CHILDBIRTH: AN OPPORTUNITY FOR CHOICE THAT SHOULD BE SUPPORTED

SYLVIA A. LAW*

In March 2006, the National Institutes of Health (NIH) held a State-of-the-Science Conference entitled "Cesarean Delivery on Maternal Request." At the end of the meeting, a multi-disciplinary panel issued a statement recognizing that, in some circumstances, "cesarean delivery on maternal request may be a reasonable alternative to planned vaginal delivery."[1]

For decades, women in the United States have given birth by Cesarean section (C-section) more than in other developed countries.[2] Since the 1970s, this national "epidemic" of unnecessary Cesarean sections has been a matter of concern in the obstetric, feminist, and public health communities.[3] In response to

* Elizabeth K. Dollard Professor of Law, Medicine and Psychiatry, NYU School of Law. Thanks for helpful comments on an earlier draft provided by Dr. Howard Minkoff; Dr. Sharon Musher; Lynn Paltrow, Executive Director, National Advocates for Pregnant Women; and Professor Michael Sparer, Columbia University School of Public Health. Able research assistance was provided by Leora Eisenstadt, NYU School of Law; Dr. Craig Shelley, Richardson School of Law, University of Hawaii; Suzy Kim Lee, NYU Department of Sociology; and Abby Herzberg, NYU School of Law 2009. The editors of the Review of Law & Social Change improved the analysis. I especially warmly thank Susan Dorsey and Dr. Rebecca Rudesill for conversations about the complex issues raised by this paper. Leslie Jenkins provided essential administrative support. NYU School of Law's Filomen D'Agostino & Max E. Greenberg Faculty Research Fund provided financial help.

1. NAT'L INSTS. OF HEALTH, STATE-OF-THE-SCIENCE CONFERENCE STATEMENT, CESAREAN DELIVERY ON MATERNAL REQUEST, March 27–29, 2006, at 11 [hereinafter 2006 NIH, C-SECTIONS ON MATERNAL REQUEST].

2. *See, e.g.*, 2006 NIH, C-SECTIONS ON MATERNAL REQUEST, *supra* note 1, at 3 (finding that "[o]ther countries report cesarean delivery rates increasing over recent time but generally at lower levels than found in the United States"); MARY GABAY & SIDNEY M. WOLFE, UNNECESSARY CESAREAN SECTIONS: CURING A NATIONAL EPIDEMIC 24 (1994) (reporting that, in 1988, Cesarean rates in industrialized countries ranged from a high of 25% in the United States to 8% in Czechoslovakia); Francis. C. Notzon, Paul J. Placek, & Selma M. Taffel, *Comparisons of National Cesarean-Section Rates*, 316 NEW ENG. J. MED. 386, 386 (1987) (reporting that, in 1981, nineteen industrialized countries had rates varying from a low of 5% in Czechoslovakia to a high of 18% in the United States). Women in Latin America are even more likely to give birth by C-section than those in the United States. In 2005, a large WHO global survey of twenty-four regions in eight countries in Latin America found that the median rate of Cesarean delivery was 33%, with the highest rates reaching 57%, found in private hospitals. Jose Villar, Eliette Valladares, Daniel Wojdyla, Nelly Zavaleta, Guillermo Carroli, Alejandro Velazco, Archana Shah, Liana Campodonico, Vicente Bataglia, Anibal Faundes, Ana Langer, Alberto Narvaez, Allan Donner, Mariana Romero, Sofia Reynoso, Karla Simonia de Padua, Daniel Giordano, Marius Kublickas, & Arnaldo Acosta, *Caesarean Delivery Rates and Pregnancy Outcomes:The 2005 WHO Global Survey on Maternal and Perinatal Health in Latin America,* 367 THE LANCET 1819, 1819 (2006) [hereinafter *2005 WHO Global Survey*].

3. *See generally* GABAY & WOLFE, *supra* note 2, at 24 (asserting that although Cesareans may, up to a certain point, save infant lives, those performed above a certain rate may not prevent

debate and advocacy on this issue, from 1991 until 1996 the rate of C-sections in the United States declined.[4] However, the United States C-section rate began to climb again in 1996, reaching an all-time high of 31.1% of all births in 2006.[5]

Though the NIH statement represents a sharp departure from a national effort to reduce high rates of C-sections, it also reflects a growing recognition by doctors and pregnant women that allowing C-section by choice is sometimes medically and ethically responsible. This article examines the medical, legal, ethical, and financial issues surrounding choice in childbirth. It argues that women should be free to choose their method of delivery, whether vaginal or Cesarean. It also documents the fact that women are often pressured to have C-sections they do not want and argues that these practices are wrong. Forcing and denying C-sections are different sides of the same coin in that they both restrict a woman's choice in her birthing process. In arguing for women's choice, the article relies on medical, health policy, legal, feminist, ethical, and historical literature.

Section One explores the concept of patient choice C-sections. It discusses the range of reasons—medical, social, and personal—that influence women to either schedule a C-section or attempt vaginal delivery that may or may not end in an emergency C-section.

Section Two illustrates that most C-sections are not sought by women and are sometimes unnecessary. It documents the factors leading to unnecessary, unsought C-sections.

Section Three considers questions of medical ethics and legal issues in relation to medical malpractice and informed consent. It argues that a woman's choice should be informed and supported, observes that choice is sometimes subverted, and suggests concrete changes to promote informed choice.

Section Four addresses issues of financial costs. It examines the pervasive assumption that insurance reimbursement should be limited to services that are "medically necessary." It demonstrates that insurers have widely misused the concept of "medical necessity" to deny women choices that should legitimately

---

newborn deaths); Margaret M. Donohoe, *Our Epidemic of Unnecessary Cesarean Sections: The Role of the Law in Creating It, the Role of the Law in Stopping It*, 11 WIS. WOMEN'S L.J. 197, 197–202 (1996) (reporting that the Cesarean section rate in the United States is believed to be more than twice as high as necessary to protect the health of the mother or baby).

4. FAY MENACKER & SALLY C. CURTIN, CTRS. FOR DISEASE CONTROL & PREVENTION, NAT'L VITAL STATS. REPORTS, TRENDS IN CESAREAN BIRTH AND VAGINAL BIRTH AFTER PREVIOUS CESAREAN, 1991–99, 1 (2001), *available at* http://www.cdc.gov/nchs/pressroom/01facts/cesarean.htm.

5. CTRS. FOR DISEASE CONTROL & PREVENTION, NAT'L CTR. FOR HEALTH STATS. QUICK STATS: TOTAL AND PRIMARY CESAREAN RATE AND VAGINAL BIRTH AFTER PREVIOUS CESAREAN (VBAC) RATE—UNITED STATES, 1989–2003, 54 MORBIDITY & MORTALITY WEEKLY REPORT 46 (2005) [hereinafter CESAREAN RATES], *available at* http://www.cdc.gov/mmwr/PDF/wk/mm5402.pdf; CTRS. FOR DISEASE CONTROL & PREVENTION, NAT'L VITAL STATS. REPORTS, BIRTHS: PRELIMINARY DATA FOR 2006 (2007), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_07.pdf.

be theirs, particularly in relation to reproductive health services. Section Four also probes the common assumption that C-sections consume more resources than vaginal delivery. Finally, it argues that insurance reimbursement policy should promote, rather than distort, informed dialogue and decision making between pregnant women and their physicians. With guidance from their physicians, women—not insurers—should make childbirth decisions.

I.
FRAMING SCHEDULED ELECTIVE C-SECTIONS AND FACTORS INFORMING WOMEN'S CHOICES

Historically, C-sections were a sad necessity to save the life of woman or baby, and far more dangerous than vaginal birth for both mother and child.[6] In the twenty-first century, however, developments in anesthesiology and surgery have made both C-sections and vaginal delivery safer for women and infants.[7] Nonetheless, women are sometimes denied the ability to choose elective C-sections.

The concept of "maternal choice" or "elective" C-sections raises difficult questions of terminology. A comprehensive review of the medical literature notes that "maternal request Cesareans have two properties: they are performed before onset of labor (timing) and in the absence of medical conditions presenting a risk to the pregnant woman or the fetus for labor (absence of risk)."[8] Identification of the timing factor is relatively easy; the woman schedules the C-section prior to the onset of labor.[9] It is far more difficult to determine the second factor: whether medical risks support a C-section.

Since a C-section is not considered elective if medical indications call for the Cesarean birth, various experts have attempted to identify those indicators. Using data about women who delivered live births from the National Hospital Discharge Survey and the diagnostic codes of the International Classification of Diseases, Ninth Revision, Clinical Modification (IDC-9-CM), several researchers have developed a list of twelve maternal, fetal, and placental pregnancy complications that account for over 90% of primary C-sections without a trial of labor. The list includes: malpresentation; antepartum hemorrhage, abruption

6. *See* Donohoe, *supra* note 3, at 200.

7. Howard Minkoff & Frank Chervenak, *Elective Primary Cesarean Delivery,* 348 NEW ENG. J. MED. 946, 946 (2003); Susan Gilbert, *Doctors Report Rise in Elective Caesareans*, N.Y. TIMES, Sept. 22, 1998, at F7.

8. Ginger L. Gossman, Jutta M. Joesch, & Koray Tanfer, *Trends in Maternal Request Cesarean Delivery from 1991 to 2004*, 108 OBSTETRICS & GYNECOLOGY 1506, 1509 (2006).

9. The 2005 WHO Global Survey ignores the absence of risk factor and defines a C-section as "elective, if decision to do the operation was made before onset of labour." *2005 WHO Global Survey*, *supra* note 2, at 1820. This approach may lead to some under- and over-counting. For example, a woman who had planned a C-section but went into labor before the planned date would be considered non-elective, whereas a woman who undergoes a C-section prior to the onset of labor because of compelling medical reason, e.g., serious traumatic injury to the woman late in pregnancy, would be considered elective even though she would have preferred a vaginal delivery.

placentae, placenta previa; herpes simplex; severe pre-eclampsia and eclampsia; uterine scar not elsewhere classified; multiple gestation; macrosomia; unengaged fetal head; abnormality of organs and soft tissues of pelvis; other hypertension complicating pregnancy; preterm gestation; and central nervous system malformation in fetus or chromosomal abnormality.[10] HealthGrades Inc., a private company that evaluates heath services, uses a similar list of "medical indication[s]"—the absence of which indicates that a C-section was "patient-choice," or elective.[11]

While this approach seems to represent a developing consensus on the means of defining what constitutes an elective C-section, the methodology is problematic. First, many women with the conditions listed as justifying a C-section are successfully able to labor and deliver a healthy baby. "There are very few absolute indications" for Cesarean delivery before labor.[12] Second, there are many conditions, not included on the list, that increase the risk that attempted labor will fail and an emergency C-section will be necessary. These include: advanced age, gestational diabetes mellitus, and other physical conditions.[13] For example, it is not obvious why twins make a C-section medically necessary, but advanced age does not. Many conditions increase the risks of vaginal birth, but few make it impossible. Third, and by far most important, the timing and "absence of risk factors" criteria do not capture the critical question of patient choice. Risk is always present in pregnancy, whether a woman delivers vaginally or by C-section, and whether or not a woman has one of the identified, recognized risks. Many women with the conditions that justify a scheduled C-section may choose to attempt vaginal delivery and succeed. The use of timing and specified medical indicators to define "elective C-section" gives no weight to the key question of whether the choice is actually made by the woman or the

10. Gossman, *supra* note 8, at 1508; Kimberly D. Gregory, Lisa M. Korst, Jeffrey A. Gornbein, & Lawrence D. Platt, *Using Administrative Data to Identify Indications for Elective Primary Cesarean Delivery,* 37 HEALTH SERVS. RESEARCH 1387, 2002); Susan F. Meikle, Claudia A. Steiner, Jun Zhang, & William L. Lawrence, *A National Estimate of the Elective Primary Cesarean Delivery Rate*, 105 OBSTETRICS & GYNECOLOGY 751, 751 (2005).

11. HEALTHGRADES, THIRD ANNUAL REPORT ON "PATIENT-CHOICE" CESAREAN SECTION RATES IN THE UNITED STATES: RATES CONTINUE TO RISE BUT VARY WIDELY BY HOSPITAL AND REGION 3 (2005), https://www.healthgrades.com/media/DMS/pdf/PatientChoiceCSectionStudy2005Sept12.pdf.

12. Gregory, *supra* note 10, at 1396. *See also* Section II, *infra* on breech birth, prior C-section, and other conditions that may justify, but not require, a C-section.

13. JEANNE-MARIE GUISE, MARIAN S. MCDONAGH, JASON HASHIMA, DALE F. KRAEMER, KAREN B. EDEN, MICHELLE BERLIN, PEGGY NYGREN, PATRICIA OSTERWEIL, KATHRYN PYLE KRAGES, & MARK HELFAND, DEP'T OF HEALTH AND HUMAN SERVS., VAGINAL BIRTH AFTER CESAREAN, EVIDENCE REPORT/TECHNOLOGY ASSESSMENT, NO. 71 4 (2003) [hereinafter 2003 HHS TECHNICAL REPORT] (identifying factors significantly associated with successful vaginal delivery as maternal age less than forty, prior vaginal delivery (particularly vaginal delivery after Cesarean), a nonrecurrent indication for the prior C-section (i.e., prior C-section for reasons that have changed), and favorable cervical factors); David K. Turok, Stephen D. Ratcliffe, & Elizabeth G. Baxley, *Management of Gestational Diabetes Mellitus*, 68 AM. FAMILY PHYSICIAN 1767, 1767 (2003) (reporting that gestational diabetes increases the risk of Cesarean delivery).

physician.

The 2006 NIH State-of-the-Science report offers several core observations. First, the data about the relative risks and benefits of the choice between vaginal birth and C-section is weak.[14] Given that childbirth is common, the absence of rich, reliable data is disturbing.[15] Second, the risk of death or serious injury to either women or babies associated with childbirth in the United States is low, regardless of the method of delivery.[16] Third, while the United States rate of infant mortality and morbidity is high compared to other industrialized countries, research indicates that these rates result because babies are born prematurely, not because of the birth process. In 2004, an alarming number of United States babies—12.5%—were born preterm, i.e., after less than thirty-seven weeks of gestation.[17] The childbirth process itself is very safe.[18]

How does a woman think about the choice between a scheduled C-section and a trial of labor that might end in a C-section or a vaginal birth? Many medical factors support vaginal birth.[19] First, the risk of maternal death, while very low for both vaginal and C-section delivery, is higher for C-sections.[20] Second,

---

14. 2006 NIH, C-SECTIONS ON MATERNAL REQUEST, *supra* note 1, at 5–9, 14 (noting that "[t]here is insufficient evidence to evaluate fully the benefits and risks of Cesarean delivery on maternal request as compared to planned vaginal delivery").

15. With approximately four million births in the United States each year, pregnancy and childbirth-related conditions are the leading causes for hospital stays and account for almost 11% of United States hospitalizations. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, HOSPITALIZATION IN THE UNITED STATES, 2002: HEALTHCARE COST AND UTILIZATION PROJECT FACTBOOK NO. 6 10–11 (2005), *available at* www.ahrq.gov/data/hcup/factbk6/factbk6.pdf.

16. In 2007, the risk of infant mortality in the United States was 6.37 per 1,000 births. CENTRAL INTELLIGENCE AGENCY, THE WORLD FACTBOOK, RANK ORDER—INFANT MORTALITY RATE (2007), *available at* https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.htmlinafter CIA WORLD FACTBOOK, 2007]. In 2005, the risk of maternal mortality in the United States was 11 per 100,000 live births. WHO/UNICEF/UNFPA ESTIMATES OF MATERNAL MORTALITY FOR 2005 (2007), *available at* http://www.childinfo.org/areas/maternalmortality/ countrydata.php. Other non-fatal risks are considered for C-sections, *see infra* notes 22–30, and for vaginal delivery, *see infra* notes 30–34.

17. INSTITUTE OF MED. OF THE NAT'L ACADEMIES, PRETERM BIRTH: CAUSES, CONSEQUENCES, AND PREVENTION 1–3 (Richard E. Behrman & Adrienne Stith Butler eds., 2007). Furthermore, "[t]here are significant, persistent, and very troubling racial, ethnic, and socioeconomic disparities in the rates of preterm birth." *Id.* at 1. In 2006, forty-one nations had lower infant mortality rates than the United States, including virtually all European countries and less developed countries such as Cuba. CIA WORLD FACTBOOK, 2007, *supra* note 16.

18. *See, e.g.*, Gilbert, *supra* note 7 at F7.

19. *See, e.g.*, Carol Sakala & Linda J. Mayberry, *Vaginal or Cesarean Birth?: Application of an Advocacy Organization-Driven Research Translation Model*, 55 NURSING RESEARCH S68 (2006) (describing the not-for-profit organization Childbirth Connection, formerly Maternity Center Association which has created a program to promote evidence-based maternity care (primarily favoring vaginal birth) through research, education, and advocacy).

20. In Great Britain "[f]rom 1988 to 1990, women undergoing an elective cesarean delivery were more than eight times as likely to die than women having a vaginal delivery; from 1994 to 1996, they were approximately three times as likely to die; and by 1997 to 1999, the relative risk of death had decreased to slightly more than 2." Minkoff & Chervenak, *supra* note 7, at 948. *See also* Marsden Wagner, *Choosing Caesarean Section,* 356 THE LANCET 1677, 1677 (2000) (stating that although C-sections may be safer than ever, there is still an "increased risk of maternal mortal-

babies need to grow in utero until lungs develop, thus, there is a consensus that elective C-sections should not be performed before thirty-nine weeks of gestation.[21] However, it is sometimes difficult to pin-point this date.[22] The process of vaginal delivery itself may help to develop a baby's lung function, and provide other benefits to the newborn, though the evidence for this claim is not strong.[23] Third, breast feeding is beneficial to infants,[24] and vaginal birth may make it easier to breast feed, though again, the evidence for this claim is weak.[25] Fourth, C-sections pose special problems for women who want to give birth to multiple children.[26] Vaginal birth after C-section (VBAC) is possible, but difficult.[27]

Given these reasons to prefer vaginal delivery, why would any responsible woman choose a C-section? First, a planned and scheduled C-section is safer for woman and child than an emergency C-section after a failed attempt at vaginal delivery.[28] For some women, a trial of labor is more likely to fail, necessitating

---

ity with women's choice elective CS [C-section]").

21. 2006 NIH, C-SECTIONS ON MATERNAL REQUEST, *supra* note 1, at 14; Minkoff & Chervenak, *supra* note 7, at 948–49.

22. Robin Harvey, *Elective C-Section Risks Under Scrutiny*, TORONTO STAR, Oct. 20, 2006, at E02.

23. 2006 NIH, C-SECTIONS ON MATERNAL REQUEST, *supra* note 1, at 8. *See also* Nicholas S. Fogelson, M. Kathryn Menard, Thomas Hulsey, & Myla Ebeling, *Neonatal Impact of Elective Repeat Cesarean Delivery at Term: A Comment on Patient Choice Cesarean Delivery*, 192 AM. J. OBSTETRICS & GYNECOLOGY 1433 (2005) (finding that babies born by elective repeat C-section are more frequently admitted to advance care nurseries, most often with respiratory problems, than those born to women who deliver by C-section after a trial of labor, though the babies born by elective C-section have higher Apgar scores. An Apgar score is a simple, commonly used method to rank newborn health.).

24. Roni Rabin, *Breast-Feed or Else*, N.Y. TIMES, June 13, 2006, at F1 (reporting that breast feeding provides significant benefits to infants, though some women are not able to do it for physical or social reasons).

25. 2006 NIH, C-SECTIONS ON MATERNAL REQUEST, *supra* note 1, at 6.

26. Darios Getahun, Yinka Oyelese, Hamisu M. Salihu, & Cande V. Ananth, *Previous Cesarean Delivery and Risks of Placenta Previa and Placental Abruption*, 107 OBSTETRICS & GYNECOLOGY 771, 774–75 (2006); Melissa Gilliam, Deborah Rosenberg, & Faith Davis, *The Likelihood of Placenta Previa with Greater Number of Cesarean Deliveries and Higher Parity*, 99 OBSTETRICS & GYNECOLOGY 976, 976 (2002).

27. *See infra* notes 71–88 and accompanying text.

28. *See, e.g.*, I. Yoles & S. Maschiach, *Increased Maternal Mortality in Cesarean Section as Compared to Vaginal Delivery? Time for Re-evaluation*, 178 AM. J. OBSTETRICS & GYNECOLOGY S78, S78 (1998) (asserting that women attempting vaginal birth may suddenly be subjected to an emergency C-section—which has a much higher maternal mortality rate than elective C-section or vaginal birth delivery—whereas elective C-section delivery has no higher maternal mortality rate than vaginal delivery); R. J. Lilford, H. A. Van Coeverden de Groot, P.J. Moore, & P. Bingham, *The Relative Risks of Caesarean Section (intrapartum and elective) and Vaginal Delivery: A Detailed Analysis to Exclude the Effects of Medical Disorders and Other Acute Pre-existing Physiological Disturbances*, 97 BR. J. OBSTETRICS & GYNAECOLOGY 883, 890 (1990) (stating that "[o]verall, 'emergency' caesarean sections were found to have a three-fold increased mortality over elective sections. If only direct deaths were included, then the mortality rate of emergency operations was six times that of elective surgery"); 2006 NIH, C-SECTIONS ON MATERNAL REQUEST, *supra* note 1 at 8.

an emergency C-section. Women who are older, diabetic, or who have had a prior C-section or other medical conditions, are more likely to encounter problems in labor and require an emergency C-section.[29] A woman who is more likely to need a C-section after trial of labor has greater reason to schedule a C-section than those who are more likely to have a successful vaginal delivery.

Second, "[a]n attempted vaginal birth involves a small fetal risk of death or serious morbidity that is almost completely avoided with Cesarean delivery."[30] Reliable data on the magnitude of the risk of death or serious morbidity that vaginal delivery poses to the fetus is virtually non-existent. Trial lawyers promote the view that many birth injuries are caused by negligence in the delivery process.[31] By contrast, gynecologists promote the view that serious fetal injury or death is never, or almost never, caused by the birth process, but rather results from genetics or factors that pre-dated labor.[32]

Doctors commonly attempt to determine the conditions under which additional C-sections will prevent harm to a single fetus.[33] The medical literature balances the small but serious risks to the fetus against the number of C-sections needed to avoid it.[34] Pregnant women may balance these risks differently. A woman who is older or has had difficulty in conceiving may be less willing to accept even a very small risk of serious or fatal injury to the fetus.[35] C-sections are, in fact, more common among older women.[36]

Third, vaginal delivery may increase the risk that women will experience incontinence, as a result of damage to the pelvic floor, although the increased risk

---

29. *See supra* notes 10, 13 and accompanying text.

30. Susan P. Walker, Elizabeth A. McCarthy, Antony Ugoni, Anna Lee, Sharon Lim, & Michael Permezel, *Cesarean Delivery or Vaginal Birth: A Survey of Patient and Clinician Thresholds*, 109 OBSTETRICS & GYNECOLOGY 67, 68 (2007).

31. *See generally* BARRY WERTH, DAMAGES (1988).

32. *See, e.g.* Alastair MacLennan, Karin B. Nelson, Gary Hankins, & Michael Speer, *Who Will Deliver Our Grandchildren?: Implications of Cerebral Palsy Litigation*, 294 J. AM. MED. ASS'N. 1688, 1688 (2005) (arguing that cerebral palsy is not caused by the vaginal birth process: "[L]ack of oxygen causes only a small proportion of CP [cerebral palsy] cases, and despite serious efforts, CP due to birth asphyxia has not been shown to be preventable.").

33. *See, e.g.*, Howard L. Minkoff & Richard Berkowitz, *The Myth of the Precious Baby*, 106 OBSTETRICS & GYNECOLOGY 607, 608 (2005).

34. *See, e.g., id.*

35. Minkoff and Berkowitz argue that while every baby is precious, there is growing use of the term "precious" to describe pregnancies achieved late in life or using assisted reproductive technologies. *Id.* at 607. "[T]he mother of the precious child is disadvantaged by the need to consider risks that are so low they are assumed by the provider to be of no interest to mothers of other children." *Id.* at 609. The core point of the article is that doctors should not make assumptions about women's attitudes toward C-sections and the small risks of serious fetal injury. *See generally id.*

36. *See, e.g.*, Herng-Ching Lin & Sudha Xirasagar, *Maternal Age and the Likelihood of a Maternal Request for Cesarean Delivery: A 5-Year Population-Based Study*, 192 AM. J. OBSTETRICS & GYNECOLOGY 848, 848 (2005) (reporting that requests in Taiwan for Cesarean deliveries increase steadily with age).

may only be slight.[37] Finally, vaginal birth may be less important to women who believe that they are unlikely to have more children. A woman who hopes to have many children has a stronger interest in avoiding a C-section because subsequent vaginal birth is made more difficult and multiple C-sections expose the woman to many dangers.[38]

This description of medical facts does not entirely capture the choices confronting pregnant women. Childbirth is not simply or primarily a medical event. Childbirth is a deeply spiritual experience, connecting families and communities. Some women attach high value to vaginal child birth.[39] Many women do not want this central life experience to be defined and controlled as a medical event. Other women see a planned C-section as preferable.[40] Some of these women, who manage complex obligations to work and family, seek to avoid the uncertainties of the timing of vaginal delivery.[41]

---

37. Guri Rortveit, Anne Kjersti, Yngvild S. Hannestad, & Steinar Hunskaar, *Urinary Incontinence after Vaginal Delivery or Cesarean Section*, 348 NEW ENG. J. MED. 900, 907 (2003) (finding that women who have delivered vaginally have higher rates of urinary incontinence than women who have delivered through C-section and that both types of women have higher rates of urinary incontinence than women without any birth experience); Scott A. Farrell, Victoria M. Allen, & Thomas F. Baskett, *Parturition and Urinary Incontinence in Primiparas*, 97 OBSTETRICS & GYNOCOLOGY 350 (2001) (finding that vaginal deliveries are associated with higher rates of urinary incontinence than Cesarean deliveries). *But see* Gunhilde M. Buchsbaum, Erin E. Duecy, Lindsey A. Kerr, Li-Shan Huang & David S. Guzick, *Urinary Incontinence in Nulliparous Women and Their Parous Sisters*, 106 OBSTETRICS & GYNECOLOGY 1253 (2005) (finding no significant difference in prevalence or severity of incontinence between pairs of postmenopausal sisters, one of whom had had at least one vaginal delivery, and one of whom had not borne a child, and suggesting that research on female incontinence be focused on causes other than birth, such as familial factors).

38. Victoria Nisenblat, Shlomi Barak, Ofra Barnett Griness, Simon Degani, Gonen Ohel, & Ron Gonen, *Maternal Complications Associated With Multiple Cesarean Deliveries*, 108 OBSTETRICS & GYNECOLOGY 21 (2006) (finding that multiple C-sections are associated with more difficult surgery and increased blood loss and that the risk of major complications increases with each C-section); David D. Mankuta, Moshe M. Leshno, Moshe M. Menasche, & Mayer M. Brezis, *Vaginal Birth After Cesarean Section: Trial of Labor or Repeat Cesarean Section? A Decision Analysis*, 189 AM. J. OBSTETRICS & GYNECOLOGY 714, 718–19 (2003) (concluding that the decision for trial of labor or Cesarean section is optimally determined by the wish for future pregnancies).

39. *See, e.g.*, EUGENE R. DECLERCQ, CAROL SAKALA, MAUREEN P. CORRY, SANDRA APPLEBAUM, & PETER RISHER, EPORT OF THE FIRST NATIONAL U.S. SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES 7 (2002) [hereinafter LISTENING TO MOTHERS] (reporting that 83% of new mothers preferred vaginal birth to Cesarean for future births).

40. *See, e.g.*, Lucy Danziger, *Parent and Child: Natural Birth vs. On-Time Delivery,* N.Y. TIMES, Aug. 3, 1995, at C1. After a first birth through C-section following 14 hours of labor, Danziger elected to schedule a C-section for the birth of her second child in 1995. Her primary concern was for the health of the baby, but she also remarked that a scheduled birth helped her to meet responsibilities for her two year old. She noted, "In the eyes of doctors, hospitals, insurance companies and even other mothers, I'm considered part of a national problem." *Id.*

41. For example, some women schedule C-sections so that fathers can be present prior to military deployment. *See, e.g.*, Susan Ruttan, *Demand for Elective C-sections Increasing: 22.5 per cent of Canadian Births. Doctors Have Become Less Skilled in Handling Complicated Deliveries, Obstetrics Group Says*, THE GAZETTE (MONTREAL, QUEBEC), July 2, 2004, at A14; Gilbert, *supra* note 7 at F7. Others schedule C-sections because of the demands of work or business ownership. *See, e.g.*, Harvey, *supra* note 22 at E02. Yet others schedule birth to facilitate planning for the care

In 2003, after the American College of Obstetricians and Gynecologists released a statement asserting that it is sometimes medically and ethically responsible to perform C-sections, without medical indication, in response to a pregnant woman's request, elective C-sections became professionally responsible.[42] In the same year, the prestigious *New England Journal of Medicine* published an analysis of the ethics of elective C-sections, acknowledging that they are sometimes medically and ethically permissible.[43] In 2004, *Obstetrics & Gynecology*, the journal of the American College of Obstetricians and Gynecologists, published a similar article.[44] In 2006, the NIH Consensus statement agreed.[45] Despite the professional consensus that maternal choice C-sections are sometimes medically and ethically responsible, surveys show a wide range of attitudes among practicing physicians toward performing C-sections without medical indication.[46]

Are women actually choosing to have elective C-sections? Again, the evidence is unclear. HealthGrades Inc., a private corporation that gathers and disseminates health care information, reports that the proportion of women who had a pre-planned, first-time C-section rose from 1.87% in 2001 to 2.55% in 2003.[47]

---

of existing children. *See, e.g.*, Stacy Lu, *Not-So-Special Delivery: State Leads in C-sections*, N.Y. TIMES, Feb. 20, 2005, at Section 14NJ, Page 1. *But cf.* Sora Song, *Too Posh to Push?: As More Pregnant Women Schedule C-sections, Doctors Warn That the Procedure is Not Risk-Free*, TIME, Apr. 19, 2004, at 58 (describing women who seek scheduled C-sections for seemingly trivial reasons).

42. SURGERY AND PATIENT CHOICE, OP. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS NO. 289 (2003) [hereinafter 2003 ACOG Opinion].

43. Minkoff & Chervenak, *supra* note 7.

44. *See* Howard Minkoff, Kathleen R. Powderly, Frank Chervenak, & Lawrence B. McCullough, *Ethical Dimensions of Elective Primary Cesarean Delivery*, 103 OBSTETRICS & GYNECOLOGY 387, 390–91 (2004).

45. 2006 NIH, C-SECTIONS ON MATERNAL REQUEST, *supra* note 1, at 14.

46. *Compare* Chiara Ghetti, Benjamin K. S. Chan, & Jeanne-Marie Guise, *Physicians' Responses to Patient-Requested Cesarean Delivery*, 60 OBSTETRICAL & GYNECOLOGICAL SURVEY 348, 348–49 (2005) (reporting that most obstetricians surveyed in Portland, Oregon in 2000 would not perform a C-section without clear medical indication), *with* Kimberly Kenton, Cynthia Brincat, Martina Mutone, & Linda Brubaker, *Repeat Cesarean Section and Primary Elective Cesarean Section: Recently Trained Obstetrician-Gynecologist Practice Patterns and Opinions*, 192 AM. J. OBSTETRICS & GYNECOLOGY 1872, 1872 (2005) (reporting that 59% of recently trained Ob-Gyns would perform a primary elective C-section); Christina S. Cotzias, Sara Paterson-Brown, & Nicholas M. Fisk, *Obstetricians Say Yes to Maternal Request for Elective Cesarean Section: A Survey of Current Opinion*, 97 EUR. J. OBSTETRICS & GYNOCOLOGY & REPROD. BIOLOGY 15, 15 (2001) (reporting that almost 70% of consultants surveyed in England and Wales would agree to a maternal request for Cesarean in uncomplicated pregnancy). *See also* Raghad Al-Mufti, Andrew McCarthy, & Nicholas M. Fisk, *Survey of Obstetricians' Personal Preference and Discretionary Practice*, 73 EUR. J. OBSTETRICS & GYNECOLOGY & REPROD. BIOLOGY 1, 2 (1997) (reporting that 31% of female obstetricians surveyed in London would prefer a primary elective C-section for themselves).

47. HEALTHGRADES, *supra* note 11, at 4. *See also* Barbara A. Bettes, Victoria H. Coleman, Stanley Zinberg, Catherine Y. Spong, Barry Portnoy, Emily DeVoto, & Jay Schulkin, *Cesarean Delivery on Maternal Request*, 109 OBSTETRICS & GYNECOLOGY 57, 61 (2007) (reporting that 58% of obstetricians surveyed observed an increase in inquiries regarding elective C-section in the past year).

The researchers acquired hospital discharge data about women who delivered babies in 1,500 hospitals in seventeen states.[48] They identified women who had a C-section for a first birth, with no labor prior to delivery. They then excluded women who had one of twelve clinical indications for a medically necessary C-section.[49] This methodology is not strong: it may understate the number of planned, elective C-sections. For insurance purposes, women and doctors have an incentive to provide a diagnosis that indicates medical need.[50] Therefore, some of the women having C-sections defined as "medically necessary" might actually have been patient choice C-sections.

The number of women requesting elective C-sections may also be overstated. Childbirth Connection,[51] a respected evidence-based research organization, sponsors surveys of pregnant women called Listening to Mothers. One of these surveys found that only one out of 1300 women surveyed (0.08%) requested an elective, primary C-section.[52] Almost 10% of the women surveyed reported "feeling pressured from a health professional to have a cesarean delivery. . . ."[53] Thus, it is possible that some of the scheduled C-sections identified by HealthGrades as "Patient-Choice" were the result of pressure by physicians. The HealthGrades methodology is not designed to tease out whether a scheduled C-section was sought by the woman, by the doctor, or by both.

II.
EXPLANATION OF AND FACTORS CONTRIBUTING TO UNNECESSARY AND UNWANTED C-SECTIONS

For decades the high rates of C-sections within the United States have been perceived as problematic.[54] Between 1965 and 1985, the rate of C-sections increased five fold, from 1 in 20 to 1 in 4 deliveries.[55] Between 1990 and 1996 the rate decreased slightly, but since 1996 has again continued to rise.[56] As with many medical procedures, C-section rates in the United States vary substantially among geographical regions, hospitals and individual doctors, without corre-

48. HEALTHGRADES, *supra* note 11, at 3.

49. *Id.*

50. *Infra* Part IV.

51. *See supra* note 19.

52. Press Release, Childbirth Connection, New National Survey Results from Mothers Refute Belief that Women are Requesting Cesarean Sections Without Medical Reason 1 (Mar. 20, 2006), *available at* http://childbirthconnection.com/pdfs/LTMIIpressrelease.pdf.

53. *Id.*

54. *See, e.g.*, FAY MENACKER, CTRS. FOR DISEASE CONTROL & PREVENTION, NAT'L VITAL STATS. REPORTS VOL. 54, TRENDS IN CESAREAN RATES FOR FIRST BIRTHS AND REPEAT CESAREAN RATES FOR LOW-RISK WOMEN: UNITED STATES, 1990–2003, 2005), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_04.pdf.

55. Kimberly D. Gregory, Sally C. Curtin, Selma M. Taffel, & Francis C. Notzon, *Changes in Indications for Cesarean Delivery: United States, 1985 and 1994*, 88 AM. J. PUB. HEALTH 1384, 1384 (1998).

56. MENACKER, *supra* note 54, at 1.

sponding variations in either demographic characteristics or health outcomes.[57]

C-sections are recommended by physicians in four common situations. Dystocia, or "failure to progress," is the leading indication for a C-section, accounting for 35% of all C-sections in 1985 and 40% in 1994.[58] Repeat Cesarean section was the second most frequent indication, though the percentage of C-sections attributable to this indication declined from 28% in 1985 to 21% in 1994.[59] Cesarean sections attributable to breech presentation, the third most frequent indication, increased slightly from 11% to 13% between 1985 and 1994.[60] The remaining C-sections were attributable to other indications, most commonly fetal distress.[61]

This section considers the evidence, and suggests that some C-sections are unnecessary and unwanted. Some unnecessary C-sections take place because women are not given the supportive help they need to labor effectively.[62] Medical care is organized to deny some women the opportunity to attempt a vaginal birth after a prior C-section, or to attempt to change the breech position of the fetus.[63] Finally, pervasive, coerced use of unreliable electronic fetal monitoring technology can falsely identify problems of fetal distress.[64]

Failure to progress. Failure to progress, or dystocia, the most common indication for C-section, covers a broad range of problems that prolong labor. The diagnosis of dystocia increased from 7.2% of all deliveries in 1980 to 11.6% in 1989.[65] The rates of C-section attributable to failure to progress vary enormously from hospital to hospital.[66] In the 1970s and 1980s, many obstetrical programs intentionally and substantially reduced C-section rates without compromising maternal or infant health, and, in some programs, improving newborn

57. *See* Katharine Baicker, Kasey S. Buckles, & Amitabh Chandra, *Geographic Variation in the Appropriate Use of Cesarean Delivery,* 25 HEALTH AFFS. w355, w363 (2006) (reporting that significant geographic variation in the use of Cesarean delivery is not fully explained by demographic factors). *See also* GABAY & WOLFE, *supra* note 2, at 91, 93–103 (demonstrating wide variations in C-section use by geography and hospital); John E. Wennberg, *Practice Variations and Health Care Reform: Connecting the Dots,* 10 HEALTH AFFS. var140 (2004) (explaining that the phenomena of unexplained area variations is common in medicine and widely thought to be troubling).

58. Gregory, *supra* note 55, at 1385. *But see* U.S. DEP'T. OF HEALTH AND HUMAN SERVICES, RATES OF CESAREAN DELIVERY—UNITED STATES, 1991, 42 MORBIDITY AND MORTALITY WEEKLY REPORT 285, 285–89 (1993), *available at* http://www.cdc.gov/mmwR/preview/mmwrhtml/00036845.htm (stating that repeat Cesarean delivery was the leading indication for C-sections in 1991 accounting for 35% of C-sections, with dystocia—the second leading indication accounting for 30% of C-sections).

59. Gregory, *supra* note 55, at 1385.

60. *Id.*

61. *Id.*

62. *Infra* text accompanying notes 67–8.

63. *Infra* text accompanying notes 78–86, 92–98.

64. *Infra* text accompanying notes 99–117.

65. GABAY & WOLFE, *supra* note 2, at 36.

66. *Id.*

outcomes.[67] Providing trained labor companions throughout labor helps labor go more quickly, reduces C-sections, and produces healthier babies.[68] Midwives have particularly low C-section rates, achieved by providing information about the benefits of vaginal delivery and supportive services throughout labor.[69] Midwives' admirable record may however be misleading in that they typically decline to provide care to high-risk women.[70] The ability to reduce C-section rates with supportive services suggests that some C-sections may be unnecessary.

VBACs (Vaginal Birth After C-section). Prior to the 1980s, the conventional medical wisdom was that a woman who had a C-section could not give birth vaginally in a subsequent pregnancy. In the 1980s, as surgical techniques for C-sections improved and made the operation less invasive and the medical community became determined to stem the skyrocketing national rates of C-sections, the consensus of medical opinion determined that some women who had previous C-sections should be allowed to try vaginal labor, or VBAC, if they wanted to do so.[71] Between 1990 and 1996, the proportion of women who gave birth vaginally after a prior Cesarean section increased from 21.3% to 28.3%.[72]

Between 60 to 82% of women who try vaginal birth after a C-section are

---

67. *See id.* at 60–75; Luis Sanchez-Ramos, Andrew M. Kaunitz, Herbert B. Peterson, Beverly Martinez-Schnell, & Robert J. Thompson, *Reducing Cesarean Sections at a Teaching Hospital,* 163 AMER. J. OBSTETRICS & GYNECOLOGY 1081, 1081–82 (1990) (reporting that a university medical center, with high-risk indigent patient population, decreased C-section rates from 28% in 1986 to 11% in 1988; newborn complications remained steady, but deaths decreased); Michael L. Socol, Patricia M. Garcia, Alan M. Peaceman, & Sharon L. Dooley, *Reducing Cesarean Births at a Primarily Private University Hospital,* 168 AMER. J. OBSTETRICS & GYNECOLOGY 1748, 1748, 1752 (1993) (reporting that, in response to initiatives targeting rising C-section rates, C-section rates at Northwestern Memorial Hospital dropped from 27.3% to 16.9%, with perinatal mortality dropping from 19.5% to 10.3%); Stephen A. Myers & Norbert Gleicher, *A Successful Program to Lower Cesarean-Section Rates,* 319 NEW ENG. J. MED. 1511, 1511 (1988) (reporting that a medical center lowered its C-section rates from 17.5% to 11.5% in two years and concluding that such a reduction did not have substantial adverse consequences on mother or infant).

68. *See* John Kennell, Marshall Klaus, Susan McGrath, Steven Robertson, & Clark Hinkley, *Continuous Emotional Support During Labor in a U.S. Hospital,* 265 J. AM. MED. ASS'N 2197, 2197 (1991); GABAY & WOLFE, *supra* note 2, at 64.

69. Jane Butler, Barbara Abrams, Jennifer Parker, James M. Roberts, & Russell K. Laros, Jr., *Supportive Nurse-Midwife Care Is Associated with a Reduced Incidence of Cesarean Section,* 168 AM. J. OBSTETRICS & GYNECOLOGY 1407, 1409–10 (1993) (finding that midwives engaged in traditional midwifery practice have average C-section rates of less than 10%, with maternal and fetal outcomes the same or better than most hospitals and physicians).

70. Emily M. Bernstein, *Law Lets Midwives Supervise Only Low-Risk Cases,* N.Y. TIMES, Mar. 6, 1995, at B5. The Medical Board of California, for example, limits midwives' practices to the care of "normal childbirth." Medical Board of California, Licensed Midwives, http://www.mbc.ca.gov/allied/midwives.html (last visited Mar. 5, 2008).

71. *See, e.g.*, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, CESAREAN CHILDBIRTH, NIH PUBLICATION NO. 82-2067 11–12 (1981), Michael F. Greene, *Vaginal Delivery After Caesarean Section—Is the Risk Acceptable?*, 345 NEW ENG. J. MED. 54 (2001).

72. MENACKER, *supra* note 4, at 1. *See also* CESAREAN RATES, *supra* note 5, at 46 (stating that the rate of VBAC increased during 1989–1996).

successful, while the others have unscheduled repeat C-sections.[73] As noted previously, emergency C-sections are more dangerous to women than either planned C-sections or vaginal birth.[74] However, doctors have useful indicators to help them predict which women are likely to be able to deliver successfully.[75] An important factor in deciding whether to attempt a VBAC or to schedule a C-section is whether or not the woman desires to have additional children.[76] The risks to the woman grow exponentially with each subsequent C-section after the first or second one.[77]

Despite the safety and success of VBAC, the VBAC rate fell from 28.3% in 1996 to 10.6% in 2003.[78] The availability of VBAC varies widely from doctor to doctor.[79] By 2004, hundreds of hospitals refused to allow women to attempt vaginal birth after Cesarean section.[80] When VBAC is commonly denied, many women who would prefer vaginal birth are denied that choice.

Two events were critical to this shift. First, in 1999 the American Association of Obstetricians and Gynecologists (ACOG) adopted a standard emphasizing the need for those institutions offering VBAC to have the facilities and personnel, including obstetric, anesthesia, and nursing personnel *immediately* available to perform emergency Cesarean delivery when conducting a trial of labor for women with a prior uterine scar.[81] The practical effect of the standard

---

73. 2003 HHS TECHNICAL REPORT, *supra* note 13, at 2; Neal Clemenson, *Promoting Vaginal Birth After Cesarean Section,* 47 AM. FAMILY PHYSICIAN 139, 139 (1993) (noting a 74% success rate).

74. *Supra* note 28.

75. *Supra* note 13 and accompanying text. *See also* William A Grobman, Yinglei Lai, Mark B. Landon, Catherine Y. Spong, Kenneth J. Leveno, Dwight J. Rouse, Michael W. Varner, Atef H. Moawad, Steve N. Caritis, Margaret Harper, Ronald J. Wapner, Yoram Sorokin, Menachem Miodovnik, Marshall Carpenter, Mary J. O'Sullivan, Baha M. Sibai, Oded Langer, John M. Thorp, Susan M. Ramin & Brian M. Mercer, *Development of a Nomogram for Prediction of Vaginal Birth After Cesarean Delivery*, 109 OBSTETRICS & GYNECOLOGY 806 (2007) (patient-specific prediction of the chance of successful deliver can be made at the first prenatal visit). *But see*, Sindhu K. Srinivas, David M. Stamilio, Erika J. Stevens, Anthony O. Odibo, Jeffrey F. Peipert & George A. Macones, *Predicting Failure of a Vaginal Birth Attempt After Cesarean Delivery*, 109 OBSTETRICS & GYNECOLOGY 800 (2007) (reliable prediction not possible).

76. *Supra* note 26 and accompanying text.

77. *Supra* note 37 and accompanying text.

78. Denise Grady, *Trying to Avoid 2nd Caesarean, Many Find Choice Isn't Theirs,* N.Y. TIMES, Nov. 29, 2004 at A1.

79. Socol, *supra* note 67, at 1748.

80. *See, e.g.*, Grady, *supra* note 78, at A18 (reporting that half the hospitals in Vermont and New Hampshire have stopped allowing women who have had C-sections to attempt vaginal delivery); LISTENING TO MOTHERS, *supra* note 39, at 2 (finding that the willingness of care-givers and hospitals to permit vaginal birth after a previous Cesarean birth declined substantially from 1999 to 2001). *See also* EUGENE R. DECLERCQ, CAROL SAKALA, MAUREEN P. CORRY, & SANDRA APPLEBAUM, LISTENING TO MOTHERS II: REPORT OF THE SECOND NATIONAL U.S. SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES, EXECUTIVE SUMMARY 4 (2006) (finding that only 11% of its respondents had a VBAC "though quite a few would have liked to have had the choice but had providers or hospitals unwilling to support their vaginal births").

81. *Vaginal Birth After Previous Cesarean Delivery,* 5 ACOG PRACTICE BULLETIN 1, 5 (1999). By contrast, the Canadian Task Force on the Periodic Health Exam recommends that

is to confine VBAC to university and tertiary-level medical centers staffed round the clock by surgeons, anesthesiologists, and surgical teams.[82]

Second, in 2001, the prestigious *New England Journal of Medicine* (NEJM) published a lead article discussing the dangers of uterine rupture in pregnancies following a C-section.[83] The study focused on the years 1987 to 1996, prior to ACOG's more cautious guidance on VBACs. The editors of the NEJM also published a strongly worded commentary by Dr. Michael Greene urging doctors to do elective repeat C-sections rather than attempting VBAC.[84] The press picked up the NEJM story and commentary.[85] Critics of the *New England Journal* article pointed out that the study offered no new data and that the editorial comment was inflammatory: "Misinterpretation of study findings leading to diminished options for women seeking VBAC is not in the best interests of mothers and babies."[86]

When a hospital or doctor insists that any woman who has had a previous C-section must have another, without attempting vaginal birth, choice is denied. Most recent literature shows that while both VBAC and C-sections are very safe, VBAC is marginally more dangerous to women and infants than planned C-section after prior C-sections.[87] But, as noted above, safety and risk depend on

---

VBAC should be offered only in a hospital "where a timely Caesarean section is available." Marie-Jocelyne Martel & Catherine Jane MacKinnon, *Guidelines for Vaginal Birth After Previous Caesarean Birth,* 155 SOGC CLINICAL PRACTICE GUIDELINES 164, 167 (2005).

82. Michael J. Myers, *ACOG's Vaginal Birth After Cesarean Standard: A Market Restraint Without a Remedy?*, 49 S.D. L. REV. 526, 528 (2004). *See also* MARSDEN WAGNER, INTERNATIONAL CESAREAN AWARENESS NETWORK, WHITE PAPERS, CRITIQUE OF ACOG PRACTICE BULLETIN #5, JULY 1999, "VAGINAL BIRTH AFTER PREVIOUS CESAREAN SECTION" 5 (2002), *available at* http://ican-online.net/resources/white_papers/wp_acog.pdf (finding that ACOG's policy, if followed, "drastically reduces or eliminates several options available to women with previous Cesarean section, including having their birth at home or in a freestanding birth center or in a small community hospital").

83. Mona Lydon-Rochelle, Victoria L. Holt, Thomas R. Easterling, & Diane P. Martin, *Risk of Uterine Rupture During Labor Among Women with a Prior Cesarean Delivery*, 345 NEW ENG. J. MED. 3 (2001).

84. Greene, *supra* note 71.

85. *See, e.g.*, Sheryl Gay Stolberg, *A Risk is Found in Natural Birth after Cesarean,* N.Y. TIMES, July 5, 2001, at A1; Rita Rubin, *Vaginal Births after C-Section Risk Uterine Damage,* USA TODAY, July 5, 2001, at D9.

86. Bruce L. Flamm, *Vaginal Birth after Cesarean and the* New England Journal of Medicine*: A Strange Controversy,* 28 BIRTH 276, 279 (2001).

87. *See, e.g.*, Mark B. Landon, John C. Hauth, Kenneth J. Leveno, Catherine Y. Spong, Sharon Leindecker, Michael W. Varner, Atef H. Moawad, Steve N. Caritis, Margaret Harper, Ronald J. Wapner, Yoram Sorokin, Menachem Miodovnik, Marshall Carpenter, Alan M. Peaceman, Mary Jo O'Sullivan, Baha Sibai, Oded Langer, John M. Thorp, Susan M. Ramin, Brian M. Mercer, & Steven G. Gabbe, *Maternal and Perinatal Outcomes Associated with a Trial of Labor after Prior Cesarean Delivery,* 351 NEW ENG. J. MED. 2581, 2581 (2004) (reporting that although absolute risks are low, VBAC is connected with greater perinatal risk than elective, repeated C-section); Gordon C. S. Smith, Jill P. Pell, Alan D. Cameron, & Richard Dobbie, *Risk of Perinatal Death Associated with Labor after Previous Cesarean Delivery in Uncomplicated Term Pregnancies,* 287 J. OF AM. MED. ASS'N 2684, 2684 (2002) (finding that, though the overall risk of a trial of labor following a previous C-section is low, the risk relative to planned repeat Cesarean delivery is

particular circumstances. Commenting on the risks, Dr. Michael F. Greene observed, "Some people will consider the estimated 588 Cesarean deliveries [out of a population of 33,000] needed to prevent a severe adverse perinatal outcome to be a reasonable number, whereas others will consider the perinatal risks associated with a trial of labor small and well worth taking for the benefit of a vaginal delivery. Ultimately, risk, like beauty, is in the eye of the beholder."[88]

In short, women who have had C-sections are commonly denied the freedom to choose vaginal delivery for subsequent births, even though the medical evidence suggests that the choice is complex, but reasonable. This denial of choice may fall most harshly on women who live in areas remote from tertiary hospitals and those who want large families. In theory, a woman who strongly desires a vaginal birth after a C-section can travel to an urban center and give birth at a tertiary care hospital. However, it is difficult to predict when natural labor will begin and an extended stay in a distant city is costly in both financial and human terms.

Breech presentation. The third most common indication for a C-section is breech presentation, in which the fetus is in the uterus with the buttocks or feet down, as opposed to the more common head-first position. Breech presentation accounts for 11–15% of all C-sections.[89] After 37 weeks of pregnancy and before birth, a trained professional can manually turn a fetus in breech presentation to the head-first position in about 65% of attempts.[90] When the fetus is successfully moved, vaginal delivery is successful in 85% of the cases.[91] This procedure—external cephalic version—is often not offered in the United States,[92]

---

significantly higher). *But see* Ron Gonen, Victoria Nisenblat, Shlomi Barak, Ada Tamir, & Gonen Ohel, *Results of a Well-Defined Protocol for a Trial of Labor After Prior Cesarean Delivery,* 107 OBSTETRICS & GYNECOLOGY 240, 240 (2006) (reporting that a program that encouraged trial of labor between 2000 and 2005 found that VBAC is as safe for mother and infant as C-section).

88. Michael F. Greene, *Vaginal Delivery after Cesarean Revisited*, 351 NEW ENG. J. MED. 2647, 2648 (2004) (reporting that a large, recent study shows that elective repeated Cesarean delivery is associated with less perinatal risk than trial of labor).

89. *See, e.g.*, Gregory, Curtin, Taffel, & Notzon, *supra* note 55, at 1385; GABAY & WOLFE, *supra* note 2, at 39; E. Kathleen Adams, Patrick D. Mauldin, Jill G. Mauldin, & Robert M. Mayberry, *Determining Cost Savings From Attempted Cephalic Version in an Inner City Delivering Population,* 3 HEALTH CARE MGMT. SCI. 185, 185 (2000).

90. GABAY & WOLFE, *supra* note 2, at 40 (summarizing the literature). *See also* Adams, *supra* note 89, at 187 (finding the version successful in 44% of attempts).

91. GABAY & WOLFE, *supra* note 2, at 40.

92. *Id. Cf.* S. Caukwell, L. A. Joels, P. M. Kyle, & M. S. Mills, *Women's Attitudes Towards Management of Breech Presentation at Term,* 22 J. OBSTETRICS & GYNAECOLOGY 486, 486 (2002) (reporting that at a hospital in the United Kingdom one third of women potentially suitable for attempted external cephalic version were not told of the option). *But see* Justin P. Lavin, Jennifer Eaton, & Michael Hopkins, *Teaching Vaginal Breech Delivery and External Cephalic Version: A Survey of Faculty Attitudes*, 45 J. REPROD. MED. 808, 808 (2000) (finding that, though support for teaching vaginal breach delivery remains high, there are not sufficient numbers of vaginal breech deliveries to teach this procedure with a "hands on" approach; only 65% of Obstetricians and Gynecologists surveyed were trained in ECV procedure).

even though it is safe and effective.[93] When the procedure is not offered, women who would prefer a vaginal delivery are denied choice.

In 2000, the influential British medical journal, The Lancet, published the results of the Term Breech Trial collaboration.[94] It was a worldwide study. Two thousand eighty-eight women at 121 centers in twenty-six countries, with breech presentation at term, were randomly assigned to be delivered by planned C-section or attempted vaginal birth. The researchers confined the trial to centers that had clinicians experienced in vaginal breech delivery since they "wished to give the option of vaginal breech delivery its best, and perhaps last, chance to be proven a reasonable method of delivery."[95] The study found that planned Cesarean section was better than planned vaginal birth for the term fetus in the breech presentation; serious maternal complications were similar between the two groups.[96] In the Netherlands, for example, within two months after publication of the Term Breech Trial, the overall Cesarean rate for fetuses in the breech position increased from 50% to 80%.[97] In the United States, where the rates of C-sections for fetuses in the breech position was already 84.5% in 1999, the rate grew to 87% by 2003.[98] It is uncertain to what extent those C-sections were chosen by both women and their physicians.

Fetal distress. Between 1980 and 1992, the reported incidence of fetal distress rose from 1.2% to 9.4% of all deliveries.[99] Between 1970 and 2000 the rate of C-sections, resulting in part from fetal distress, increased five-fold. The increase in fetal distress C-sections is a direct result of electronic fetal monitoring (EFM).[100] However, the use of EFM and the attendant increase in C-sections has not reduced the incidence of cerebral palsy, which some believed doctors could prevent through improved fetal monitoring.[101] In fact, EFM has not been

93. Caukwell, *supra* note 91, at 486; GABAY & WOLFE, *supra* note 2, at 40.

94. Mary E. Hannah, Walter J. Hannah, Sheila A. Hewson, Ellen D. Hodnett, Saroj Saigal, & Andrew R. Willan, *Planned Caesarean Section Versus Planned Vaginal Birth for Breech Presentation at Term: A Randomised Multicentre Trial*, 556 THE LANCET 1375 (2000).

95. *Id.* at 1381.

96. *Id.* at 1381–1382.

97. Christine C. T. Rietberg, & Gerard H. A. Visser, *Correspondence: The Effect of the Term Breech Trial on Medical Intervention Behaviour and Neonatal Outcome in The Netherlands: An Analysis of 35,453 Breech Infants,* 112 BR. J. OBSTETRICS & GYNAECOLOGY 1163 (2005).

98. MENACKER & CURTIN, *supra* note 4, at 13; JOYCE A. MARTIN, BRADY E. HAMILTON, PAUL D. SUTTON, STEPHANIE J. VENTURA, FAY MENACKER, & MARTHA L. MUNSON, CTRS. FOR DISEASE CONTROL & PREVENTION, NAT'L VITAL STATS. REPORTS, VOL. 54, BIRTHS: FINAL DATA FOR 2003 16 (2005), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_02.pdf.

99. GABAY & WOLFE, *supra* note 2, at 41.

100. *See, e.g.*, Margaret Lent, *The Medical and Legal Risks of Electronic Fetal Monitor*, 51 STAN. L. Rev. 807, 816–17 (1999); GABAY & WOLFE, *supra* note 2, at 43. The EFM monitors fetal heart rate and uterine contractions either externally with a belt around the woman's abdomen or internally by inserting an electrode into the baby's scalp after the woman's water has broken. GABAY & WOLFE, *supra* note 2, at 42. Both forms of EFM impede a woman's mobility and ability to labor comfortably and effectively. Lent, *supra*, at 817.

101. Steven L. Clark & Gary D.V. Hankins, *Temporal and Demographic Trends in Cerebral Palsy—Fact and Fiction,* 188 AM. J. OBSTETRICS & GYNECOLOGY 628, 628 (2003).

proven to improve delivery outcomes or to prevent neurological disorders.[102]

EFM technology was developed in the 1950s, defused rapidly in the 1970s, and was required in most deliveries by 1975.[103] In 1976, 278 of 279 obstetrical residency programs required use of EFM.[104] In the 2002, a survey found that 93% of women who gave birth in hospitals were required to use electronic fetal monitors.[105]

Fetal monitors are required even though their efficacy has never been proven.[106] One article recently explained that although "[t]welve randomized controlled trials have evaluated the efficacy of EFM. . . . [n]one of the trials showed that EFM decreases the rates of stillbirth, neonatal death, or neonatal intensive care admissions" and only one trial showed a substantial decrease in rate of perinatal death.[107] The United States Preventive Services Task Force evaluated EFM in 1989 and 1996 and concluded, in 1996, that "[r]outine electronic fetal monitoring for low-risk women in labor is not recommended."[108] By 2001, no prominent clinical group would recommend the routine use of EFM in low-risk pregnancies.[109] In fact, "[o]perative intervention based on electronic fetal heart rate monitoring has probably done more harm than good . . . ."[110]

A major problem with EFM is that it does not provide reliable information. A study in the mid-1980s asked four experienced obstetricians to read fifty EFM tracings.[111] The readings were repeated two months later. The study found that, more often than not, doctors did not agree with one another about whether an infant was compromised. The obstetricians changed their own minds 21% of the

---

102. Lent, *supra* note 100, at 813–15.

103. H. David Banta & Stephen B. Thacker, *Historical Controversy in Health Technology Assessment: The Case of Electronic Fetal Monitoring*, 56 OBSTETRICAL & GYNECOLOGICAL SURVEY 707, 707 (2001) (reviewing the history of the debate around EFM and concluding that the EFM experience demonstrates the need to evaluate new technologies before their widespread diffusion into clinical practice).

104. Lent, *supra* note 100, at 812.

105. LISTENING TO MOTHERS, *supra* note 37, at 1.

106. Banta & Thacker, *supra* note 103, at 709–10 (describing a comprehensive report issued in 1978 by the National Center for Health Services Research of the Department of Health, Education and Welfare (HEW) which concluded that there was "little increased benefit from EFM compared to auscultation . . . . The risk from EFM is substantial, especially but not wholly through the increased Cesarean section rate that its use apparently engenders"). Auscultation is the traditional process of fetal monitoring, mostly replaced by EFM, whereby "a caregiver periodically (every 15 minutes during the first stage of labor and every five minutes during the second stage) listens to the fetal heart rate using a stethoscope-like device called a fetoscope." GABAY & WOLFE, *supra* note 2, at 42.

107. Lent, *supra* note 100, at 813.

108. Quoted in Banta & Thacker, *supra* note 103, at 715.

109. Banta & Thacker, *supra* note 103 at 716.

110. Clark & Hankins, *supra* note 101, at 631 (finding that electronic fetal monitoring has had no impact on rates of cerebral palsy).

111. P. V. Nielsen, B. Stigsby, C. Nickelsen & J. Nim, *Intra- and Inter-Observer Variability in the Assessment of Intrapartum Cardiotocograms*, 66 ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA 421 (1987).

time when reading the same tracings two months later.[112] Because EFM readings are unreliable, EFM harms women both by leading to unnecessary surgical interventions and by restricting movement helpful to the laboring women.[113]

Given this strong professional consensus that EFM is not reliable and is potentially harmful to women, why are laboring women required to use it? First, doctors may see EFM as more cost efficient than auscultation by stethoscope or fetoscope.[114] Listening on a regular basis requires a trained, reliable professional. By contrast, the EFM machine can be hooked up to listen all the time. Of course, someone has to read the results that the machine produces. Thus, it is not obvious that the EFM is more efficient or cost effective. Furthermore, a listening professional can gather a more accurate set of information than a machine and the laboring woman may benefit from having a person, rather than a machine, following her progress.[115]

Second, and probably more important, because of the risk of malpractice when a baby dies in childbirth or is born with serious problems, obstetricians feel that they are not free to choose whether to use EFM.[116] Despite the lack of evidence supporting the universal use of EFM in low-risk deliveries, because virtually all hospitals require EFM, it has become the presumptive "standard of care."[117]

In sum, a substantial proportion of the very high rates of C-sections in the United States are attributable not to patient choice, but rather to professional practices. These practices—EFM, C-section for breech birth, or C-section after prior Cesarean section—are reasonable in many circumstances. However, often they represent a choice between two equally reasonable alternatives. The next section argues that voices of women should be given greater weight, particularly in circumstances such as those presented in this section where professional opinion is in conflict and women bring different values to the birthing experience.

III.
STANDARDS OF MEDICAL PROFESSIONALISM AND LEGAL LIABILITY: BARRIERS TO INFORMED CHOICE?

The past four decades have seen a remarkable transformation in professional and popular assumptions about doctor-patient relations. This section briefly describes changes in professional ethics and legal standards related to informed consent to treatment, with a particular focus on childbirth. Finally, this section

112. *Id.* at 422.

113. Lent, *supra* note 100, at 817.

114. Dr. Jana Silva, University of Hawaii Burns School of Medicine, pointed this out in my health policy colloquium at the Richardson School of Law, University of Hawaii, Manoa, Hawaii (March 14, 2006). For a definition of auscultation see note 106.

115. Lent, *supra* note 100, at 819.

116. Banta & Thacker, *supra* note 103, at 714.

117. *Id.*

considers these legal and ethical principles in relation to three concrete issues: elective C-sections, EFM, and VBAC.

Until the 1970s the dominant view among physicians was that patients should be told as little as possible about their condition and treatment. An essay attributed to Hippocrates advised physicians to adopt a manner of self-confident reserve, "concealing most things from the patient while you are attending to him," and "revealing nothing of the patient's future or present condition[,] [f]or many patients through this cause [i.e. disclosure] have taken a turn for the worse."[118] In 1984, Dr. Jay Katz of Yale University wrote that "disclosure and consent, except in the most rudimentary fashion, are obligations alien to medical thinking and practice."[119] As a matter of theory, American common law viewed the patient as an autonomous person with the "right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages."[120] But the patient's explicit or implicit consent was assumed unless the doctor did something that the patient had affirmatively prohibited, performed entirely the wrong procedure, or committed fraud.[121]

In the 1960s, as a reaction to the increasing sophistication of medical technology and decision making, most courts recognized that doctors have an affirmative obligation to inform patients in seeking consent to treatment.[122] The standard applied was a professional one: did the doctor conform to professional medical standards in seeking patient consent?[123] The professional standard demanded that the patient challenging the adequacy of information provided present expert testimony about the standards of the relevant professional community. The requirement of expert testimony, combined with the fact that often there was no professional custom about conveying information, meant that the law did little to encourage physician communication or patient choice.[124]

Traditions of paternalism and disrespect for patient choice are particularly strong in relation to childbirth and reproduction. From 1900 to 1950, the propor-

118. MELVIN KONNER, MEDICINE AT THE CROSSROADS: THE CRISIS IN HEALTH CARE 4–5 (1993).

119. JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 1 (1984).

120. *See, e.g.*, Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).

121. SYLVIA LAW & STEVEN POLAN, PAIN & PROFIT: THE POLITICS OF MALPRACTICE 108 (1978).

122. *Id.* at 108–09.

123. Natanson v. Kline, 350 P.2d 1093, 1106 (Kan. 1960); LAW & POLAN, *supra* note 121, at 108–09.

124. *See* LAW & POLAN, *supra* note 121, at 108–09, 111 (describing a shift away from the requirements of expert testimony in some states and noting the difficulty in determining any professional standard). *See* RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 141 (1986) ("The legal doctrine of informed consent and the much-trumpeted legal right of self-determination have not had and are not likely ever to have a direct and deep impact on the daily routines of the physician-patient relationship.").

tion of American babies born in a hospital rose from 10% to 90%.[125] Routine care for normal childbirth required that the woman be sedated throughout labor, the baby removed from the unconscious mother by forceps, an incision be made to facilitate use of the forceps, and the placenta removed by injecting a drug (ergot).[126] Because the anesthetized woman might thrash about and injure herself, her arms and legs had to be restrained. Fathers and supportive friends and family were excluded throughout labor and delivery.[127] The medical establishment imposed this routine on virtually all women, even though ideas and information about more natural forms of childbirth were available.[128] Doctors, sometimes with the support of the courts, could even force nonconsenting women to have C-sections.[129]

The denial of reproductive choice was not limited to the birthing process. For the first half of the twentieth century most states authorized mandatory sterilization.[130] When official mandates were abandoned, some doctors made their child delivery services contingent upon a woman's "consent" to be sterilized at childbirth, such as when the doctor's personal view was that poor black women should not have more children.[131] In the 1950s and 1960s, with the rise of ideals of domesticity, doctors often refused to sterilize women until she had several children.[132] Until 1973 abortion was a crime, not a choice, in almost all

125. RAND E. ROSENBLATT, SYLVIA A. LAW, & SARA ROSENBAUM, LAW AND THE AMERICAN HEALTH CARE SYSTEM 1268 (1997).

126. *See* Roslyn Lindheim, *Birthing Centers and Hospices: Reclaiming Birth and Death*, 2 ANN. REV. PUB. HEALTH 1, 5, 7 (1981).

127. ADRIENNE RICH, OF WOMAN BORN 175–76 (1976). *See* Fitzgerald v. Porter Mem'l Hosp., 523 F.2d. 716 (7th Cir. 1975) (holding that fathers have no constitutionally protected right to attend child birth at the request of both woman and physician).

128. *See, e.g.*, GRANTLY DICK-READ, CHILDBIRTH WITHOUT FEAR: THE PRINCIPLES AND PRACTICE OF NATURAL CHILDBIRTH (1944) (encouraging women to learn about the childbirth process and utilize relaxation techniques to enable them to labor more effectively and minimize pain).

129. *See, e.g.*, Veronika E.B. Kolder, Janet Gallagher & Michael T. Parsons, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192 (1987); Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951 (1986).

130. *See* Buck v. Bell, 274 U.S. 200, 205–07 (1927) ("[S]ociety can prevent those who are manifestly unfit from continuing their kind. . . . Three generations of imbeciles are enough."). *Cf* Paul A. Lombardo, *Three Generations, No Imbeciles: New Light on* Buck v. Bell, 60 N.Y.U. L. REV. 30 (1985) (documenting that Carrie Buck and her daughter were not mentally handicapped, only poor). The policies of the Nazi government underscored the dangers of eugenic sterilization. David M. Pressel, *Nuremberg and Tuskegee: Lessons for Contemporary American Medicine*, 95 J. NAT'L MED. ASS'N 1216 (2003) (documenting Nazi sterilization policies). State mandated sterilization is probably no longer constitutional. *See* Skinner v. Oklahoma, 316 U.S. 535 (1942) (holding that mandatory sterilization of two-time blue-collar felons is unconstitutional).

131. Walker v. Pierce, 560 F.2d 609 (4th Cir. 1977), *cert. denied*, 434 U.S. 1075 (1978) (affirming a doctor's right to condition his services on woman's "consent" to sterilization following delivery). Federal regulations, adopted in response to the problems revealed by this case, require informed consent for sterilizations financed by federal Medicaid funds. 42 C.F.R. §§ 50.201–50.206 (2007).

132. Until 1969, under the rule of 120, Obstetricians and Gynecologists would not perform sterilizations until a woman's age multiplied by her number of children equaled 120. THOMAS M. SHAPIRO, POPULATION CONTROL POLITICS: WOMEN, STERILIZATION, AND REPRODUCTIVE CHOICE

states,[133] and abortion services remain restricted and marginalized in the twenty-first century.[134]

In the 1970s, these patterns were challenged from many directions. The consumer health movement, and most particularly the women's movement, encouraged patients to seek a more active role in making medical decisions.[135] In several jurisdictions, courts in malpractice cases required that doctors provide the information that a reasonable patient would need to know in order to be able to make an informed treatment decision.[136] While this was a large conceptual change in the law, it rarely resulted in malpractice verdicts and many states rejected it, as part of more general "malpractice reforms" limiting patients' ability to sue.[137] Nonetheless, both the consumer movement and changes in legal standards have had a large impact on medical practice. In the twenty-first century, most hospitals and doctors devote great effort to informing patients about the risks and benefits of proposed treatments.[138]

In many situations, the provision of information is not likely to influence patient choice. For example, where broad medical consensus exists that a particular treatment is the best way to treat a serious condition, all but the most idiosyncratic patients will agree with the doctor's recommendation. Or where choices depend on technological judgments beyond the ability of most patients to understand, most patients will leave decisions to the doctor.[139] Sometimes patients'

87–88 (1985) (describing change in medical practice making sterilization available to women without requiring threshold age and number of children be met).

133. Roe v. Wade, 410 U.S. 113, 118, 164–65 (1973).

134. Sylvia A. Law, *Silent No More: Physicians' Legal and Ethical Obligations to Patients Seeking Abortions,* 21 N.Y.U. REV. L. & SOC. CHANGE 279, 280–88 (1995). *See generally* Gonzales v. Carhart, 550 U.S. _ (2007) (Ginsburg, J., dissenting).

135. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 388–93 (1982) (describing popular movements that challenged professional dominance over decision-making); BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, OUR BODIES, OURSELVES: A NEW EDITION FOR A NEW ERA 701–58 (35th anniversary ed. 2005) (describing the ways in which medical paternalism hurts women and denies them choice, educating women about their bodies, and outlining collective and individual strategies to gain greater control of medical care). First published in 1970, by 1997 OUR BODIES, OURSELVES had sold over four million copies in fifteen languages and supported a movement that transformed women's health care and lives. Sara Rimer, *They Talked and Talked, and Then Wrote a Classic*, N. Y. TIMES, June 22, 1997, at WH27.

136. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772, 782 (D.C. Cir.1972) (finding "as a part of the physician's overall obligation to the patient, a similar duty of reasonable disclosure of the choices with respect to proposed therapy and the dangers inherently and potentially involved"); Cobbs v. Grant, 502 P.2d 1, 7–11 (Cal. 1972); Sard v. Hardy, 379 A.2d 1014, 1019–22 (Md. 1977); Largely v. Rothman, 540 A.2d 504, 508–10 (N.J. 1988); Korman v. Mallin, 858 P.2d 1145, 1145, 1151 (Alaska 1993). *See* LAW & POLAN, *supra* note 121, at 111–14 (discussing the impact of the Canterbury and subsequent changes in state laws).

137. LAW & POLAN, *supra* note 121, at 112–14.

138. JEREMY SUGARMAN, DOUGLAS C. MCCRORY, DONALD POWELL, ALEX KRASNY, BETSY ADAMS, ERIC BALL & CYNTHIA CASSELL, EMPIRICAL RESEARCH ON INFORMED CONSENT, 29 THE HASTINGS CENTER REPORT 1 (1999) ("Obtaining the informed consent of patients is now an expected part of clinical medicine and research.").

139. *See* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 81–83 (1982) [here-

ability to assimilate information and make decisions is limited by pain or the need for prompt action. Even in these common situations, provision of information is useful as a form of reassurance, if not as the basis for informed patient choice.

Childbirth, however, presents unusual opportunities for patient choice. Pregnancy lasts for nine months during which women are competent to consider their choices in delivery, as well as prepare to welcome a child. Pregnancy and delivery present many questions on which reasonable professionals, and hence reasonable patients, disagree.[140] Scheduled C-section vs. a trial of labor? EFM or not? Attempt at reversing a breech position vs. breech birth vs. C-section? VBAC? Furthermore, personal values, as opposed to technical medical considerations, may have greater weight in childbirth decisions than in other medical procedures. For example, whether a woman anticipates having many children may have a profound impact on her attitude toward both initial C-section and VBAC.[141] Women have different attitudes toward the very small risks of serious injury to the fetus associated with vaginal birth.[142] Some women place a high value on the experience of conscious vaginal birth, while others do not.

The remainder of this section explores the application of legal and ethical principles of patient choice and informed consent in relation to three issues: maternal choice C-sections, vaginal birth after C-section (VBAC), and mandatory electronic fetal monitoring.

Scheduled elective C-section. As professional consensus emerged that there are circumstances in which a woman might legitimately choose to schedule a C-section even though it was not strictly medically necessary,[143] the American College of Obstetricians and Gynecologists (ACOG) asked its Ethics Committee to provide a statement to guide physicians.[144] After canvassing the range of legal and ethical approaches to decision making, the Opinion suggests that if a woman asks to discuss the possibility of a scheduled C-section, doctors should provide a full range of reliable information.[145]

The Opinion notes that a woman does not have the right to insist that a particular doctor perform a scheduled C-section.[146] The general rule is that doctors

---

inafter 1982 PRESIDENT'S COMM'N] (presenting "informed consent" transcripts in which the doctor presents complex information that the patient cannot understand).

140. *See supra* Parts I–II.

141. *See supra* note 26 and accompanying text.

142. Minkoff & Berkowitz, *supra* note 33, at 608.

143. *Supra* text accompanying notes 42–46.

144. 2003 ACOG Opinion, *supra* note 42, at 21.

145. *Id.* at 25.

146. *Id.* at 22 (noting that "[i]n almost all situations, the patient has a right to refuse unwanted treatment. She does not, however, have a parallel right to demand treatment that the physician believes is unwise or overly risky."). Minkoff and colleagues argue that to give the woman the right to choose whether or not to have an elective C-section "would be to systematically devalue expert clinical judgment and with it the integrity of medicine as a profession." Minkoff, Powderly, Chervenak & McCullough, *supra* note 44, at 390.

are not affirmatively obligated to serve particular patients or provide particular procedures; and the exception, imposing affirmative duties, is controversial, especially among doctors.[147] To the credit of the ACOG Ethics Committee, it notes that "referral to another health care provider would be appropriate if the physician and patient cannot agree on a route of delivery."[148]

Curiously, the ACOG Opinion suggests that the physician should only discuss the possibility of a scheduled C-section if the woman raises the subject: "Given the lack of data, it is not ethically necessary to initiate discussion regarding the relative risks and benefits of elective cesarean birth versus vaginal delivery with every pregnant patient. There is no obligation to initiate discussion about procedures that the physician does not consider medically acceptable or are unproved."[149]

This is puzzling because ordinary principles of informed consent impose an affirmative obligation upon doctors to offer information that might reasonably influence patient decision making. As the court said in the landmark case, *Canterbury v. Spence*,

> We discard the thought that the patient should ask for information before the physician is required to disclose. Caveat emptor is not the norm for the consumer of medical services. Duty to disclose is more than a call to speak merely on the patient's request, or merely to answer the patient's questions; it is a duty to volunteer, if necessary, the information the patient needs for intelligent decision.[150]

Perhaps ACOG's reluctance to ask doctors to raise the subject of scheduled

147. *See. e.g.*, Campbell v. Mincey, 413 F. Supp. 16 (N.D. Miss. 1975), *aff'd* 542 F.2d 573 (5th Cir. 1976) (holding that neither hospital nor emergency room doctors have a duty to provide care to a woman in active labor, despite their ability to do so, nor to treat her after she gave birth in her car in the hospital parking lot). For a defense of the no-duty principle, see Robert M. Sade, *Medical Care as a Right: A Refutation*, 285 NEW ENG. J. MED. 1288, 1289 (1971) (arguing that "medical care is neither a right nor a privilege: it is a service that is provided by doctors and others to people who wish to purchase it."). However, federal and state laws require that doctors working in emergency rooms provide care to people with emergency conditions, including women in active labor. *See, e.g.*, Burditt v. U.S. Dep't. of Health and Human Servs., 934 F.2d 1362 (5th Cir. 1991) (upholding a federal fine imposed on a doctor who was on-call in the emergency room and refused to treat a woman in active labor); People v. Anyakora, 616 N.Y.S.2d 149 (Sup. Ct. 1993) (upholding the New York criminal conviction of an on-call doctor who refused to help EMS personnel deliver a baby).

148. 2003 ACOG Opinion, *supra* note 42, at 24. By contrast, doctors treating women who discover they are pregnant and want an abortion often refuse to offer referrals for abortions that the doctor is unable or unwilling to provide. Law, *Silent No More, supra* note 134, at 288–94.

149. 2003 ACOG Opinion, *supra* note 42, at 25. Minkoff and colleagues note that "[a]lthough physicians ought not routinely to offer cesarean delivery, they may still need to respond to requests for counseling in that regard." Minkoff, Powderly, Chervenak, & McCullough, *supra* note 44, at 390.

150. Canterbury v. Spence, 464 F.2d 772, 783, n.36 (D.C. Cir. 1972). *See also* Eleanor S. Glass, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533, 1555–61 (1970) (urging a legal standard assuring patients the information needed to make intelligent medical treatment choices).

C-section can be attributed to an admirable effort to avoid the appearance of coercion. In some situations, mentioning the possibility of a scheduled C-section would be unnecessary, for example in counseling a healthy young woman who enthusiastically anticipates the experience of a natural childbirth. Nonetheless, it seems that ordinary principles of informed consent require that doctors offer information that might influence a woman's choices and that the ACOG standards depart from these principles by demanding that the woman first ask about the option of a scheduled C-section. Where medical risks are in balance, and a reasonable doctor would agree to a scheduled C-section or an attempt at vaginal delivery, the doctor should provide the information to facilitate choice, without waiting for the woman to ask.[151]

Vaginal Birth After C-Section (VBAC). The 1999 ACOG policy insisting that hospitals offering VBAC have obstetric and anesthesia personnel *immediately* available[152] likely denies vaginal birth to hundreds, perhaps thousands, of women who do not live within two or three hours of a tertiary care hospital. For some of these women, particularly those who want to have large families, effectively requiring a repeat C-section is a significant burden.[153] Some women can afford to travel to a tertiary care center where VBAC is available, but many cannot.[154] Doctors at rural hospitals that no longer offer VBAC report that some women attempt vaginal delivery at home, with the assistance of a midwife, or wait at home or in the hospital parking lot until birth is near.[155] These are obviously dangerous alternatives.

Dr. Charles Lockwood, Chairman of the Department of Obstetrics, Gynecology and Reproductive Sciences at Yale and an author of the VBAC guidelines asserts that "the real death knell to VBAC's was the malpractice crisis. . . ."[156] This probably reflects a misunderstanding of the law. Certainly a woman contemplating a VBAC at a community hospital needs to be given full information about the benefits of attempting delivery at a tertiary care institution

151. *See* Sebastien Tassy, Guillaume Gorincour, Julie Banet & Claude d'Ercole, Letters to the Editor, *Ethical Dimensions of Elective Primary Cesarean Delivery,* 104 OBSTETRICS & GYNECOLOGY 192, 192 (2004) (agreeing with Minkoff, Powderly, Chervenak & McCullough's position, *supra* note 44, against regularly recommending an elective C-section, but criticizing their suggestion that a doctor need not disclose the option or make it available to a woman as violative of a patient's autonomy).

152. ACOG Practice Bulletin, *supra* note 81.

153. *See* Getahun, Oyelese, Salihu & Ananth, *supra* note 26. *See also* Gilliam, Rosenberg & Davis, *supra* note 26.

154. *See supra* note 82. Neither Medicaid nor private insurance pay for the travel costs and living expenses for a woman who seeks to travel to an urban center for a VBAC. Even if insurance funded these expenses, this support would not be available to the large numbers of women who are not insured. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE UNINSURED AND THEIR ACCESS TO HEALTH CARE 1 (Nov. 2005). Often the only way for the uninsured to receive free, or discounted, medical attention is to access hospitals in an emergency. *See* Joel S. Weissman, *The Trouble with Uncompensated Hospital Care,* 352 NEW ENG. J. MED. 1171 (2005).

155. Grady, *supra* note 78, at A18.

156. *Id.*

where skilled personnel are available around the clock. But, even as malpractice rules have incorporated national standards for judging skill and effort, they have retained a respect for local differences and limitations. The law does not insist that the standard of care provided at community hospitals meet the standards that apply in university hospitals or tertiary care institutions.[157] As the Mississippi Supreme Court explained in adopting national negligence standards:

> [T]here remains a core of validity to the premises of the old locality rule. For reasons well known to all . . . [the] resources reasonably available to Mississippi's physicians vary from community to community. . . Because of these difference in facilities, equipment, etc., . . . [a] physician practicing in Noxubee County, for example, may hardly be faulted for failure to perform a CAT scan when the necessary facilities and equipment are not reasonably available.[158]

In short, national standards are used to evaluate knowledge, skill and effort, but local considerations must be taken into account in evaluating the adequacy of facilities, equipment and specialized services. The malpractice law does not expect a local community hospital to have all of the resources available at a tertiary care center. Hospital and physician misperceptions about risk or malpractice liability in this context are understandable, and efforts to dispel those myths have the potential to increase patient choice in primary and secondary care centers.

The 1999 ACOG VBAC rule may be too rigid. It prohibits doctors and women from choosing VBAC whenever a full surgical team is not *immediately available*, whatever the adequacy of alternative arrangements or the burdens of accessing a tertiary care institution.[159] The principle underlying the ACOG rule would, as an analogy, prevent a hospital from offering obstetrics services if it did not have a neo-natal intensive care unit, which is sometimes necessary on an emergency basis.[160] But health policy generally recognizes the importance of providing basic health care services in rural areas.[161] Important values support

---

157. *See* ROSENBLATT, LAW & ROSENBAUM, *supra* note 125, at 843–47. Mississippi was the last state to abandon the locality rule. *Id.* at 846–47 (citing Hall v. Hilbun, 466 So.2d 856 (Miss. 1985)).

158. Hall v. Hilbun, 466 So.2d at 872.

159. Tertiary care is "highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities." MedlinePlus, Medical Dictionary, http://www2.merriam-webster.com /cgi-bin/mwmednlm (last visited Apr. 4, 2008).

160. This, of course, would be difficult since most hospitals lack a neo-natal intensive care unit. *See, e.g.*, John D. Yeast, Mary Poskin, Joseph W. Stockbauer & Stanley Shaffer, *Changing Patterns in Regionalization of Perinatal Care and the Impact on Neonatal Mortality*, 178 AM. J. OBSTETRICS & GYNECOLOGY 131, 132 (1998) (reporting that only 39.3% of all births in Missouri occurred in hospitals with a high level neonatal intensive care unit; a Level III hospital); Marie C. McCormack & Douglas K. Richardson, *Access to Neonatal Intensive Care*, 5 THE FUTURE OF CHILDREN: LOW BIRTH WEIGHT 162, 166 (1995) (finding that, in 1994, approximately 500 hospitals reported having a NICU).

161. *See, e.g.*, Howard K. Rabinowitz, James J. Diamond, Fred W. Markham & Nina P. Paynter, *Critical Factors for Designing Programs to Increase the Supply and Retention of Rural*

the ability of women to choose to give birth close to home and to choose VBAC. While the medical risks to both woman and infant are greater giving birth in a community hospital close to home than in a distant tertiary university hospital, there are also benefits, and the degree of risk varies enormously with individual circumstances.[162] These are choices that informed women and their physicians should be able to make.

Mandatory, Routine Electronic Fetal Monitoring (EFM). Mandatory, routine EFM imposes large burdens on pregnant women while providing little benefit.[163] In addition to the unnecessary C-sections that result from false positive or ambiguous readings, the EFM machinery limits the laboring woman's ability to move and do other things that would make her labor easier. Moreover, a woman attached to a machine may be less likely to receive watchful and supportive attention from caregivers. The readings of the machine, rather than the woman herself, become the center of attention. Physicians are also injured by hospital policies that demand routine EFM. The doctor is denied the capacity to make judgments about whether alternative approaches to delivery might be wiser for a particular woman or whether support staff is better able than the machine to monitor for potential problems.

In the twenty-first century it seems that few knowledgeable observers defend mandatory, routine EFM on its merits. Rather, this type of monitoring persists because of fear of litigation. If a baby suffers a serious birth injury, parents have an enormous incentive to sue. The costs of raising a child with a serious disability are high and juries are sympathetic to such plaintiffs.[164] No doctor is ever sued for doing an unnecessary C-section.[165] Margaret Lent argues that physician fears of medical malpractice liability are exaggerated, and that their professional obligation is to practice in accordance with the best available evidence.[166] Nonetheless, mandatory, routine EFM suggests that fear of liability is a powerful motivator. No positive law requires that doctors routinely use EFM, but when hospital policy does so, a doctor would reasonably fear that the failure to do so would be offered as evidence of negligence in the event that a baby was born with an injury.

In this situation, changes in the law, as opposed to changes in professional ethics and informed patient requests, might have a positive impact. If fear of

---

Primary Care Physicians, 286 J. AM. MED. ASS'N. 1041, 1041 (2001) (reporting that 20% of the U.S. population lives in rural areas, but only 9% of doctors practice in rural areas and describing efforts to increase rural health services).

162. *See supra* text accompanying notes 87–88.

163. *See supra* text accompanying notes 103–117.

164. *See, e.g.*, WERTH, *supra* note 31, *passim*.

165. *See* Wagner, *supra* note 20, at 1678 (reporting that doctors are not criticized for performing unnecessary C-sections and often choose to do so as a form of "defensive obstetrics"); Rob Stein, *Once a C-Section, Always a C-Section?*, WASH. POST, Nov. 24, 2005, at A1 (reporting some hospitals have prohibited VBAC attempts because of fear of lawsuit). *But see* Betsy A. Lehman, *Woman Wins $1.53m Suit on Unwanted Caesarean*, BOSTON GLOBE, June 16, 1993 at A1.

166. *See* Lent, *supra* note 100, at 824–30.

legal liability is a major factor supporting the persistence of mandatory, routine EFM, perhaps the law needs to provide a disincentive to this useless and harmful practice. A class of pregnant women and their physicians could institute an affirmative legal challenge to mandatory EFM, arguing that such policies illegally restrict the liberty and choice of both women and their physicians. The inclusion of a physician plaintiff is critical, both because doctors and patients are injured by the mandatory EFM policies and because the doctors' claims underscore that the women's complaints are not illegitimate or merely idiosyncratic. Physicians often join patients in civil rights claims challenging policies that restrict patient choice of medical treatment.[167] Because constitutional principles only apply to public institutions, such a claim would need to be targeted at a public hospital.[168] However, since all obstetric programs follow similar policies, success against a public hospital might well be followed by similar actions by private programs and professional associations.

In sum, even though pregnancy presents a special opportunity for patient choice, routine medical practices often subvert the choices that women are able to make. Recommended practices do not offer women the choice of a planned C-section unless the woman takes the initiative to ask that the option be considered. Women who seek to attempt vaginal delivery after a C-section are denied that choice unless they can obtain care at a tertiary care center. All women are denied the ability to choose manual, rather than electronic, monitoring as the labor progresses. These denials of choice are inconsistent with general ethical and legal principles of informed patient consent.

IV.
NEITHER INSURANCE REIMBURSEMENT STRUCTURES NOR COST CONCERNS JUSTIFY DENIAL OF INFORMED PATIENT CHOICE REGARDING CHILDBIRTH

Even if elective C-sections are medically and ethically appropriate in some circumstances, public and private insurance programs might refuse to reimburse them. C-sections are not reimbursed either because they are not "medically necessary"[169] or because they claim that elective C-sections unjustifiably increase

167. *See, e.g.*, Doe v. Bridgeton Hosp. Ass'n, Inc., 366 A.2d 641 (N.J. 1976) (holding that hospitals cannot prohibit doctors from performing abortions and noting that common law prohibits certain private actors, such as common carriers, innkeepers and public utilities, from denying services on an arbitrary basis unrelated to the purpose of the enterprise); Washington v. Glucksberg, 521 U.S. 702 (1997) (holding against doctors who joined terminally ill patients in challenging state laws prohibiting physician-assisted suicide).

168. *See* Blum v. Yaretsky, 457 U.S. 991 (1982) (holding that extensive regulation and public funding do not transform a private heath care organization into a state actor for purposes of a challenge on constitutional grounds).

169. Insurers assert that they never pay for elective C-sections because they are not "medically necessary." I began thinking about these issues when I was a Visiting Professor at the Richardson School of Law and the Burns School of Medicine at the University of Hawai'i in 2006. Hawai'i Medical Service Association (HMSA), the state's Blue Cross/Blue Shield organization, covers sixty percent of the insured population in Hawai'i. I asked William J. Osheroff, from the

the costs of child birth, and hence the costs of health insurance. This section considers these issues.

Medical necessity. Private insurance in the United States has historically limited payment to those services that are deemed "medically necessary."[170] Following this model, the public insurance programs, Medicare and Medicaid, also limited payment to "medically necessary" services.[171] Until the 1970s, both public and private insurance programs required only that physicians affirm that the services they recommended or provided fulfilled this criterion, and insurers did not monitor or second-guess these medical judgments.[172] As health care costs soared, however, insurers and especially managed care organizations, began to enforce more demanding concepts of "medical necessity."[173]

The meaning of "medical necessity" is not fixed, but varies with the terms of the insurance contract or, in a public program, the governing rules and regulations, as well as with the attitudes of courts interpreting these provisions. Some contracts and courts emphasize the need to respect physician discretion and rely on professional customs and standards.[174] This practice is problematic in that, to the extent that common practice is wasteful, insurance reimbursement supports it. By contrast, some contracts and courts limit medical necessity to those tests and procedures that have already been proven effective in rigorous clinical trials.[175] The difficulty with this is that only a small portion of medical practices are ever subject to rigorous scientific verification, and even those that are even-

---

HMSA Medical Management Department, "whether and when reimbursement is provided for elective Cesarean sections, chosen by the woman." He responded, "we have recently conducted a random chart audit of C-section cases looking for instances when women elected a section with no medical indications. In the entire sample, there were none. We would not cover cases where medical indications are totally lacking." E-mail from William J. Osheroff, HMSA Med. Mgmt. Dep't, to Sylvia A. Law, Professor of Law, NYU School of Law (June 19, 2006, 10:20 EST) (on file with author). An official at Kaiser Permanente, the second largest insurer in Hawai'i, confirmed this message saying that Kaiser Permanente does not cover services that are not medically necessary. Telephone Interview with Chris Pablo, Vice President for Pub. Affairs, Kaiser Permanente (June 15, 2006).

170. *See* ROSENBLATT, LAW & ROSENBAUM, *supra* note 125, at 211–13.

171. *See, e.g.*, White v. Beal, 555 F.2d 1146, 1152 (3d Cir. 1977) (holding that Social Security Act and associated regulations authorize Medicaid expenditures for medically necessary services). *See also* SYLVIA A. LAW, BLUE CROSS: WHAT WENT WRONG? 117–21 (1974).

172. *See* ROSENBLATT, LAW & ROSENBAUM, *supra* note 125, at 146–47, 212. *See also* Van Vector v. Blue Cross Ass'n, 365 N.E.2d 638 (Ill. App. Ct. 1977) (holding that Blue Cross could not deny patient benefits solely because of its disagreement with physician judgment of medical necessity).

173. *See* ROSENBLATT, LAW & ROSENBAUM, *supra* note 125, at 224–82.

174. *See, e.g.*, Adams v. Blue Cross/Blue Shield of Md., Inc., 757 F. Supp. 661, 669 (D. Md. 1991) (holding that the concept of "acceptable medical practice" is determined by views and practices of the community of local physicians).

175. *See, e.g.*, Fuja v. Benefit Trust Life Ins. Co., 18 F.3d 1405 (7th Cir. 1994) (holding that treatments subject to on-going research are not "medically necessary"). *See generally* David M. Eddy, *Rationing Resources While Improving Quality: How to Get More for Less*, 272 J. AM. MED. ASS'N. 817 (1994) (arguing that insurers should develop explicit criteria to assure that only high-value treatments are reimbursed).

tually verified may be obsolete before they are available to patients.[176] Plainly the concept of "medical necessity" is not limited to life saving treatments. Drugs to control high blood pressure or cholesterol may be "necessary" even if the problem might be adequately addressed through diet and exercise. Anesthesia is often not strictly "medically necessary" though it is routinely provided and reimbursed. In short, the concept of "medical necessity," while useful, is notoriously messy and controversial.

Just as paternalistic concepts of patient consent have often been applied in ways particularly harmful to women and reproductive health services,[177] so too, concepts of "medical necessity" have disfavored reproductive choice. Consider three examples: denying insurance coverage for childbirth, contraception, and medically necessary abortions.

Until the late 1970s, private insurance commonly excluded coverage for vaginal delivery.[178] The theory behind this exclusion was probably that birth was natural, a lifestyle choice, and a joy, unless surgery was involved. However, when a woman is nine months pregnant, some form of medical intervention, whether it be a C-section or support for vaginal delivery, is regarded as "necessary." In response to lobbying by the obstetrical and pediatric professions, state laws mandated that insurance cover both vaginal and surgical birth.[179]

Similarly, otherwise comprehensive medical disability insurance commonly excluded disabilities related to pregnancy. When the Supreme Court held that a denial of benefits for pregnancy-related disability was not discrimination based on sex, and thus did not violate Title VII of the Civil Rights Act,[180] Congress adopted the Pregnancy Discrimination Act. The Act announced that employer discrimination against pregnant women is sex discrimination and required employer-provided health insurance to cover pregnancy and childbirth as it would cover comparable conditions.[181] In the twenty-first century, some small firms, not covered by the federal Pregnancy Discrimination Act, continue to exclude

176. Jan Blustein & Theodore R. Marmor, *Cutting Waste By Making Rules: Promises, Pitfalls, and Realistic Prospects,* 140 U. PA. L. REV. 1543, 1549 (1992).

177. *See supra* text accompanying notes 125–134.

178. *See* Brief for Am. Pub. Health Ass'n as Amici Curiae Supporting Appellee, Metro. Life Ins. Co.v. Mass., 471 U.S. 724 (1985) (Nos. 84-325 & 83-356) at Table I, *noted in* Sylvia A. Law & Barry Ensminger, *Negotiating Physicians' Fees: Individual Patients or Society? (A Case Study in Federalism),* 61 N.Y.U. L. REV. 1, 59–60 n.301 (1986).

179. *See, e.g.*, N.Y. Ins. Law § 3216 (McKinney 2007) ("Every policy which provides hospital, surgical or medical coverage shall provide coverage for maternity care, including hospital, surgical or medical care to the same extent that hospital, surgical or medical coverage is provided for illness or disease under the policy. Such maternity care coverage, other than coverage for perinatal complications, shall include inpatient hospital coverage for mother and for newborn for at least forty-eight hours after childbirth for any delivery other than a caesarean section, and for at least ninety-six hours after a caesarean section.").

180. Gen. Elec. Co. v. Gilbert, 429 U.S. 125 (1976).

181. Pregnancy Discrimination Act of 1978, Pub. L. 95-555, 92 Stat. 2076 (codified as amended in 42 U.S.C. 2000e(k) (1994)).

benefits for maternity services or offer them only at high additional costs.[182]

A second example of the use of "medical necessity" to disadvantage women involves reimbursement for prescription oral contraception. Contraception is commonly excluded from otherwise comprehensive coverage for prescription drugs on the grounds that birth control is not considered "medically necessary."[183] Why? From a financial point of view, insurers who cover childbirth could save money by covering contraception.[184] From a woman's point of view, it is better to avoid unwanted pregnancy. However, when the California legislature debated a bill to require that prescription contraception be treated equally to other prescription drugs, some legislators analogized prescription contraceptives to hair spray; a matter of cosmetic, lifestyle choice.[185] Never mind that hair spray is not a prescription product. Since 2000, both the EEOC and some federal courts have held that insurance plans that offer otherwise comprehensive coverage for prescription drugs may not exclude prescription contraception. The courts held that an exclusion would constitute gender discrimination prohibited by Title VII of the Civil Rights Act.[186]

Insurance coverage for abortion represents a third, complex example of the use of the concept of "medical necessity" to disadvantage women and reproductive health services more generally. Subsequent to the Supreme Court's 1973 holding that the Constitution protects a woman's right to an abortion,[187] federal Medicaid principles, following the private insurance model, required coverage of "medically necessary" services and prohibited exclusions on the basis of diagnosis or condition.[188] After *Roe v. Wade*, some states sought to apply stringent standards to determine when an abortion was "medically necessary."[189] For ex-

182. *See* HENRY J. KAISER FAMILY FOUNDATION, MATERNITY CARE AND CONSUMER-DRIVEN HEALTH PLANS 2 (2007), *available at* http://www.kff.org/womenshealth/upload/7636.pdf [hereinafter KAISER FAMILY, MATERNITY CARE].

183. *See* ALAN GUTTMACHER INSTITUTE, UNEVEN AND UNEQUAL: INSURANCE COVERAGE AND REPRODUCTIVE HEALTH SERVICES 8–17 (1995) [hereinafter AGI 1995] (finding in a 1993 survey of the largest commercial insurance companies that oral contraceptives were routinely covered by only 33% of large-group plans).

184. *See* Sylvia A. Law, *Sex Discrimination and Insurance for Contraception,* 73 WASH. L. REV. 363, 366 (1998).

185. *See id.* at 393–94, n.153.

186. *See, e.g.*, Stocking v. AT & T Corp., 436 F. Supp. 2d 1014, 1016–17 (W.D. Mo. 2006); Cooley v. Daimler Chrysler Corp., 281 F. Supp. 2d 979 (E.D. Mo. 2003); Erickson v. Bartell Drug Co., 141 F. Supp. 2d 1266 (W.D. Wash. 2001). *See also* U.S. Equal Employment Opportunity Comm'n Decision on Coverage of Contraception (Dec. 14, 2000), *available at* http://www.eeoc.gov/policy/docs/decision-contraception.html. *But see In re* Union Pac. R.R. Employment Practices Litig. 479 F.3d 936, 938 (8th Cir. 2007) (upholding the exclusion of contraception "when used for the sole purpose of contraception" and when not "medically necessary for a non-contraceptive purpose").

187. Roe v. Wade, 410 U.S. 113 (1973).

188. *See, e.g.*, White v. Beal, 555 F.2d 1146 (3d Cir. 1977) (holding that the state may not limit Medicaid coverage of eyeglasses to those cases of impaired visions caused by eye pathology).

189. Maher v. Roe, 432 U.S. 464, 468–69 (1977) (Connecticut); Beal v. Doe, 432 U.S. 438, 442 (1977) (Pennsylvania).

ample, for Medicaid purposes, Connecticut only covered first trimester abortions if they were performed in an accredited hospital or licensed clinic, supported by a written request from the patient (and, in the case of a minor, from her parent or guardian), and accompanied by a prior certification from the attending physician that the abortion was "medically necessary" and a prior authorization by the Chief of Medical Services of the Department of Social Services.[190] The lower federal court held that the restrictive state definition of "medical necessity," which precluded coverage of non-medically indicated abortions, violated the constitutional principles of Equal Protection since the state's Medicaid program generally subsidized other pregnancy and childbirth expenses.[191] Abortion and childbirth were, "when stripped of the sensitive moral arguments . . . simply two alternative medical methods of dealing with pregnancy . . . ."[192] The Supreme Court reversed, holding that the "Constitution imposes no obligation on the States to pay the pregnancy-related medical expenses" of pregnant women.[193] States remained free to fund "medically necessary" abortions under Medicaid, but were not required to do so.[194]

In 1976, Congress adopted the Hyde Amendment,[195] further restricting Medicaid funding for abortion by prohibiting the use of federal funds "to perform abortions except where the life of the mother would be endangered if the fetus were carried to term."[196] The exclusion was challenged on several grounds and the Federal District Court in the Eastern District of New York held extensive hearings.[197] Prestigious doctors from many specialties, with diverse views on abortion, explored the medical meaning of the exclusion. The evidence showed that potentially life-threatening conditions can be identified early in pregnancy, but that it is not possible to know, early in pregnancy, which women will face a life threatening condition at term.[198] In short, while doctors can identify a pregnancy as high risk, it is not possible to predict whether the risk will develop. In addition, the evidence showed that if a woman wanted to continue a pregnancy and was willing to work with doctors there are virtually no situations in which a doctor could say that a pregnancy is life threatening.[199] By contrast, if the

190. Maher v. Roe, 432 U.S. at 466.

191. *Id.* at 468.

192. *Id.*

193. *Id.* at 468–69.

194. *Id.* at 469–70.

195. Pub. L. 96-123, § 109, 93 Stat. 126 (1979).

196. *See* McRae v. Califano, 491 F. Supp. 630, 641 (E.D.N.Y. 1980).

197. *Id.*

198. "The medical testimony made clear that potentially life threatening conditions identified very early in the pregnancy very often could not be predicted as even relatively certain to create an unacceptably high risk of mortality at a later stage in the pregnancy notwithstanding that it would be said that such a condition would inevitably in a statistically significant number of pregnancies cause pregnant women's deaths." *Id.* at 665.

199. "The medical testimony was substantially in agreement that by the use of the most advanced present day medical techniques, and with close medical supervision, it was possible for

woman does not want to be pregnant, or is unable or unwilling to cooperate, many conditions pose serious threats to her health and life.[200] The woman's attitude toward her pregnancy inescapably and profoundly influences whether the risks of pregnancy endanger her life.

How does this history of the concept of "medical necessity" inform the choice between a scheduled C-section and a trial of vaginal delivery? "Medical necessity" is rarely a purely technical or scientific concept. The needs, plans, and desires of the patient have a large influence on whether or not a service is necessary. For a woman who prefers childbirth at home, attended by friends and family, insurance coverage for vaginal delivery is not medically necessary. Most women prefer childbirth in a hospital, attended by doctors, and for them insurance coverage is medically necessary. Contraception is medically unnecessary for a woman who is not heterosexually active. Abortion is not necessary for a woman who wants to be pregnant.

Many choices confronting pregnant women and their physicians raise honestly debatable medical and ethical questions.[201] However, when insurance companies impose rigid concepts of medical necessity to determine whether or not a particular form of delivery will be compensated, they distort the complex and delicate decision-making process through which women negotiate these questions. A woman who selects a mode of delivery based on what she is told her insurance will reimburse is not exercising choice based on the best interests of her child and self. Doctors' choice is also limited by this structure. When informing patients of their options, they must conform their own medical analyses to fit the requirements of "medical necessity," distorting the doctor-patient relationship.

When a woman is nine months pregnant, the assumption in the United States is that some form of medical intervention is warranted.[202] Even if an insurer seeks to deny reimbursement for C-sections that are purely "elective," insurance programs should reimburse the woman for the most economical form of delivery so she only bears the cost of the difference. There is no evidence that any insurance program, public or private, follows this policy. Rather, insurers assert that they provide no coverage for "medically unnecessary" services.[203] Insurers, in fact, do pay for all deliveries by insured women who request reimbursement, including elective C-sections. But this reimbursement process occurs

---

women with life threatening conditions to survive pregnancy and bear children with a comparatively low ratio of maternal mortality; it was reasonably clear that the testimony rested on the assumption that the pregnant woman was desirous of bearing the child, and was cooperative throughout the pregnancy." *Id.* at 665.

200. *Id.* at 671–72.

201. *Supra* Parts I–II.

202. GEORGE J. ANNAS, HOMEBIRTH: AUTONOMY VS. SAFETY, 8 HASTINGS CENTER REPORT 19 (Aug. 19, 1978) (noting that ACOG considers home birth dangerous, many physicians consider the practice tantamount to child abuse, and many hospitals will withdraw staff privileges from doctors and nurses who help a woman give birth at home).

203. *See supra* notes 170–171 and accompanying text.

in a way that distorts communications between doctors, women, and insurers by insisting that doctors describe the C-section as "medically necessary."

Costs. Like so much about the very common and important phenomena of childbirth,[204] it is not possible to make reliable statements comparing the costs of various forms of childbirth. The conventional wisdom is that C-sections are significantly more expensive than vaginal birth. At first blush, it seems obvious that C-sections cost more. They require surgery, anesthesiology, and a longer stay in the hospital. Vaginal delivery can be quick, drug free, and allow the mother and baby to go home within a few hours. But, in fact, in the twenty-first century, vaginal delivery is not typically low-tech or low-cost. Ninety-three percent of laboring women have electronic fetal monitoring, 86% have intravenous drips, and 63% have epidermal analgesia, which is the same analgesia generally given to women who have C-sections.[205]

There are two main components to the financial costs of childbirth. First, the hospital is reimbursed for room and board, care from nurses, residents, and other salaried employees, and other ancillary services. Second, the physicians (obstetrician, anesthesiologist, and pediatrician) are paid separately for their services. Historically, hospitals were most often paid on the basis of their "reasonable costs," while physicians were paid on the basis of their charges.[206] Since the 1990s, many insurers pay both hospitals and doctors on the basis of a set fee, which is often the subject of negotiation, particularly in the case of managed care organizations and large insurers.[207]

In thinking about payment for medical services, it is essential to distinguish among three concepts: reimbursement rates, costs, and charges. Reimbursement rates are the amounts paid by an insurance program. In the private sector "[f]ee schedules that insurers use to pay for services are proprietary and closely guarded."[208] Reimbursement fees may be paid to the provider or to the insured patient. Whether the provider may charge the patient more than the insurer will pay depends upon the agreement between the insurer and the individual, and the agreement, if any, between the insurer and the provider. Costs are the resources that the provider must spend, directly and indirectly, to provide the services. Charges are the prices that the provider demands from patients who pay out of pocket. Very few people pay charges, particularly for services provided in a hospital. In the inpatient context, hospital "charges" are a largely meaningless concept. The only patients to whom charges are applied are the uninsured. Most of the uninsured are poor and, ironically, often confront charges much larger

204. *See, e.g.*, 2006 NIH, C-SECTIONS ON MATERNAL REQUEST, *supra* note 1, at 5 (explaining that the NIH has found a lack of reliable data on maternal request C-sections).

205. LISTENING TO MOTHERS, *supra* note 39, at 1.

206. *See* ROSENBLATT, LAW & ROSENBAUM, *supra* note 125, at 466–86.

207. *Id.* at 478, 520–21 (noting that many insurers use a form of DRG reimbursement for hospitals and most physicians accept a set Medicare fee for their services).

208. KAISER FAMILY, MATERNITY CARE, *supra* note 182, at 10.

than the reimbursement rates paid to hospitals by insurance programs.[209] For people with insurance, either public or private, hospitals collect the reimbursement rates either set by the insurer or negotiated between the insurer and the hospital. While there is some relationship between costs, charges, and reimbursement rates, it is not precise.

It is difficult to find information about either the costs of various forms of childbirth services or the reimbursement rates paid by different insurers. However, information is available on charges. The United States Agency for Healthcare Research and Quality reports that in 2003 facility labor and birth charges varied by site and method of delivery. Average charges were as follows: hospital Cesarean with complications, $15,519; hospital cesarean without complications, $11,524; hospital vaginal delivery with complications, $8,177; and hospital vaginal delivery without complications, $6,239.[210] These charges do not include fees for obstetricians, pediatricians, or anesthesiologists. The figures for C-sections include emergency C-sections as well as those that were scheduled. Many studies asserting that C-sections "cost" more than vaginal delivery rely on charge figures that are essentially meaningless.[211]

One study examined the direct hospital costs of childbirth in a community hospital in Texas from September 2000 to August 2001.[212] The study concludes that vaginal delivery, that includes induction and a labor anesthetic, costs about 9.5% more than elective, scheduled C-sections. A failed attempt at vaginal delivery would raise the costs even higher. Indirect costs and the costs of physician services were excluded.[213] The study found that personnel accounted for most of the costs of vaginal delivery; about 77%. There was wide variation in

209. Jonathan Cohn, *Uncharitable?*, N.Y. TIMES, Dec. 19, 2004, Mag., at 53 (reporting that charges to uninsured patients are often much higher than amounts paid by insurance programs for the same services, partly since the uninsured do not have a representative negotiating lower charges and since the uninsured do not benefit from lower prices that the government dictates for Medicare and Medicaid recipients).

210. Charges for Giving Birth by Facility and Mode of Birth, Childbirth Connection, http://www.childbirthconnection.org/article.asp?ck=10463 (last visited May 1, 2008) (data available through U.S. Agency for Healthcare Research and Quality, *HCUPnet, Healthcare Costs and Utilization Project, Rockville, MD: AHRQ*, [DRGs 370-373]). The figures do not include the costs of medical provider charges, anesthesia services, or newborn care.

211. Jesse D. Malkin, *Not as Much as You Think: Toward a Truer Estimate of the Difference in Direct Medical Costs Between Vaginal and Cesarean Deliveries,* 28 BIRTH 208, 208 (2001) (reviewing medical literature and noting that although charges are higher for C-sections than for vaginal deliveries, little is known about the actual differences in costs since most of the studies have focused on charges, which is almost a meaningless measure).

212. Brent W. Bost, *Cesarean Delivery on Demand: What Will it Cost?*, 188 AM. J. OBSTETRICS & GYNECOLOGY 1418 (2003).

213. *Id.* at 1419 (noting, however, that vaginal delivery without either augmentation/induction or epidural anesthesia was cheaper than elective C-section). Physician costs were excluded from the Texas study because they would distort the cost analysis. For example, different outcomes would result depending on whether or not the existence of a residency program were taken into account and as to how the "costs" of a resident physician would be calculated. Resident physicians are not paid directly for services rendered, but a fixed salary, regardless of the number of patients they see. *Id.* at 1422.

the costs of vaginal delivery. Women having their first child labor longer and cost more. Costs also increase if birth is induced or the woman has anesthesia. The direct medical costs for first time mothers who required Pitocin induction and/or augmentation and labor anesthetic were 9.5% higher than the direct medical costs of women who had an elective C-section.[214] A trial of labor followed by emergency C-section was most expensive.[215] Though this study raises doubts about the conventional wisdom, it was a small study and has many limitations.

Similarly, there is little reliable information comparing physician charges, and more importantly, insurance reimbursement, for various forms of childbirth. A 2007 study by the Kaiser Family Foundation, based on a rich data base from Maryland, shows that on average doctors billed $3,140.50 for vaginal delivery and $3,700 for C-section; insurance plans reimbursed $2,007.21 on average for a vaginal delivery and $2,256.57 for a C-section.[216] While physician services for C-sections cost more, the difference is arguably modest. Earlier studies report similarly modest differences in physician fees.[217]

The truth is that reliable information comparing the costs of vaginal delivery, scheduled C-sections, and emergency C-sections is not available. The most useful cost comparisons would take account of demographic differences. The data show that older women and women with health problems are more likely to have C-sections.[218] Therefore, if C-sections cost more than vaginal delivery, the differences might be attributable in part to demographic differences.

In addition to the absence of comparative cost information about current practices, it is possible that the costs of vaginal delivery are understated. Section II suggests that some undesired C-sections can be avoided with more extensive, trained support for labor. Programs that offer women supported delivery can reduce C-sections, but they cost money; not for technological services, but for caring professionals.[219] Women who have had C-sections are often able to have vaginal birth, but it requires support.[220] Many informed professionals believe that a trained professional listening to the progress of delivery is better than

214. *Id.* at 1419.

215. *Id.*

216. KAISER FAMILY, MATERNITY CARE, *supra* note 182, at 13.

217. *See* Emmett B. Keeler & Mollyann Brodie, *Economic Incentives in the Choice between Vaginal Delivery and Cesarean Section*, 71 THE MILBANK QUARTERLY 365, 365 (1993) (reporting that in 1989 the average charge for a C-section was $2,850 more than vaginal delivery; the average physician fee for a C-section was about $500 greater than the fee for vaginal delivery); Margaret Mushinski, *Average Charges for Uncomplicated Vaginal, Cesarean and VBAC Deliveries: Regional Variations, United States, 1996*, 79 STATISTICAL BULLETIN OF THE METROPOLITAN LIFE INSURANCE CO. 17, 25–26 (1998) (reporting, on the basis of insurance claim data, that the national average physician charge for uncomplicated vaginal delivery in 1996 was $3,180, for uncomplicated Cesarean delivery was $4,590, for VBAC was $3,630).

218. *See supra* note 13.

219. *See supra* text accompanying notes 68–69.

220. *See supra* text accompanying notes 71–72.

EFM, but it requires more time from the caregiver.[221] For many women, vaginal delivery costs less than a C-section because insurance programs, public and private, are less willing to devote the resources necessary to make it safe and effective. More detailed work is needed to evaluate the relative financial costs of various routes to childbirth. Most especially, work is needed to assess the costs of supporting vaginal birth.

In summary, this article does not challenge the assumption that health insurers have legitimate interests in limiting payments to services that are medically necessary. Unnecessary medical interventions waste resources and cause injuries to patients. However, when a woman is ready to deliver, some form of medical intervention is medically necessary. In relation to reproductive health services, we have a long history in the United States of defining medical necessity in terms that disrespect women's choices. In the end, childbirth choices should be made by women and their physicians, not by insurance companies.

CONCLUSION

Elective C-sections by maternal choice are a relatively new phenomena. Avoidable C-sections, unsought by pregnant women, are far more common. While this article has sought to defend women who choose to schedule C-sections without compelling medical justification, it would be tragic if respect for those choices led to an increase in the number of women pressured to have C-sections. As Section I indicates, there is substantial evidence that, in most situations, supported vaginal birth is substantially better for both women and infants. The fear is that if maternal choice C-sections are regarded as legitimate, concern about pressured C-sections will decrease. If some women choose C-sections, why should we be alarmed if other women are pressured to have them? The answer is that informed choice matters. The hope of this article is that more open, honest discussion about C-sections, chosen by women, will promote an environment in which all choices are respected.

221. *See supra* text accompanying notes 106–115.