetic, drains the woman's bladder, scrubs her skin, opens the abdomen using a low "bikini" incision, peels the bladder away from the uterus, cuts through the uterine wall, and removes the fetus. The surgeon typically hands off the baby immediately to another physician or advanced-training nurse to care for, then removes the placenta, sews the bladder back into place, and closes the incision with six or seven layers of stitching.[67]

Overall, without differentiation for high-risk individuals, the C-section procedure is two to twelve times more likely to result in maternal death than vaginal delivery.[68] Even physician sources, which might be suspected of being apologists for the practice, concede the higher risk of complications from C-sections as compared to vaginal delivery.[69] The C-section, as a major surgical procedure, also typically requires a longer recovery period. Most mothers spend an average of four days in the hospital recovering from the surgery.[70] Common maternal complications include: infection, heavy blood loss, blood clot in a vein, nausea, vomiting, and severe headache post-delivery attributable to anesthesia and abdominal procedure.[71] In addition, many women feel weakened from the impact of the anesthesia and surgical stress for weeks

64. *See e.g.*, Mark Israel, Caesarean Section, http://alt-usage-english.org/excerpts/fxcaesar.html (last visited Oct. 10, 2009). *See also* Benjamin P. Sachs, *Vaginal Birth After Cesarean: A Health Policy Perspective*, 44 Clinical Obstetrics & Gynecology 553, 553–60 (2001) (discussing the history of caesareans and their current use).

65. Sachs, *supra* note 64, at 553–60. *See also* Christopher Norwood, How to Avoid a Cesarean Section 21 (Simon and Schuster 1984).

66. Bruce L. Flamm, Birth After Cesarean: The Medical Facts 17 (Prentice Hall Press 1990).

67. Norwood, *supra* note 65, at 20–21.

68. *See, e.g.*, Lorna McBarnette, *Women and Poverty: The Effects on Reproductive Status*, 12 Women & Health 55, 72 (1988).

69. *Id.*

70. Norwood, *supra* note 65, at 21.

71. T.F. Porter & James R. Scott, *Cesarean Delivery, in* Danforth's Obstetrics and Gynecology 499, 450–51 (James R. Scott et al. eds., Lippincott Williams & Wilkins 9th ed. 2003). *See also* F.G. Cunningham et al. Williams Obstetrics 592 (Andrea Seals et al. eds., McGraw-Hill 22d ed. 2005); Norwood, *supra* note 65, at 21–23; Cesarean Sections—Risks and Complications, http://www.webmd.com/baby/tc/cesarean-section-risks-and-complications (last visited Oct. 10, 2009).

or months after they go home.[72] Nearly all of these women will experience depression, discomfort, and infections.[73]

These are merely the short-term risks. The long-term risks associated with cesarean sections, which increase with each additional C-section, include uterine rupture during a subsequent pregnancy, placenta previa, and the growth of the placenta either lower in the uterus and/or deeper into the uterine wall than normal—all of which can lead to severe bleeding after childbirth, sometimes requiring a hysterectomy.[74]

Cesarean sections also pose risks for the infant, including injury during delivery, special-care requirements in neonatal intensive care units, and lung immaturity if the due date was miscalculated or delivery occurred prior to thirty-nine weeks of gestation.[75]

Simply put, it takes more time and special care to heal from a cesarean section. Overall, it requires about a third more hospital time, and three to four times as many weeks for recovery.[76]

B. The Expanding Popularity of C-sections in the United States

The cesarean section is the second most prevalent surgical procedure in the United States. At just over one million in 2002,[77] this is an unacceptably high rate, especially given the official health policy in place aimed at reducing this rate.[78] The American C-section rate has long been one of the highest in the world.[79] A complex interaction of conservative physician culture, financial incentives, technological availability, fear of medical malpractice liability, judicial reluctance to address the issue, and the absence of legislation contribute to the particularly high rate.[80]

In 1980, the National Institute of Child Health and Human Development held a Consensus Development Conference on Cesarean Childbirth to analyze the then-record-high American cesarean birth rate of 15%. The report they later issued

72. Norwood, *supra* note 65, at 21.

73. *Id.* at 23.

74. *Id. See also* Porter, *supra* note 71, at 450–51.

75. Toril Kolås et al., *Planned Cesarean Versus Planned Vaginal Delivery at Term: Comparison of Newborn Infant Outcomes*, 195 Am. J. Obstetrics & Gynecology 1538, 1541–43 (2006).

76. Cesarean Sections—Risks and Complications, http://www.webmd.com/baby/tc/cesarean-section-risks-and-complications (last visited Oct. 10, 2009).

77. Joyce A. Martin et al., *Births: Final Data for 2002*, Nat'l Vital Stat. Rep., Dec. 17, 2003, at 1, 82, *available at* http://www.nber.org/natality/2002/docs/FinalRpt.pdf (reporting births by method of delivery: 2,958,423 vaginal deliveries, 634,426 primary cesareans, 409,420 repeat cesareans, for a national cesarean delivery rate of 26.1%).

78. *See* Healthy People 2000, *supra* note 2; Cesarean Childbirth, *supra* note 2.

79. *See, e.g.*, Notzon, *supra* note 2, at 3287.

80. *See, e.g.*, Kelly F. Bates, *Cesarean Section Epidemic: Defining the Problem-Approaching Solutions*, 4 B.U. Pub. Int. L.J. 389, 396–406 (1995).

lamented the 15% rate and called for a reduction.[81] Notwithstanding this clarion call, the rate actually rose to approximately 25% in 1986, one of the highest levels ever reported in the United States.[82] Some ten years later, nearly half of American C-sections were found to be medically unnecessary. In 1990, out of the 982,000 cesareans performed in the United States, 480,520 procedures were found unnecessary.[83] Thus, the problem of a persistent, excessive number of C-sections was compounded by the needlessness of half of them.

The U.S. cesarean rate increased from 5.5% in 1970 to 26.1% in 2002, the highest rate ever reported in the United States.[84] The World Health Organization says there is no justification for any region in the world to have a cesarean rate more than 10 to 15%.[85] Currently, "the United States ranks behind no fewer than forty other nations in preventing maternal deaths."[86] In fact, in recent years, the death rate in the U.S. has steadily been on the rise, averaging 7.5 deaths per 100,000 births in 1982, 13.2 deaths per 100,000 births in 2004, and 15.1 deaths per 100,000 births in 2005.[87]

The level of concern over the C-section rate is mounting, fed in part by performance of surgeries that are either against the wishes of the mother or unnecessary from a medical point of view.[88] Questions have also arisen as to a possible link between the C-section rate in the United States, including forced C-sections, and the economic and racial characteristics of its recipients. A national study found that approximately 80% of the patients who received court-ordered cesarean sections were African-American, African, Asian, or Latina.[89] In particular, nearly half of the court-ordered C-sections, transfusions, and hospital detentions for pregnant women were directed against African American women.[90] Nearly half of the women were unmarried, and almost one-fourth did not speak English as their primary language.[91]

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81. *See* Cesarean Childbirth, *supra* note 2.

82. *See* Rodwin, *supra* note 53, at 150.

83. Bates, *supra* note 80, at n.16.

84. Cesarean Childbirth, *supra* note 2; Brady E. Hamilton, *Births: Preliminary Data for 2002*, Nat'l Vital Stat. Rep., Jun. 25, 2003, at 1, 4, *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_11.pdf.

85. *See* Citizens for Midwifery, *Cesarean Rate Rises to Highest Ever Reported in the United States—26.1%*, http://www.cfmidwifery.org/pdf/NationalStatistics2002.pdf (last visited Oct. 10, 2009).

86. Ina May Gaskin, *Maternal Death in the United States: A Problem Solved or a Problem Ignored?*, J. of Perinatal Educ., Mar. 4, 2008, *available at* http://www.inamay.com/view_article.php?Article_ID=44&page_number=1.

87. *Id.*

88. *See, e.g.*, *In re* Baby Boy Doe v. Mother Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994) (a pregnant woman was taken to court by state officials in Illinois to challenge her rejection of a C-section on religious grounds. Both the trial court and appellate court upheld her right to make this choice). *See also* Don Terry, *Legal Fight Over Caesarean Pits Mother Against Fetus*, N.Y. Times, Dec. 14, 1993, at A22.

89. Veronika E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 New. Eng. J. Med. 1192 (1987).

90. *Id*. at 1194. This figure does not include African women, who were counted along with Asians as representing 33% of those receiving forced cesareans.

91. *Id*. at 1198.

The same study revealed that 46% of the directors of fellowship programs in maternal and fetal medicine believed that mothers who refused medical advice when their fetuses were "in danger" required detention in hospitals or other facilities until compliance with the advice could be obtained. In a particularly telling and chilling response, approximately one-quarter of these directors supported state surveillance of women in the third trimester of pregnancy.[92]

American research consistently suggests that the effort to reduce growing C-section rates is more a process of changing physician behavior than of medical education or clinical need.[93] Doctors perform unneeded and unwanted cesarean sections.[94] Overall, without differentiation for specific high-risk populations, "[c]esarean births usually present greater risk than vaginal births for women, cost more, and often leave women far less satisfied."[95]

C. The Problem and Precedent of Forced C-sections

Subjective factors such as cultural ideology and fetal protectionist beliefs may influence doctors to perform forced cesarean sections. For instance, some doctors express hostility toward women who refuse a cesarean section based on cultural or religious values.[96] Some doctors view these women as irresponsible, irrational, callous, or insufficiently caring for their children.[97]

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92. *Id*. at 1195. According to data from this study:

> Court orders have been obtained for cesarean sections in 11 states, for hospital detentions in 2 states, and for intrauterine transfusions in 1 state. Among 21 cases in which court orders were sought, the orders were obtained in 86 percent; in 88 percent of those cases, the orders were received within six hours . . . . All the women were treated in a teaching-hospital clinic or were receiving public assistance. No important maternal morbidity or mortality was reported . . . . We conclude from these data that court-ordered obstetrical procedures represent an important and growing problem that evokes sharply divided responses from faculty members in obstetrics. Such procedures are based on dubious legal grounds, and they may have far-reaching implications for obstetrical practice and maternal and infant health.

Id. at 1192.

93. *See e.g.*, Elliott K. Main, *Reducing Cesarean Birth Rates with Data-driven Quality Improvement Activities*, 103 Pediatrics (No. 1 Supp.) 374, 374 (1999).

94. *See* Ingrid Van Tuinen & Sidney M. Wolfe, Unnecessary Cesarean Sections: Halting a National Epidemic (Public Citizen's Health Research Group 1992); Carol Sakala, *Medically Unnecessary Cesarean Births: Introduction to a Symposium*, 37 Soc. Sci. & Med. 1177 (1993); Carol Sakala, *Midwifery Care and Out-of-Hospital Birth Settings: How Do They Reduce Unnecessary Cesarean Section Births?*, 37 Soc. Sci. & Med. 1233 (1993); *Too Many Cesareans*, Consumer Reps., Feb. 1991, at 120.

95. Rodwin *supra* note 53, at 158.

96. *See, e.g.*, Deborah J. Krauss, *Regulating Women's Bodies: The Adverse Effect of Fetal Rights Theory on Childbirth Decisions and Women of Color*, 26 Harv. C.R.-C.L. L. Rev. 523, 532 (1991).

97. *Id.*

In one case, for example, doctors forcibly restrained a Nigerian woman to her hospital bed because she opposed a cesarean section.[98] The doctors removed the woman's husband from the delivery room, bound the woman's ankles and wrists in leather cuffs, and performed the forced surgery on her.[99] In another case, doctors characterized a Bedouin woman—who rejected the procedure because she feared she would die if operated on—as ignorant and incapable of arriving at an intelligent decision.[100]

"The complex problem of physicians performing forced and unnecessary cesarean sections on pregnant women has generated national concern."[101] Early case law gave short shrift to the rights of the parents to refuse surgical intervention, even on religious grounds. From 1981 to 1986, fifteen court orders were sought in the United States to authorize cesarean sections against women who refused them, of which thirteen were granted.[102] In several cases involving pregnant women who have refused surgery in violation of a court order, the women delivered healthy babies through natural childbirth.[103]

The terse 1981 opinion from Georgia, *Jefferson v. Griffin Spalding County Hospital Authority,* illustrates the problem.[104] Mr. and Mrs. Jefferson opposed the surgical delivery of their unborn child on religious grounds, but their wishes were overridden by orders of the Superior and Juvenile Courts in Butts County.[105] The orders authorized the plaintiff hospital to perform a cesarean section on the mother for the delivery of her unborn child, and awarded temporary custody of the unborn child to the State Department of Human Resources.[106] A hospital physician allegedly found that the mother had a condition in her pregnancy—a complete placenta previa—such that the unborn child would not survive a vaginal delivery, but would almost certainly live if delivered by caesarean section prior to the beginning of labor. The fetus was viable and fully capable of sustaining life independent of the mother.[107] The trial courts upheld the orders, awarding the state temporary custody of the unborn child and ordering the mother to submit to the cesarean section.[108]

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98. Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal Rights*, 10 Harv. Women's L.J. 9, 9–10 (1987).

99. *Id.*

100. Krauss, *supra* note 96, at 532.

101. Bates, *supra* note 80, at 389.

102. Michael Phillips, *Maternal Rights v. Fetal Rights: Court-Ordered Cesareans*, 56 Mo. L. Rev. 411 (1991).

103. *See, e.g.*, Baby Boy Doe v. Mother Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994); Jefferson v. Griffin Spalding County Hospital Authority, 274 S.E.2d 457 (Ga. 1981). Physician predictions of fetal harm are often incorrect. *Id. See also* George J. Annas, Forced Cesareans: The Most Unkindest Cut of All, *in* Hastings Center Report, June 1982, at 15–16.

104. 274 S.E.2d 457 (Ga. 1981).

105. *Id.* at 459–60.

106. *Id.* at 459.

107. *Id.*

108. *Id.* at 460.

This startling issue only rarely percolates to the surface of the law. Many forced C-sections go unreported.[109] According to one scholar, "[t]he problem of coerced cesarean sections has not received the public attention and social commentary it deserves because of the lack of written decisions."[110]

In the 1990s, the judicial temperament seems slowly to have cooled toward tying pregnant women down and cutting them open. For example, in *Doe v. Doe*, the State of Illinois attempted to override a pregnant woman's decision to refuse a cesarean section.[111] A doctor for the hospital claimed that without the surgery, the baby might "be born dead or severely retarded."[112] The trial court ruled that the state could not force the woman to submit to a C-section, and the Illinois Appellate Court unanimously affirmed.[113] Not long after the court's decision, the woman delivered a healthy baby boy through natural childbirth.[114] The Illinois decision is overtly pedagogical, and merits quoting at some length:

> Both the State and the Public Guardian argued that the circuit court should have balanced the rights of the unborn but viable fetus which was nearly at full term and which, if the uncontradicted expert testimony of the physicians had been accurate, would have been born dead or severely retarded if Doe delivered vaginally, against the right of the competent woman to choose the type of medical care she deemed appropriate, based in part on personal religious considerations. We hold today that Illinois courts should not engage in such a balancing, and that 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*.
>
> [A] woman's right to refuse invasive medical treatment, derived from her rights to privacy, bodily integrity, and religious liberty, *is not diminished during pregnancy*. The woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature, that she can exercise when she is not pregnant. The potential impact upon the fetus is not legally relevant; to the contrary, the [Illinois Supreme Court in Stallman v. Youngquist] (citation omitted) explicitly rejected the view that the woman's rights can be subordinated to fetal rights . . . . A woman is under no duty to guarantee the mental and physical health of her child at birth, and thus cannot be compelled to do or not do anything merely for the benefit of her unborn child.[115]

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109. Bates, *supra* note 80, at 413 n.95.

110. *Id.*

111. Baby Boy Doe v. Mother Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994).

112. *Id*. at 327.

113. *Id.; see also* Terry, *supra* note 88, at A22.

114. *Doe*, 632 N.E.2d at 329.

115. *Id.* at 397, 401 (emphasis added). The Illinois Appellate Court relied heavily on the U.S. Supreme Court's decision in *Cruzan v. Dir., Mo. Dept. of Health,* 497 U.S. 261 (1990) (holding that the due process clause of the Fourteenth Amendment confers a significant liberty interest in avoiding unwanted medical procedures).

Four years before the *Baby Boy Doe* case, the Supreme Court determined in a non-C-section case that the Fourteenth Amendment stood for the principle that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."[116] The Court had the opportunity to review (and therefore reverse) the Illinois ruling (holding that a woman's right to refuse treatment was not diminished by pregnancy), but declined to do so.[117]

Similarly, in the case of *In re* A.C., a physician at George Washington University Hospital in the District of Columbia decreed to Angela Carder, a dying cancer patient, that if she did not have a cesarean section, her health and her baby's life would be seriously endangered. [118] The hospital sought a declaratory order from the Superior Court to determine whether it should proceed with the procedure to save the life of the fetus.[119] After a three-hour hearing in Carder's hospital room, the trial court ordered the performance of a cesarean section.[120] Carder refused. The doctor performed the surgery over his patient's objection.[121] Mrs. Carder and her baby died shortly after the procedure.[122] The appellate court then granted a petition for a rehearing, vacated the trial court's order, and held that a physician should defer to a competent pregnant woman's decision to accept or reject a cesarean section operation.[123] The court noted with great emphasis that "it would be an extraordinary case indeed in which a court might ever be justified in overriding the patient's wishes and authorizing a major surgical procedure such as a caesarean section."[124] The case was not appealed to the U.S. Supreme Court.

Although these cases illustrate an initial regard for upholding a pregnant woman's decision to accept or reject a cesarean section, the social climate would again cool toward the rights of pregnant women as America's conflicted attitude toward C-sections persisted into the new millennium.

D. Negative Attitudes Toward the Rights of Pregnant Women

In 2004, some ten years after *Baby Boy Doe* was decided, the State of Utah charged Melissa Rowland with the murder of her stillborn fetus.[125] Utah claimed that the

116. *Cruzan*, 497 U.S. at 278.

117. *Baby Boy Doe*, 632 N.E.2d 326, *cert. denied*, 510 U.S. 1168 (1994).

118. 573 A.2d 1235, 1238 (D.C. 1990).

119. *Id.*

120. *Id.*

121. *Id.*

122. *Id.*

123. *Id.* at 1237.

124. *Id.* at 1252.

125. Howard Minkoff & Lynn M. Paltrow, *Melissa Rowland and the Rights of Pregnant Women*, 104 Obstetrics & Gynecology 1234, 1234 (2004). Ms. Rowland ultimately avoided the homicide charge by pleading guilty to lesser child endangerment charges. *Id.*

death resulted from Ms. Rowland's rejection of the advice of her physicians to deliver her twins surgically.[126] According to commentators at New York's National Advocates for Pregnant Women, "the approach taken by the State raises important and troubling issues regarding the autonomy rights of pregnant women, as well as their right to speak on behalf [of] their unborn children."[127] The commentators further concluded that:

> [I]f Ms. Rowland is to be judged legally culpable for the death of her fetus, then the courts must first create a new and significant exception to the doctrine of informed consent . . . . Such a precedent could introduce a substantial disparity between the rights of pregnant women and those of all other persons.[128]

At the other end of the spectrum, the *National Review* published a remarkably mean-spirited commentary making light of Ms. Rowland's plight. In a piece by Jennifer Graham entitled *Give Me a "C"! Bed rest, doting nurses, epidurals . . . what's not to like?*, Ms. Graham opined about Ms. Rowland:

> We can only speculate as to what Melissa Ann Rowland was thinking when she said—allegedly, of course—that having a Caesarean section to save the lives of her twins would "ruin her life." Was she about to embark on a new career as a *Penthouse* pet? Model swimsuits for *Sports Illustrated*? . . . Now, no one wants to see a woman who just gave birth sitting in jail when she should be home nursing the surviving infant—assuming, of course, that breastfeeding wouldn't ruin her life.[129]

Ms. Graham's caustic humor at the expense of women undergoing major surgery they don't want is hardly original. In a telling display of what many surgeons find funny, the humor magazine *Journal of Irreproducible Results*—which solicits articles that appeal to scientists, doctors, and engineers[130]—published a bogus research study summary entitled, "The Reciprocal Natural Childbirth Index."[131] The Index, posted in at least one Ivy League medical school,[132] added "points" to a woman's made-up

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126. *Id.*

127. *Id.*

128. *Id.*

129. Jennifer Graham, *Give Me a "C"! Bed rest, doting nurses, epidurals . . . what's not to like?*, National Review, Mar. 16, 2004, *available at* http://www.nationalreview.com/jgraham/graham200403160901.asp. Ms. Graham continued:

> But let's assume, just for the heck of it, that Rowland wasn't just concerned about how fetching her naked body would look to future suitors. What if she really did fear surgery? Even with the C-section rate exceeding 25 percent nationwide, driven upward in part by women who would rather not labor, the worry warts insist on calling it "Major Surgery," and sure, there are some risks. But as Major Surgery goes, a C-section—without complications, and with a good insurer—is a pretty good deal.

Id.

130. Journal of Irreproducible Results Home Page, http://www.jir.com/home.html (last visited Oct. 10, 2009).

131. For a discussion of the Index, see Wagner, *supra* note 1, at 19.

132. *Id.* (citing A. Berg, *The Reciprocal Natural Childbirth Index*, Journal of Irreproducible Results, 36 Mar.–Apr. 1991, at 27).

"childbirth services score" if: she or another person checks her cervix prior to arrival at the hospital; she or her husband has a hyphenated last name; she has more than four years of college; she has a written birth plan; she is insured by a managed healthcare plan; and other rollicking factors.[133] Concludes the author:

> We have found that a Reciprocal Natural Childbirth Index score of 30 or greater should earn the woman in labor immediate consideration for cesarean section. In fact, since you can get a score of 30 without even being in labor, someone with a high enough score could be offered a C-section at her convenience during regular working hours.[134]

Ms. Rowland is not alone in being deemed a criminal for her maternity conduct. Certain states in the U.S. have, in recent years, pursued increasingly aggressive prosecution of pregnant women who are deemed to have failed at pre-natal care. A prime example is South Carolina, whose supreme court has applied a state statute punishing child abuse to fetal health, upholding a murder conviction arising from a stillbirth to a mother who had taken cocaine during her pregnancy.[135] The jury was unable to return a verdict, so the prosecution re-brought the action and, on round two, won a conviction.[136] South Carolina is the only state where the courts have included viable fetuses within the scope of child abuse laws in an attempt to prosecute pregnant women. The U.S. Supreme Court declined to review the matter.[137]

Meanwhile, an American College of Obstetricians and Gynecologists ("ACOG") publication asks: "Should refusal to undergo a cesarean delivery be a criminal offense"?[138]

IV. THE HUMAN RIGHTS AND ANTI-TRUST IMPLICATIONS OF PROFESSIONAL STANDARDS THAT PREVENT VAGINAL BIRTHS AFTER C-SECTIONS

A. Brief Overview of ACOG

The organization that claims to be the "nation's leading authority on women's health for more than 50 years"[139] is the American College of Obstetricians and

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133. *Id.*

134. *Id.*

135. State v. McKnight, 576 S.E.2d 168, 173 (S.C. 2003). The state court observed:

> The drug "cocaine" has torn at the very fabric of our nation. Families have been ripped apart, minds have been ruined, and lives have been lost . . . . The addictive nature of the drug, combined with its expense, has caused our prisons to swell with those who have been motivated to support their drug habit through criminal acts. In some areas of the world, entire governments have been undermined by the cocaine industry.

Id. (citing State v. Major, 391 S.E.2d 235, 237 (S.C. 1990).

136. *McKnight*, 576 S.E.2d at 171.

137. *Id.* at 168, 540 U.S. 819.

138. Richard L. Berkowitz, *Should Refusal to Undergo a Cesarean Delivery Be a Criminal Offense?* 104 Obstetrics & Gynecology 1220 (2004).

139. ACOG Fact Sheet, http://www.acog.org/from_home/ACOGFactSheet.pdf (last visited Oct. 10, 2009).

Gynecologists ("ACOG"). ACOG boasts a membership that includes more than 90% of all American board-certified ob-gyns, and is the self-described voice of women's health.[140] It sets the standards for obstetrical practice in this country, in large part, because of its members' belief that "failure to comply with the ACOG recommendations will increase medical legal risks should a poor outcome be experienced."[141] Its members testify before U.S. congressional committees on the formulation of public policy.[142] Its practice standards govern not only dispensation of services to women, but also influence whether a service will be covered by health insurance. Insurance companies routinely monitor changes in ACOG policies to adjust their coverage accordingly.[143]

Membership in ACOG is limited to obstetrician-gynecologists. It is, in fact, a trade association:

> ACOG is not a college in the sense of an institution of higher learning, nor is it a scientific body. It is a "professional organization" that in reality is one kind of trade union. Like every trade union, ACOG has two goals: promote the interests of its members, and promote a better product (in this case, well-being of women).[144]

One-third of all cesareans are performed on women who have had at least one cesarean in the past.[145] This reflects the traditional American physician's wisdom: "once a cesarean, always a cesarean."[146] Yet, there are many women who, having delivered surgically in the past, wish to deliver vaginally. These women are designated as "VBACs"—vaginal birth after cesarean.

Many hospitals mandate that any pregnant patient who has previously undergone uterine surgery (including a C-section) *must* deliver surgically if the delivery is to take place on hospital premises. Dr. Marsden Wagner, M.D., a perinatal epidemiologist and former Director of the European Regional Office of the Women and Children's Health for the World Health Organization, has called this trend in

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140. *Id.*

141. Robert D'Angelo, *Comment On "Neonatal Morbidity Associated with Uterine Rupture: What Are the Risk Factors?" by Emmanuel Bujold*, Obstetric Anesthesia Digest, Sept. 2002, at 132.

142. *See, e.g.*, *Who Will Deliver America's Babies? The Impact of Excessive Litigation: Hearing Before the Comm. on Health, Education, Labor, and Pensions*, 108th Cong. (2003), *available at* http://www.leg.state.nv.us/72nd/Exhibits/Senate/JUD/SJUD3041C.pdf (testimony of Shelby L. Wilbourne on behalf of ACOG).

143. *See, e.g.*, Premier AEIX Risk E-lert Newsletter, *ACOG updates labor and delivery best practices*, Jan. 13, 2006, *available at* http://www.premierinc.com/risk/education-newsletters/risk-e-lert/2006/January06.jsp; Aetna, *Clinical Policy Bulletin: Home Births*, Policy No. 0329, Review Date June 26, 2007, *available at* http://www.aetna.com/cpb/medical/data/300_399/0329.html.

144. Marsden Wagner, *What Every Midwife Should Know About ACOG and VBAC: Critique of ACOG Practice Bulletin No. 5, July 1999, "Vaginal Birth After Previous Cesarean Section," available at* http://www.midwiferytoday.com/articles/acog.asp.

145. *See, e.g.*, The Am. Coll. of Obstetricians & Gynecologists, Practice Bulletin No. 5, Vaginal Birth After Previous Cesarean Delivery (1999) [hereinafter ACOG Practice Bulletin #5].

146. *See, e.g.*, Bruce L. Flamm, *Once A Cesarean, Always A Controversy*, 90 Obstetrics & Gynecology 312 (1997).

American hospitals a "widespread failure to honor the rights of pregnant and birthing women."[147]

For purposes of the instant paper, the question is not whether VBAC is desirable from a medical point of view. Analysis of the merits of any given *medical* decision to assist or deny VBAC is beyond the scope of this paper. The focus of this work is the identification and analysis of *non-medical* motivations in the formulation of clinical recommendations for or against surgical intervention in the birth process, specifically, a cesarean section for a woman who has previously delivered surgically but wishes to deliver vaginally in a subsequent pregnancy.

That is, does the formulation of clinical standards and recommendations in favor of surgical delivery for women who have delivered surgically before, based in part on non-clinical considerations such as financial reward and potential legal liability, violate the rights of pregnant women who may wish to refuse surgical intervention in the birthing process if they were fully informed?

B. ACOG's Influence on VBACs for Non-Medical Reasons

ACOG acknowledges the impropriety of basing patient health recommendations on financial considerations. According to the ACOG Code of Ethics, "the welfare of the patient must form the basis of all medical judgments." It describes the "right of individual patients to make their own choices about their health care" as "fundamental," and specifically identifies financial constraints as a conflict of interest that must be disclosed to the patient.[148]

ACOG does not dispute that VBAC is safe: "Over the past 30 years, more than 50 studies have documented the safety of VBAC."[149] For years, ACOG has acknowledged both the "strong consensus that trial of labor is appropriate for most women" with a history of C-section, and the general agreement that the U.S. C-section rate is high.[150]

However, there is substantial evidence that standards promulgated by ACOG have the effect of restricting access to medical and non-medical services in support of VBAC. Such restrictions reflect, *inter alia*, provider and/or hospital considerations and liability concerns and not simply the best judgment for the health of the mothers and babies involved.

In 1997, ACOG published an article by a member physician that stated frankly: "For the physician, elective repeat cesareans offer advantages, including convenience, time savings, and sometimes increased compensation."[151] Two years later, ACOG

147. Wagner, *supra* note 1, at 178.

148. Code of Professional Ethics of the American College of Obstetricians and Gynecologists, Jan. 2008, *available at* www.acog.org/from_home/acogcode.pdf (last visited Nov. 2, 2009).

149. Flamm, *supra* note 146, at 313.

150. ACOG Practice Bulletin #5, *supra* note 145, at 1. Of course, repeat C-sections may be indicated for clinical reasons in the case of any particular individual patient. The question under discussion is whether ACOG discourages VBAC deliveries for non-medical reasons.

151. Flamm, *supra* note 146, at 313.

noted that one-third of all C-sections were performed on patients who had previously delivered surgically.[152] ACOG expressly related the increased C-section rate to the "increased medical-legal pressures" faced by American physicians arising from claims related to fetal morbidity and mortality, and admitted at the same time that the increase in C-sections as a reaction to those claims had *not* proven to be an improvement in terms of newborn outcome.[153]

Indeed, ACOG reminded its membership that complications arising from *any* unsuccessful trial of labor have increasingly "led to malpractice suits" whether or not a VBAC was involved. Thus, reducing the number of VBACs by restricting their availability was a way to reduce the overall number of trials of labor, which in turn decreased the specter of legal liability for malpractice.[154]

It was this desire to limit members' liability that led ACOG to acknowledge a "need to reevaluate VBAC recommendations."[155] One of the sources cited by ACOG in its reevaluation was entitled, "*Characteristics of successful claims for payment by the Florida Neurologic Injury Compensation Association Fund*," another ACOG publication.[156] Not surprisingly, the "reevaluated" VBAC recommendations portended a decrease in VBACs, essentially limiting them to major regional hospitals that could supply the extensive battery of high-tech equipment and personnel required under the new guidelines.[157]

The practice guidelines set forth in ACOG's Practice Bulletin #5 established severe restrictions on the practical availability of professional services to women seeking a VBAC, despite the acknowledged absence of scientific evidence supporting the recommendation: "VBAC should be attempted in institutions equipped to respond to emergencies with physicians immediately available to provide emergency care."[158] It further recommended that the decision to proceed with a VBAC be made not by the "patient" herself, but rather by "the patient and her physician,"[159] despite

152. ACOG Practice Bulletin #5, *supra* note 145, at 1.

153. *Id.*

154. *See* David J. Birnbach, *Obstetrical Anesthesia: Reaffirming Our Commitment to Safety and Comfort*, Am. Soc'y of Anesthesiologists Newsl., July 2003, *available at* http://www.asahq.org/Newsletters/2003/07_03/whatsNew07_03.html.

155. ACOG Practice Bulletin #5, *supra* note 145, at 2.

156. B.L. Stalnaker et al., *Characteristics of Successful Claims for Payment by the Florida Neurologic Injury Compensation Association Fund*, 177 Am. J. Obstetrics & Gynecology 268 (1997).

157. ACOG Practice Bulletin #5, *supra* note 145.

158. *Id.* at 5. ACOG Vice-President of Practice Activities, Stanley Zinberg, M.D., in noting the small risk of uterine rupture in a VBAC woman, asserted to fellow professionals that VBAC services are "often accompanied by legal action no matter what the clinical outcome or how excellent the clinical care." However, Dr. Zinberg notes that although ACOG "recognizes the implications such immediate availability [requirement] has . . . for the practice patterns of obstetricians and anesthesiologists and for the incidence of VBAC in general," defendant physicians and hospitals are "in a better position from a liability perspective if the physicians were present at the time of the complication." Birnbach, *supra* note 154.

159. *Id.*

the ethical prescription for the fundamental right of individual patients to make their own choices about their healthcare.

ACOG's Practice Bulletin #5 is billed as part of the "clinical management guidelines for obstetrician-gynecologists,"[160] presumably rendering it subject to ACOG's ethical maxim that such decisions must be based on patient welfare, and not on conflicting financial constraints. Yet, the bulletin text itself expressly manifests the non-clinical factors at play including increased costs to the hospital, increased costs to the physician, and medical malpractice payments. "The difficulty in assessing the cost benefit of [restricting] VBAC[s] is that the costs are not all incurred *by one entity*."[161]

According to ACOG's practice ethics, however, there is only one entity whose welfare governs clinical judgments: the patient.[162] Yet the clinical guidelines proffered by ACOG to its member physicians expressly consider lawsuits, medical malpractice payments, compensation rates, as well as hospital and physician costs. One is left wondering: "Is this good medicine or just a misguided attempt at risk management?"[163]

In 2004, ACOG replaced Practice Bulletin #5 with Practice Bulletin #54. ACOG had apparently learned something from the controversy generated by its candor in 1999: its previously frank references to "malpractice suits" were omitted.[164] Nonetheless, the key restrictive provision functionally limiting the availability of VBAC services was carried forward and remains in effect to the present day: "VBAC should be attempted in institutions equipped to respond to emergencies with physicians immediately available to provide emergency care."[165] This language is a direct carry-over from the 1999 Bulletin, and had been previously criticized for its adverse impact on the availability of VBAC services. One commentator notes that Practice Bulletin #54 "has a huge impact on the system of maternity care in the United States" by "drastically reduc[ing] or eliminate[ing] several options available to women with previous cesarean section, including having their birth at home, in a freestanding birth center or in a small community hospital."[166] Another medical commentator notes that the phrase "immediately available" has "significant implications for both anesthesia and obstetric care providers whose practices have been based on a home call system."[167] As the guidelines require that physicians remain

160. *Id.* at 1.

161. *Id.* at 3 (emphasis added).

162. Conflicts between the welfare of the mother giving birth and the baby and/or fetus are beyond the scope of this paper. For purposes of the issue at hand, it is safe to assume that the discussion is limited to those instances where the interests of the mother and the fetus or newborn are in alignment.

163. Flamm, *supra* note 146, at 315.

164. The Am. Coll. of Obstetricians & Gynecologists, Practice Bulletin No. 54, Vaginal Birth After Previous Cesarean Delivery (2004).

165. *Id.* at 6.

166. Wagner, *supra* note 144.

167. D'Angelo, *supra* note 141, at 132.

immediately available, "no longer is it simply enough to make the incision within 30 minutes of the decision for a cesarean section."[168] The commentator notes further that altering such practices simply may not be feasible in many rural practices.[169]

Ulterior financial motives are also at play in the "reevaluated" ACOG standards. One commentator notes: "ACOG's primary allegiance to the needs of its members over the needs of women . . . requires their recommendations to be suspect unless confirmed by overwhelming scientific evidence . . . . [Such] recommendations . . . should never be the sole basis, nor even the most important justification, for maternity care policy in the United States."[170]

C. Independent Researchers Acknowledge the ACOG Problem

Researchers from different disciplines are in accord with ACOG's own admissions on its role in the restriction of VBAC services and availability. For example, economists at Tulane University have written: "Theoretical and empirical studies suggest that risk of malpractice lawsuits encourages physicians to practice 'defensive medicine,' utilization of medical resources beyond its optimal level of use . . . . Results suggest that a higher degree of malpractice risk increases the probability of C-section delivery."[171]

A disturbing study released in 2001 identified a number of non-clinical factors as affecting physician choice to deliver surgically.[172] In an effort to elucidate which factors were most important in deciding the birth mode, the study examined obstetricians' reasoning when deciding whether or not to perform cesarean sections. The authors of the study identified forty-two birthing predictor variables, which were divided into three categories: (1) maternal clinical characteristics present at the

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168. *Id.*

169. *Id.*

170. Wagner, *supra* note 144.

171. Dhankhar, P. et al., *Threat of Malpractice Lawsuit, Physician Behavior and Health Outcomes: Testing the Presence of Defensive Medicine*, Annual Meeting Paper, American Economic Association (2005), *available at* http://www.aeaweb.org/annual_mtg_papers/2005/0107_0800_1213.pdf (dividing data into two groups, necessary C-sections and unnecessary C-sections). One doctor describes it this way:

> Many physicians earnestly want to avoid unnecessary repeat cesarean operations but fear that they will be found legally liable if any untoward event occurs during a trial of labor . . . . [A]t least one major medical malpractice insurance company (Cooperative of American Physician, Inc., Mutual Protection Trust) already has mailed a modification of [the VBAC] consent form . . . . No risks for elective repeat cesarean are listed . . . . Widespread implementation of this or similar consent forms essentially would mean the end of VBAC . . . . On a national level, giving up VBAC would mean performing an additional 100,000 cesareans every year. It is unlikely this huge number of operations could be performed without many serious complications and perhaps even some maternal deaths.

Flamm, *supra* note 146, at 314.

172. Martin MacDowell et al., *Understanding Birthing Mode Decision Making Using Artificial Neural Networks*, 21 Med. Decision Making 433 (2001).

time of labor, such as preeclampsia; (2) baby clinical characteristics, such as the so-called "fetal distress" and malpresentation; and (3) patently non-clinical factors, such as those related to the physician's practice setting, financial parameters, legal issues, and practitioner characteristics.[173]

The authors concluded that non-clinical factors were "important" in determining the birthing mode, and "emphasized that a clinician's decision on the appropriate birthing mode is based not only on scientific understanding, but on other factors, such as the mother's attitude toward the birthing mode [and] the malpractice environment . . . ."[174] Physician convenience also appeared to be a factor: delivery occurring during the day shift at a hospital was found to have the effect of increasing the likelihood of a cesarean section.[175] The authors interpreted the results as suggesting possible ways of reducing the cesarean section rate, including by educating the mother on the "advantages of a vaginal birth versus a cesarean section" and "[e]ducating physicians about the appropriate use of induction."[176]

In one geographically localized study, it was shown that after issuance of ACOG's Practice Bulletin #5, "independent practitioners shut down their VBAC practice because they could not treat patients in their clinic setting and simultaneously attend a VBAC patient in a community hospital."[177] The authors of the study provided additional detail on the economic considerations acknowledged, but glossed over them in the bulletin itself. The study especially highlighted the discrepancies in revenue experienced by hospitals between cesarean and vaginal deliveries.[178]

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173. *Id.*

174. *Id.*

175. *Id.*

176. *Id.*

177. Myers, *supra* note 5, at 528.

178. *Id.* at 528–29. The article notes:

> Cesareans produce hospital revenues of $14,000 to $17,000 each, while vaginal deliveries produce $6,000 to $8,000 each. Additionally, the hospital stands to receive additional revenues because of the increased re-hospitalization rates related to cesarean delivery. As for the OB/GYN practice? Vaginal deliveries produce no surgical fees. The record-high cesarean rate is likely to become an abstraction for executives and physicians who observe its contribution to their bottom lines. The practical effect of the standard has been to confer exclusive legitimacy for the performance of VBACs upon university and tertiary-level medical centers staffed by surgeons, anesthesiologists, and surgical teams. These islands of concentrated medical technology are not conveniently accessible to the overwhelming majority of women who desire a VBAC . . . . The profit-and-loss practicalities of medical practice prevent specialists and family practice physicians from leaving their private clinics to attend at a community hospital the labor of women awaiting a VBAC . . . . Whereas market restraints are acknowledged for their infliction of economic harm, medical markets have the unique ability to inflict clinical harm, injury, and even death upon consumers; . . . . The ACOG standard is illustrative of the capacity of a private organization, exercising peer authority, to impose upon the broader community mandates generally reserved to government . . . .
>
> *Id.*

D. Statutes Regulating Monopolies

In order to appreciate fully the extent to which the rights of individuals may potentially be violated by ACOG's influence on VBAC services, one must analyze that influence not only in regard to American health policy (as discussed *supra*), but also in light of American economic policy supporting a competitive free market.[179]

American public policy against monopolies is formalized in the federal Sherman Act, which provides that "[e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States . . . shall be deemed guilty of a felony."[180] Monopoly power is "the power to control market prices or exclude competition."[181]

"The basic antitrust statutes are few in number: The Sherman Act of 1890; the Clayton Act, first enacted in 1914 and significantly amended in 1936 by the Robinson-Patman Act and in 1950 by the Celler-Kefauver Antimerger Act; and the Federal Trade Commission Act of 1914."[182]

The Sherman Act "prohibits contracts, combinations, and conspiracies in restraint of trade, and [also] monopolization."[183] The high value our society places on free trade is illustrated by the gravity of the sanctions. "Violation of the Sherman Act can result in substantial fines and, for individual transgressors, prison terms." In addition, court orders restraining future violations are also available.[184]

The Clayton Act "deals with specific types of restraints including exclusive dealing arrangements, tie-in sales, price discrimination, mergers and acquisitions, and interlocking directorates."[185] Unlike the Sherman Act, the Clayton Act "carries only civil penalties and is enforced jointly by both the Antitrust Division and the Federal Trade Commission."[186]

The Federal Trade Commission Act, in contrast, is administered solely by the Federal Trade Commission. This Act has been described as a "catch-all enactment which has been construed to include all the prohibitions of the other antitrust laws and, in addition, may be utilized to fill what may appear to be loopholes in the more explicit regulatory statutes."[187]

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179. *See generally* D. Barlett et al., Critical Condition: How Health Care in America Became Big Business—and Bad Medicine (Doubleday 2004).

180. 15 U.S.C. § 2 (2006).

181. U.S. v. E.I. duPont de Nemours & Co., 351 U.S. 377, 391 (1956).

182. Richard M. Steur, *Executive Summary of the Antitrust Laws*, http://library.findlaw.com/1999/Jan/1/241454.html (last visited Oct. 10, 2009).

183. *Id.*

184. *Id.* These provisions are enforced primarily by the Antitrust Division of the Justice Department.

185. *Id.*

186. *Id.*

187. *Id.*

E. ACOG's Policies in the Context of the Sherman Act

Section 1 of the Sherman Act prohibits "every contract, combination . . . or conspiracy, in restraint of trade" that is unreasonable.[188] This "rule of reason" is the hallmark of judicial construction of the antitrust laws. The anti-competitive consequences of a challenged practice are weighed against the business justifications upon which it is predicated as well as its putative pro-competitive impact, and a judgment with respect to its reasonableness is made.[189]

Such an approach has obvious shortcomings. For one thing, reasonableness is an ephemeral concept, and whether a particular course of conduct will ultimately be found to be reasonable is not easy to predict when new business arrangements are contemplated. Moreover, the task of enforcing a regulatory scheme based on such a theory can be staggering.

"Trade associations, by their very nature, bristle with antitrust problems. Practically by definition the requisite agreement is present, and the inquiry focuses on the nature of the members' concerted activity."[190] In truth, "ACOG is a 'professional organization,' which amounts to a trade union"[191] and its VBAC recommendation has been singled out for its restrictive effect on VBAC services.[192] "In addition to this impact on women and families and birth outcomes, this recommendation also has a major impact on community-based midwives, family physicians, birth centers and small hospitals."[193]

Although certain "per se offenses" are obviously improper for an association, "trade associations may properly act, under supervision, in many areas."[194] Statistical reporting—including past costs, production, sales, and the like—seems to be the most usual. Standardization may also be a proper association activity "as long as standards which serve to lessen competition are avoided and all members are free to disregard them."[195]

Market structure is another key antitrust concern, and as such, antitrust law "prohibits structural phenomena likely to substantially lessen competition or to amount to monopolization."[196] In an effort to maintain a competitive economy, "the structural aspect of the law focuses on avoiding or remedying the concentration of market power in a few firms with large market shares."[197]

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188. 15 U.S.C. § 1 (2006).

189. *See generally* Lawrence A. Sullivan & Warren S. Grimes, The Law of Antitrust: An Integrated Handbook (2d ed., Thomson West 2006) (2000).

190. Steur, *supra* note 182.

191. Wagner, *supra* note 1, at 33.

192. *See generally* Wagner, *supra* note 144.

193. *Id.*

194. Steur, *supra* note 182. Such per se offenses include price fixing and market division.

195. *Id.*

196. *Id.*

197. *Id.*

Section 2 of the Sherman Act makes it unlawful to monopolize, attempt to monopolize, or conspire to monopolize, a line of commerce. Liability is premised on the "act of monopolization, which requires something more."[198] "The offense of monopolization, which is not purely structural, has two elements: (1) possession of monopoly power in the relevant market; and (2) willful acquisition or maintenance of that power."[199]

This is the power to control prices or exclude competition,[200] practically "measured by the alleged monopolist's share of the relevant market."[201] Given the rarity of an absolute monopoly, one is left to ponder "how large a share a firm must possess to come within the statutory concept."[202] Although not explicitly defined, commentators argue that "any market share of 50 percent or higher is sufficient to be of concern."[203]

"Once monopoly power is found, the question remains: Was it willfully acquired or maintained?"[204] This question is not easily answered. Although "sufficient" to establish a violation, the Sherman Act "does not require that monopoly power be abused or intentionally exercised to drive out competition."[205] Similarly, the Act does not require that there be "an evil intent to eliminate competitors."[206] "Conscious acts designed to further or maintain a monopoly market position will suffice."[207]

In addition to outlawing possession of monopoly power, "Section 2 of the Sherman Act also prohibits attempts to monopolize by companies that do not possess monopoly power but engage in anticompetitive conduct designed to achieve it."[208] Several factors must be shown in order to prove an attempt to monopolize, including (1) "specific intent to achieve monopoly;" (2) anticompetitive conduct "designed to injure . . . actual or potential competition;" and (3) "a dangerous probability that monopoly power would in fact be achieved."[209] "Since companies that actually possess monopoly power are an industrial rarity, most Section 2 litigation involves allegations of attempts to monopolize; and it is the 'dangerous probability of success' element on which the resolution of most cases turns."[210]

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198. *Id.*

199. *Id.*

200. *Id. See also E.I. duPont de Nemours*, 351 U.S. at 391.

201. Steur, *supra* note 182.

202. *Id.*

203. *Id.*

204. *Id.*

205. *Id.*

206. *Id.*

207. *Id.*

208. *Id.*

209. *Id.*

210. *Id.*

F. Anti-Trust Implications of Restrictions Placed on VBAC Births

"Profit maximization has approximately the same presence in healthcare as it does in banking, auto sales, lawyering, and other market endeavors."[211] As noted above, ACOG is functionally a trade union. Its VBAC policies resonate in the anti-trust context. The so-called "clinical" restraints on VBAC services have defeated or discouraged qualified competitors, particularly direct-entry midwives and family-practice physicians. This, in turn, has the inevitable effect of making such providers effectively unavailable to women who would otherwise utilize their services.

The problem is compounded by the refusal of many hospitals to permit VBAC on the premises, except those pursuant to the ACOG Practice Bulletin Guidelines, for fear of compromising their health insurance coverage or increasing their malpractice insurance rates.[212] In effect, such refusal forces a woman who would prefer vaginal delivery or home birth to submit herself to the heightened risk of surgical intervention in a hospital setting. This also effectively limits her selection of care providers: "[M]ost [direct-entry midwives] can only practice outside the hospital and most [certified nurse midwives] can only practice inside of hospitals. Thus . . . to choose a particular kind of midwife is also to choose a particular place of birth."[213] Even more, to choose a non-physician care provider is to choose the place of birth; and to choose a non-ob-gyn provider (even a family physician) is to choose a place of birth—if such providers can be found who are willing to buck the ACOG trend.

The ACOG Committee on Ethics issued a statement in 2003 "declaring elective cesareans to be 'ethical,' thereby providing its members with 'an ethical pass to perform a procedure that is proven more dangerous to women and babies.'"[214] The Committee "acknowledged cesarean risk in a release summarizing the results of a study that found 'a cesarean delivery significantly increased a woman's risk of experiencing a pregnancy-related death (35.9 deaths per 100,000 deliveries with a live-birth outcome) compared to a woman who delivered vaginally (9.2 deaths per 100,000).'"[215]

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211. Myers, *supra* note 5, at 527. *See, e.g.*, Masid Ali, RDA: Rats Drugs and Assumption (Life Span Press 1995); James P. Carter, Racketeering in Medicine: The Suppression of Alternatives (Hampton Roads Publishing 1992); Rosemary Gibson & Janardan Prasad Singh, Wall of Silence, The Untold Story of the Medical Mistakes that Kill and Injure Millions of Americans (LifeLine Press 2003); Daniel Haley, Politics in Healing: Suppression and Manipulation of American Medicine (Potomac Valley Press 2000); Hal A. Huggins & Thomas E. Levy, Uninformed Consent, the Hidden Dangers in Dental Care 13 (Hampton Roads Publishing, Inc. 1999); Eugene D. Robin, Matters of Life and Death: Risks vs. Benefits of Medical Care 157–64 (W. H. Freeman & Co. 1984).

212. *See generally* ACOG Practice Bulletin #5, *supra* note 145; Bates, *supra* note 80.

213. Mainstreaming Midwives, *supra* note 45, at 534.

214. Myers, *supra* note 5, at 527.

215. *Id.*

On close inspection, it is not difficult to discern the raging economic turf battle. Maternity care is big business in the U.S., especially for hospitals.[216] Of total hospital stays for women, 25% are for pregnancy and childbirth.[217] In 1999, delivery accounted for about 270 hospitalizations for every 10,000 women.[218] Obstetricians are important to a hospital's financial success for a number of reasons, including the fact that they influence around 11%, or $30 million, of inpatient charges through referrals to other physicians within the hospital.[219] In other words, obstetrical care is still a major marketing tool for hospitals; when a woman needs hospitalization for herself or for a family member, she will tend to stick with the hospital where she gave birth.

Consider that 99% of births occur in hospitals, of which more than 25% are cesarean sections, and that home birth costs as little as one-sixth the cost of an uncomplicated vaginal birth in the hospital.[220] There is an unspoken assumption that physicians' decisions should not be questioned, so there is no regulation by disinterested parties. At the same time, "there are virtually no consumer pressures . . . no restraints on anti-competitive practices . . . no meaningful consumer protections . . . no accountability for the health and well-being of mothers and babies."[221]

Despite these facts, bringing anti-trust policy to bear on provisions regarding birthing services has proven difficult, especially when the "injured" parties are not economic competitors deprived of a livelihood, but instead patients who have been effectively denied access to a certain type of service.[222] While doctors enter into agreements with hospitals, insurers and practice partners may be held accountable for these entities. Thus, there has been little in the way of regulatory or other institutional mechanisms to hold doctors accountable to patients.[223]

Under certain state laws, a hospital's refusal to appoint a healthcare professional to its medical staff is either not subject to judicial review, or is subject only to limited

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216. Figures published in 1999 show that the cost of home births typically range between $2300 and $5000; birth center births between $3500 and $8300; hospital births between $4300 and $16000; and caesarean section births top costs with a range between $9300 and $26000. Peggy O'Mara, Having a Baby Naturally 322 (2003).

217. U.S. Dept. of Health & Human Services, Agency for Healthcare Research & Policy, Healthcare Cost & Utilization Project (HCUP) Fact Book No. 3, Care of Women in U.S. Hospitals (2000), *available at* http://www.ahrq.gov/data/hcup/factbk3/factbk3.htm.

218. U.S. Dept. of Health & Human Services, Health Resources & Services Administration, Maternal Child and Health Bureau, Woman's Health USA 2002 (2002), *available at* http://mchb.hrsa.gov/whusa02/Page_68.htm.

219. Kathleen C. Hanold, *OB/GYNs Offer a Rich Source of Referrals*, Marketing Health Services, Fall 2002, at 12.

220. *See* O'Mara, *supra* note 216, at 138–39, 322.

221. Susan Hodges & Henci Goer, *Effects of Hospital Economics on Maternity Care*, reprinted in Citizens for Midwifery News Vol. 9, Issue 1, Spring/Summer 2004, *available at* http://cfmidwifery.org/resources/item.aspx?id=32.

222. *See generally* Mainstreaming Midwives, *supra* note 45.

223. *See* Marc A. Rodwin, Medicine, Money, and Morals: Physicians' Conflicts of Interest 11–34, 162–75 (Oxford University Press 1993).

review because of the reluctance of judges to substitute their judgment for that of decision-makers in private organizations.[224]

Even direct Sherman Act challenges often fail as a vehicle due to the difficulties inherent in proving the key elements of a Sherman Act claim. Generally speaking, the continuing reliance of federal courts on economic theory in antitrust cases has had a profound impact on antitrust claims brought in the healthcare context, because the economic approach demands proof that output is restricted in order to show the required foreclosure of competition and, thus, the establishment of an antitrust violation.[225] Restricted output can be very difficult to show in the healthcare context. In particular, services are provided nationwide in a decentralized fashion without a central database or other tracking service. Like the gathering of any data from local sources, such an effort is labor-intensive and time-consuming, involves the surveying of hundreds or thousands of local facilities, and perhaps tens of thousands of women (if not more).

According to Amnesty International, nursing and midwifery services contribute to international health improvements, *inter alia,* by promoting gender equality through the education of girls and women about health issues, by reducing child and maternal mortality, and by delivering maternal and child health services.[226] Yet these practitioners are stymied, and therefore their would-be clients denied these benefits, when competition with ob-gyns is suppressed in favor of a medical monopoly that is not justified by the medical evidence.

Democratic, non-legislative methods are sometimes relied on to correct monopolistic tendencies. One important method in a free society is the use of exit—that is, consumers exiting from one provider to "purchase" medical services from another provider elsewhere.[227] The women's health movement has been cited as one example of the "exit" correction to monopolistic tendencies.[228] Yet, exit is not a feasible remedy when monopolistic restraints have thwarted alternative providers.

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224. *See, e.g.*, Shahawy v. Harrison, 875 F.2d 1529, 1533 (11th Cir. 1989); Adkins v. Sarah Bush Lincoln Health Ctr., 544 N.E.2d 733, 737–38 (Ill. 1989); Barrows v. Northwestern Mem'l Hosp., 525 N.E.2d 50, 50 (Ill. 1988); Lapidot v. Mem'l Med. Ctr., 494 N.E.2d 838, 842 (Ill. App. Ct. 1986); Rao v. St. Elizabeth's Hosp., 488 N.E.2d 685, 696 (Ill. App. Ct. 1986).

225. *E.g.*, Marrese v. Am. Acad. of Orthopedic Surgeons, No. 80 C 1405, 1991 WL 5827 (N.D. Ill. Jan. 15, 1991) (first inquiry is whether the defendant possesses market power).

226. *See* Amnesty Int'l, *supra* note 13, at 2, 54, 65, 89, 95–97.

227. *See generally* Albert O. Hirschman, Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States 3–4 (Harvard University Press 1970); Albert O. Hirschman, Rival Views of Market Society and Other Recent Essays 78 (Viking Penguin Inc. 1986); A.H. Birch, *Economic Models in Political Science: The Case of 'Exit, Voice, and Loyalty,'* 5 Brit. J. Pol. Sci. 69, 73–74 (1975); Albert O. Hirschman, *"Exit, Voice, and Loyalty": Further Reflections and a Survey of Recent Contributions*, 58 Milbank Memorial Fund Q./ Health & Soc'y 430, 450 (1980); Rudolph Klein, *Models of Man and Models of Policy: Reflections on "Exit, Voice, and Loyalty" Ten Years Later*, 58 Milbank Memorial Fund Q./ Health & Soc'y 416, 417 (1980); Brian Barry, *Review Article: "Exit, Voice, and Loyalty"*, 4 Brit. J. Pol. Sci. 79, 86 (1974).

228. *See* Rodwin, *supra* note 53, at 150.

Often, doctors "act as gatekeepers for many health care resources."[229] And "while the women's health movement has had some positive effects on medicine, change has been slow and partial."[230]

There is one silver lining, however: Antitrust jurisprudence is gradually evolving to determine whether certain conduct reduces the output of products or services, as opposed to a stricter economic-impact analysis.[231] Viewed through this lens, ACOG's restrictive policies that influence the ability of a woman to freely choose VBAC seem to run counter to the American policy of anti-monopolistic provision of services.

As discussed *supra*, the so-called "clinical" constraints on VBAC services have driven many qualified competitors out of the market, particularly direct-entry midwives, nurse practitioners, and family physicians. This, in turn, has the inevitable effect of making such providers effectively unavailable to women who would otherwise utilize their services.[232]

This, then, is the nexus between the anti-competitive nature of ACOG policies and the human rights of individual American women: deprivation of entire portions of the maternity-care spectrum routinely available to women in other countries. Even in those instances when women are able to avail themselves of a direct-entry midwife, for example, their care may be compromised due to factors beyond the midwife's control. Physician resistance to midwifery and out-of-hospital birth may result in denigration of the pregnant women or midwives involved, or even denial of services in the form of refusal to accept an emergency transport to a hospital from a home birth due to failure to progress, medical emergency, or exhaustion of the mother.[233] As noted by leading scholar Robbie Davis-Floyd: "[Midwives] and their clients sometimes suffer in extreme ways from the effects of such [negative] stereotypes . . . . It is one thing to proudly hold a countercultural space in which women can make alternative choices, and another to watch your clients suffer the effects of the negative stereotyping of midwives."[234]

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229. *Id.* at 159.

230. *Id.* at 163.

> Professional power is still strong and often determines how health services are performed. Despite the women's movement's efforts to allow women greater control over childbirth, trends exist that counter such control. For example, births by cesarean section in the United States have increased steadily from 4.5% in 1965 to 24% in 1986 and stayed around this level until 1991. Despite efforts by women's groups and consumers, women frequently have been forced to have cesarean sections against their will . . . [thus] the women's movement has had only limited effects on changing practices.

Id.

231. Peter M. Sfikas, *Antitrust Challenges by Allied Health Care Professionals Involving Hospital Staff Privileges*, J. Health & Hosp. L., Dec. 1991, at 361.

232. *See generally* Rodwin, *supra* note 53, at 150.

233. *See* Mainstreaming Midwives, *supra* note 45.

234. *Id.* at 168.

It is generally recognized that the interests of the consumer are usually "better served by competitive forces in the market place."[235] There is a generalized concern that expresses itself in various governmental policies—some being part of decisional and statutory law—against combinations and agreements that operate to restrain or encumber trade.[236]

In this sense, the VBAC restrictions implicate the rights of pregnant women not only as patients, but as consumers of goods and services in a free market. There is also a potential discriminatory undercurrent: pregnant women are singled out for this particular brand of abasement and jeopardy.

The U.S. Department of Health and Human Services has recommended collaboration between physicians and midwives as one avenue of enhancing availability of birthing services.[237] According to its Commentary on Obstetricians and Midwives: "We believe . . . that the most effective systems are not one provider over another but collaborative teams of physicians and advanced practice professionals combining their skills to maximize treatment and educational strategies that can improve the health of women."[238]

The output of birthing services has been restricted not only in the ways discussed above (VBAC limitations, promotion of C-sections generally, etc.), but also by targeting midwives to discourage them from providing birthing services. These efforts include educational or (depending on one's point of view) propagandistic efforts condemning home birth as a form of child abuse, and otherwise discouraging out-of-hospital births.[239]

ACOG divisions have taken steps to collect reports on out-of-hospital births. For example, the Wisconsin Section of ACOG issued a notice to its members that it "would like to document any adverse outcomes that physicians might encounter in their practice by patients who are assisted by professional midwives."[240] To what use might such anecdotal reports be put? ACOG is the self-described "voice of women's health" (albeit without benefit of the blessing of the women for whom it claims to speak) and as such urges its members "to become more active at every level of government."[241] ACOG educates its members that it is "[m]ost difficult to have an

235. Vt. Nat'l Bank v. Chittenden Trust Co., 465 A.2d 284, 287 (Vt. 1983).

236. *See, e.g.*, State v. Heritage Realty, 407 A.2d 509 (Vt. 1979); The Consumer Fraud Act, 9 V.S.A. § 2453 (2009); The Sherman Anti-Trust Act, 15 U.S.C. § 1 (2006); The Clayton Act, 15 U.S.C. § 14 (2006); The Federal Trade Commission Act, 15 U.S.C. § 45 (a)(1) (2006).

237. Hal C. Lawrence, *Not Either/Or, but Obstetricians and Midwives Together*, Pub. Health Rep. 1997, Sept./Oct. 1997.

238. *Id.*

239. Mainstreaming Midwives, *supra* note 45, at 32–33.

240. ACOG Wisconsin Section, Adverse Outcomes Midwife Births, http://www.acog.org/acog_sections/dist_notice.cfm?recno=17&bulletin=1821 (last visited Oct. 10, 2009).

241. *See, e.g.*, Press Release, Kenneth L. Noller, President, ACOG (June 4, 2007), *available at* http://cache.zoominfo.com/CachedPage/?archive_id=0&page_id=-2140757529&page_url=%2f%2fwww.tufts-nemc.org%2fhome%2fnews%2fnemcnews%2f2007%2f0700604.htm&page_last_updated=11%2f11%2f2007+5%3a34%3a46+AM&firstName=Kenneth&lastName=Noller.

effective legislative presence without a dedicated lobbyist" and that a state section "must develop its legislative committee and its legislative agenda before hiring a lobbyist."[242] ACOG has an active "Government Relations Committee" that sponsors an Annual Lobbyist Roundtable and encourages the "growing" of "ACOG's advocacy in the state capitals" to defeat legislative initiatives that would legalize, regulate, or otherwise encourage the practice and professionalization of midwifery.[243]

It is no surprise that ACOG called for neither "anecdotes" about good-outcome midwife services, nor for bad-outcome ob-gyn deliveries. Negative publicity is typically generated by a bad-outcome, midwife-attended birth, but is "rarely applied to negative hospital outcomes."[244] Robbie Davis-Floyd writes of the "damaging stereotypes hospital practitioners tend to create and disseminate about direct-entry midwives" and observes: "[A] death at home rings loud cultural alarm bells, sounding the culturally ingrained message that home birth is an irresponsible choice for mothers, and that home-birth midwives must be far less competent that [sic] hospital-based practitioners."[245] One can readily perceive the damage this wreaks on the midwives themselves emotionally, professionally, and financially. More to the point of this paper, however, is the damage done to the laboring mother who has exercised her right to choose the services of a midwife and give birth at home. Both midwives "and their clients . . . suffer in extreme ways from the effects of such stereotypes. . . ."[246] One commentator notes that "obstetricians are vehemently opposed to midwives and have gone to great lengths to drive them out of business," with all of "the fervor of an old-fashioned witch hunt,"

242. ACOG, District VIII Annual District Advisory Council, Meeting Minutes (Nov. 7, 2006), *available at* http://www.acog.org/acog_districts/dist8/2006AdvisoryAgenda.pdf.

243. *Id.*

> On the issue of midwives, the committee discussed how the lack of comparative data on midwife-assisted birth outcomes hinders our efforts as ob-gyns, and explored ways to assist Fellows in responding to midwife bills in their state. It was proposed that ACOG collect anecdotes from Fellows who have been back-up or on call for midwife-assisted deliveries that ended in an adverse outcome.

Id.

244. Mainstreaming Midwives, *supra* note 45, at 169.

245. *Id.* at 167, 532.

246. *Id.* at 168.

> One of the most significant and challenging of these barriers is *hospital and physician resistance to midwives*, which is sometimes purely economically motivated, and sometimes motivated by an erroneous belief that midwives are not really competent professionals—at least not as competent as the doctors themselves. CNMs [Certified Nurse Midwives] experience physician or hospital administrator resistance when they are overscrutinized . . . or fired outright in large numbers, or when physicians refuse to provide backup for their birth center, homebirth practices, and even hospital practices, and/or harass the few physicians that do . . . . DEMs [direct entry midwives] experience physician resistance in the form of the same refusal of backup care, insulting treatment in the hospital when they transport a patient, investigation of their practices by physicians determined to shut them down . . . and heavy lobbying by professional medical organizations against legislation to legalize and regulate DEMs in various states.

Id. at 527–28.

thus resulting in fewer options for women.[247] In many regions of the United States, a pregnant woman who wants the care of a midwife can't get it unless she's willing to go outside mainstream healthcare channels, and, in some areas, even risks being persecuted and/or prosecuted herself.[248]

V. A PROPOSAL FOR CHANGE THROUGH TRANSPARENCY AND LITIGATION

> *OPENNESS, honest and complete OPENNESS—*
> *that is the first condition of health in all societies.*[249]

A. A Call for Transparency

The process of changing physicians' practice patterns to reduce cesarean birth rates is not an easy one. Numerous organizations including "government agencies, professional associations, physician leaders, managed care organizations, and consulting groups have all struggled with this issue for more than 20 years."[250]

The American founders believed "in the enlightened choice of the people, free from the interference of a policeman's intrusive thumb or a judge's heavy hand."[251] The free flow of information is a matter not only of legal rights, but also of good public policy in the realm of scientific endeavors. Andrei Sakharov, recipient of both the Nobel Peace Prize and the Nobel Prize for Physics, stated that he is "convinced that freedom of conscience, together with the other civic rights, provides the basis for scientific progress and constitutes a guarantee that scientific advances will not be used to despoil mankind . . . ."[252]

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247. Wagner, *supra* note 1, at 10.

248. *Id.*

249. Aleksandr Solzhenitsyn, *Letter to the Secretariat of the Soviet Writers' Union, 1969, in* A Documentary History of Human Rights 483 (Jon E. Lewis ed., 2003).

250. Elliott K. Main, *Reducing Caesarean Birth Rates with Data-driven Quality Improvement Activities*, 103 Paediatrics 374, 374–81 (1999).

> Although the national and state rates are now 10% to 20% below their peak in 1988 (which translates to a 1% to 3% reduction in the total cesarean rate), most are not near the national Healthy Person 2000 goal of 15% . . . . [M]idwife-centered care has led to some of the lowest cesarean birth rates in the United States . . . . [C]hanging behaviors of highly educated adults is not an easy task.

Id.

251. Ginzburg v. U.S., 383 U.S. 463, 498 (Stewart, J., dissenting).

252. Andrei Sakharov, Nobel Peace Prize Lecture, Peace, Progress, Human Rights (Dec. 11, 1975), *available at* http://nobelprize.org/nobel_prizes/peace/laureates/1975/sakharov-lecture.html.

> We need reform, not revolution. We need a pliant, pluralist, tolerant community, which selectively and tentatively can bring about a free, undogmatic use of the experiences of all social systems . . . . [L]ike faint glimmers of light in the dark, we have emerged . . . . We must . . . create a life worthy of ourselves and of the goals we only dimly perceive.

Id.

Science provides the moniker for one offspring of the free-speech evolution: "transparency." To scientists, a transparent object is one that does not conceal what is on the other side. To social scientists, transparency in government and in non-governmental institutions of public importance is a counterpoint to secrecy, and facilitates openness and participation through public accessibility, review, and debate. Transparency discourages abuse of power by those who hold it, *inter alia*, by making it easier to discern poor judgment or intentional wrong-doing on the part of decision-makers, and holding them accountable to improve the system.

Transparency has been applied in many different contexts to promote accountability within government. For example, the U.S. Bankruptcy Courts rely heavily on required disclosures and the transparency of bankruptcy proceedings to avert corruption and promote equity.[253] Similar techniques are utilized in family courts vis-à-vis distribution of the marital estate[254] and the U.S. General Accounting Office, which has called for greater transparency in federal spending and record-keeping to promote accountability.[255]

The principle of transparency is applied not only to governments, but to corporations and other non-governmental entities within the United States. The call for enhanced transparency has increased in volume since the Enron disaster. Even the U.S. Securities and Exchange Commission joined the fray, calling for transparent disclosure in the wake of the Enron debacle.[256]

According to one scholar, a "physician-based healthcare system that has grown beyond critical bounds . . . obscures the political conditions that render society unhealthy; and it tends to mystify and to expropriate the power of the individual to heal himself and to shape his or her environment."[257]

The doctrine of informed consent, as applied in the context of childbirth, creates a duty of disclosure upon a physician to present her patient with information on not only the material risks involved in undergoing natural childbirth, but also the risks associated with having a cesarean section.[258] "In the childbirth context, physician . . . .

253. *See, e.g.*, McVay v. Phouminh (*In re* Phouminh), 339 B.R. 231 (Bankr. D. Colo. 2005); *In re* Riccardo, 248 B.R. 717 (Bankr. S.D.N.Y. 2000).

254. Breen, G., et al., *Bankruptcy, Family Law Strengthened To Stop Bankrupts' Torts (Increasing Transparency)*, J. Banking & Fin. Services, Oct. 2004.

255. Honorable David M. Walker, Comptroller General of the U.S., *Truth and Transparency: The Federal Government's Financial Condition and Fiscal Outlook* (Sept. 17, 2003), *available at* http://www.gao.gov/cghome/npc917.pdf.

256. Ken Rankin, *SEC Warns Investors Need Transparent Disclosure in Wake of Enron Debacle (Assurance Forum)*, Accounting Today, Jan. 2002.

257. Ivan Illich, Limits to Medicine, Medical Nemesis: The Expropriation of Health 16 (Penguin Books 1976).

258. Physicians are required to disclose: (1) the risks of a particular method of treatment; (2) alternative methods of treatment; (3) the risks relating to such alternative methods of treatment; and (4) the results likely to occur if the patient remains untreated. *See* Canterbury v. Spence, 464 F.2d 772, 781–82 (D.C. Cir. 1972); Crain v. Allison, 443 A.2d 558, 561–62 (D.C. 1982); Holt v. Nelson, 523 P.2d 211, 217 (Wash. Ct. App. 1974).

bias towards cesarean sections may influence their ability to provide adequate information about childbirth methods."[259] In a violation of fiduciary duty, "[p]hysicians who find it in their best interest to perform the surgery may reveal incomplete information to a patient deciding between a cesarean or natural childbirth."[260]

Transparency is also called for in the larger American birth context through free access to the data and procedures utilized by ACOG—the standard-setter for American birthing practices—in its formulation of clinical recommendations.[261]

Not surprisingly, the corporate world resists opening its secrets to outside scrutiny. It often cites the "trade secret privilege" to justify drawing a veil over its workings.[262] The trade secret doctrine, however, is an "oddball" privilege[263] that is "difficult to justify, especially when the law does not recognize privileges for many more deserving sorts of information, *e.g.*, parent child communications."[264]

One should resist the temptations of naiveté and acknowledge that the talk of trade secrets and confidential business information may well be used to "protect the public" from knowledge important to public well-being. "Corporations have tried to use trade secret claims to conceal workplace hazards, the ingredients of harmful products, and discriminatory hiring practices as well as to . . . keep information from unions that would assist them in carrying out their collective bargaining responsibilities, and to prevent the release of regulatory data."[265]

ACOG materials are limited, for the most part, to its own members, with further dissemination prohibited. The author of this paper was denied access to ACOG committee reports and minutes of meetings relating to development of VBAC standards, despite a willingness to comply with any purchase requirements.[266] There appears to be no public library in the country that has a complete set—or anywhere near it—of ACOG-generated documents, including those consulted or developed in

259. Bates, *supra* note 80, at 400.

260. *Id.*

261. In lobbying efforts, ACOG has represented itself to the U.S. Food and Drug Administration as "the body which establishes standards of care for the ob-gyn profession." Letter from Ralph W. Hale, ACOG to the Dockets Management Branch of the U.S. Food and Drug Administration (Nov. 1, 2000), p. 1, *available at* http://www.fda.gov/ohrms/dockets/dailys/00/Nov00/111500/cp0001.pdf.

262. *See* 26 Charles Alan Wright & Kenneth W. Graham, Jr., Federal Practice & Procedures, § 5642, 288 (1992).

263. *Id.*

264. *Id.* at 350. A leading commentator observes further:

> To say that the basis of trade secret law is "commercial ethics" is to beg the question of its justification by assuming that business secrecy is justified. As the example of science suggests, it is quite possible to imagine social institutions that involve the same competing values of individualism, competition and innovation as the commercial world yet which embrace an ethics of openness.

Id. at 295–96.

265. *Id.* at 316–18.

266. Personal communications with ACOG home office research service, July & Aug. 2007 (on file with author).

relation to the 1999 "reevaluation" of the VBAC standards in response to ACOG's "malpractice suit" concern. Similarly, the "anecdotal" evidence ACOG gathers on midwife-attended births with bad outcomes is not available to the public.

The July 5, 2001 issue of the *New England Journal of Medicine* contained a study and an accompanying editorial that focused international media attention on the VBAC issue and set off a flurry of activity on internet sites and in doctors' offices all over the world.[267] The headlines suggested that new research supported repeat cesareans over VBAC, causing a number of physicians to opine that repeat cesareans were as safe as, or safer than, vaginal birth. Less attention was paid to subsequent attacks on both the study and the journal editorial, written by Michael E. Greene, M.D. The study contained "little new or groundbreaking information and relie[d] on questionable data collection."[268]

"[T]ake a closer look," wrote Jill MacCorkle, author of *Fighting VBAC-lash: Critiquing Current Research, Mothering*. Ms. MacCorkle contends that overuse of medical intervention in childbirth has transformed ordinary vaginal birth into major surgery. She argues that a "careful critique exposes the limitations of . . . the current medical model of childbirth, raising the question of whether that model still holds any credibility for pregnant women."[269] A noted critic of current obstetrical practice, Dr. Flamm, observed: "Even the charts of the women believed to have experienced uterine rupture, the very focus of this study, were apparently not available for review."[270]

B. A Need for Litigation

As discussed above, ACOG is already sensitive to potential legal liability arising from the dreaded malpractice lawsuits. This aspect of its corporate sub-culture may be useful in procuring greater respect for, and compliance with, the human rights of women who come within the purview of ACOG practice bulletins, guidelines, and practices.

Indeed, ACOG is no stranger to legal considerations: "ACOG also uses fear of litigation to control doctors and hospitals. If doctors and hospitals go against one of their recommendations, they are more vulnerable to litigation."[271]

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267. *See, e.g.*, Rita Rubin, *Vaginal Births After C-Section Risk Uterine Damage*, USA Today, July 5, 2001, at 9D; Sheryl Gay Stolberg, *A Risk is Found in Natural Birth After Cesarean*, N.Y. Times, July 5, 2001, at A1; Deborah Josefson, *Vaginal Delivery After Cesarean Section Triples Risk of Uterine Rupture*, BMJ, July 5, 2001; Press Release, American College of Nurse-Midwives, ACNM Calls for Definitive VBAC Study (July 3, 2001).

268. Jill MacCorkle, *Fighting VBAC-lash: Critiquing Current Research*, Mothering, Jan.–Feb. 2002, *available at* http://www.mothering.com/fighting-vbac-lash-critiquing-current-research.

269. *Id.*

270. Bruce Flamm, *Vaginal Birth After Cesarean and the New England Journal of Medicine: A Strange Controversy*, Birth, Dec. 2001, at 276–79.

271. Wagner, *supra* note 1, at 27.

Ob-gyns are already trained to fear the devil they know: malpractice lawsuits. The devil they don't know—but which could prove even more fearsome—is the human rights lawsuit for the procural of patient consent absent full disclosure of the non-medical motivations embedded in American birthing recommendations, and for violating consumers' right to unrestrained trade in the maternity-care field.

VI. CONCLUSION

A. American Birth Recommendations Violate International Human Rights Norms

"Everyone has the right to a standard of living adequate for . . . health and well-being . . . ."[272] This is a generally accepted international norm. In the U.S., however, it is unduly difficult and dangerous for a woman who gives birth to freely seek her choice of maternity-care providers on an informed basis. This endangers her health and well-being.

The International Covenant on Economic, Social and Cultural Rights "recognize[s] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[273] Patently, the U.S. has the resources to provide—and, in many medical specialties, does provide—the highest attainable standard of physical and mental health. Birthing is an exception, as demonstrated by the disparity between the rate of C-sections, the rate of unnecessary C-sections, and the maternal death rate between the U.S. and other industrialized countries.

According to WHO, "the right to health should be understood as extending beyond health care to . . . access to health-related education and information, including on sexual and reproductive health."[274] The secrecy surrounding ACOG standard-setting and its underlying medical evidentiary basis defeats efforts to provide an appropriate education, and full and fair information, to women faced with birthing decisions.

The Convention on the Elimination of All Forms of Discrimination against Women requires "all appropriate measures to eliminate discrimination against women . . . in particular to ensure . . . access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."[275] This has not occurred in the United States, where information residing within ACOG on the rationale and underlying data supporting the VBAC standards is difficult for the public to obtain.

The Preamble to the Constitution of WHO provides: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[276] The Convention on the Rights of the Child requires subscribing

272. Universal Declaration of Human Rights, *supra* note 6, at art. 25.

273. Int'l Covenant on Economic, Social & Cultural Rights, *supra* note 11, at art. 12.

274. *See* Amnesty Int'l, *supra* note 13, at 49–50.

275. Convention on the Elimination of All Forms of Discrimination against Women, *supra* note 19, at art. 10.

276. WHO Const., pmbl., *supra* note 15.

countries to "take appropriate measures . . . [t]o ensure appropriate pre-natal and post-natal health care for mothers."[277] Both these standards are violated by the unnecessarily high American rate of C-sections and maternal death, and the *de facto* discrimination against pregnant women in relation to their ability to make informed birthing choices.

B. American Birth Recommendations Violate American Human Rights Norms

Every person has a constitutionally protected liberty interest in her own body. No person can be deprived of life, liberty, or property without due process. Even with the belief that it is safer for mother and/or baby for birth to occur in a hospital, no action may be taken to interfere with parental choice unless there is a hearing—with adequate due-process safeguards—forcing the accuser to carry the burden of proof, allowing both sides to be heard, and resulting in a hearing based on the evidence.

Every person is constitutionally entitled to a presumption of mental competence (comparable to presumption of innocence in criminal proceedings) until there is an adjudication—meeting due process requirements—to the contrary. There is no exception to this rule for pregnant women; they do not lose their legal presumption of mental competence by becoming pregnant.

A mother is presumed to be the legal representative of her child, unless and until the state—in compliance with the due process clause—terminates or restricts parental rights, including the right to make medical choices for her child. The general constitutional rule is that unless a mother is proven to be "unfit," the state cannot interfere. If there are allegations of unfitness, such as abuse or neglect, the accuser must bring the appropriate charges and prove his or her case before interfering with maternal choice.

Therefore, a mother's right to make medical decisions for herself cannot be intruded upon except through proper adjudication—in compliance with the due process clause—that she is unfit to make those decisions. There is no legal principle that would by fiat exclude pregnant women from these rules of law.

C. Importance of Transparency as a Partial Remedy

Since the founders' eighteenth-century antipathy to government restrictions on free speech, their ardor for the "enlightened choice of the people" has evolved into a broader romance with the free flow of information throughout society in general. "Rules that limit access, encourage secrecy or curtail participation must be strictly construed because they run counter to the great countervailing principles of openness and participation. A facile or insouciant resort to pragmatic remedies soon results in the tail wagging the dog."[278]

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277. Convention on the Rights of the Child, *supra* note 20, art. 24.

278. Schwartz, et al. v. Celestial Seasonings, Order Den. Mot. To File Ex. Under Seal, No. 95-K-1045 (D. Colo. Jan. 22, 1998) (articulating "my responsibility as a judge to avoid concealment of the judicial process from public view.") (citing M.M. v. Zavaras, 939 F. Supp. 799, 801 (D. Colo. 1996) (holding

Rewarding the (presumed) superior intellect and investment of physicians via greater compensation and prestige at the expense of pregnant women does not justify current American birth practices.

> While it is true that our culture generally approves of . . . cleverness . . . one has to look only to the 'sucker-punch,' the attack on Pearl Harbor, and the law of fraud to see that at some point this admiration for the clever passes over into sympathy for the justifiably ignorant. . . . [I]t would be enough to answer that we are all 'free-riders' on the intelligence and effort of our ancestors.[279]

An increase in transparency—through the doctrine of informed consent—will inevitably lead to greater patient protection as physicians present their patients with information not only on the material risks involved in undergoing natural childbirth, but also on the risks associated with having a cesarean section.[280]

D. Importance of Litigation as a Partial Remedy

Certainly, it is fashionable to deride lawyers (amongst whom the author counts herself), and to lament the "litigious nature" of our society, as some doctors—particularly ob-gyns—are fond of doing, fomenting fear with talk of the "malpractice crisis" and other bogeymen. This is a red herring.

Defensive medicine is harmful to pregnant women. Ob-gyns exist to serve women, primarily pregnant women. Given that the financial benefits incurred by physicians still outweigh the financial risks, are we to believe that the ob-gyn specialty is in any real danger of extinction? This borders on the fatuous. In other words, ob-gyns are still making money they view as adequate to compensate them for their work—or else we would have no ob-gyns.

Is it so radical to believe that practicing good medicine, rather than defensive medicine, would be its own reward, both financially and emotionally? While Dr. Wagner acknowledges the prevalence of litigation against American obstetricians and high ob-gyn insurance premiums in the medical world, he explains that something more than financial cost is needed to explain obstetricians' "extreme attitude" toward practicing defensive medicine. "In an obstetrician's daily professional world, everyone . . . looks up to him and follows his orders . . . . [B]eing an obstetrician in the obstetric world is like living as an animal with no natural predators. A courtroom is not in the obstetric world. Predators lurk in the courtroom."[281]

The rule of law is a fundamental value in this country. It forces people to account for their behavior. It is powerful and, for the most part, positive.

There is already a substantial body of law on medical malpractice. There is already an extensive constitutional jurisprudence on bodily autonomy and integrity.

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that any privacy interest plaintiff had in remaining anonymous was "decisively outweigh[ed]" by the countervailing public interest in openness)).

279. Wright, *supra* note 262, at n.56–57.

280. *See supra* note 258.

281. Wagner, *supra* note 1, at 153.

Invocation of human rights norms—both personal and economic—in relation to American birth choices and services is the case yet to be brought, with a plaintiff yet to be heard.

That means the jury is still out.