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ACCESS TO VAGINAL BIRTH AFTER CESAREAN:
RESTRICTIVE POLICIES AND THE CHILLING OF WOMEN'S
MEDICAL RIGHTS DURING CHILDBIRTH

LISA PRATT*

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INTRODUCTION

Joy Szabo, pregnant with her fourth child, planned to give birth at her local hospital, as she had done with her first three children.¹ However, just a few months short of her due date, her doctor informed her that due to a recent change in the hospital's policies, she would have to schedule a cesarean. During her second pregnancy, Joy had a placental abruption and an emergency cesarean. Although she had a successful vaginal birth with her third pregnancy, the hospital is one of hundreds of hospitals that prohibit vaginal birth after cesarean (VBAC),² and their new policy would require her to have a medically unnecessary³ cesarean that she did not want.

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1. Joy Szabo, *Mother-Sized Activism: Page Hospital VBAC Ban*, ICAN BLOG (Oct. 2, 2009), <http://blog.ican-online.org/2009/10/02/mother-sized-vbac-ban/>.

2. VBAC (pronounced VEE-Back) is the term commonly used to describe a vaginal birth or an attempt to have a vaginal birth after cesarean section. NANCY WAINER COHEN & LOIS J. ESTNER, SILENT KNIFE: CESAREAN PREVENTION AND VAGINAL BIRTH AFTER CESAREAN (VBAC) 4 (1983). In medical literature, where the distinction matters, an attempt to VBAC is often referred to as a "Trial of Labor after Cesarean" (TOLAC), and the term VBAC is limited to successful VBAC attempts. F. Gary Cunningham et al., *National Institutes of Health Consensus Development Conference Statement on Vaginal Birth After Cesarean: New Insights March 8–10, 2010*, 115 OBSTETRICS & GYNECOLOGY 1279, 1280 (2010) [hereinafter *NIH VBAC Consensus Conference*], available at http://consensus.nih.gov/2010/images/vbac/vbac_statement.pdf. Women anticipating a vaginal birth do not generally refer to their labor as a "trial of labor." In recognition of this and for continuity throughout this document only the term VBAC is used.

3. Szabo, *supra* note 1.

Although Joy's story made national headlines, it is not unique.⁴ There has been a decline in the availability of access to VBAC; fear of legal liability is the most often-cited reason.⁵ In 2010, the National Institutes of Health (NIH) convened a Consensus Development Conference on Vaginal Birth After Cesarean. The NIH concluded, and the American College of Obstetricians and Gynecologists (ACOG) agreed, that VBAC is a safe option and should be offered to women.⁶ Despite the medical consensus, VBAC remains a limited option, both in-hospital and outside of the hospital.⁷ Joy was lucky she had the resources available to travel to another hospital.⁸ Women who do not have these resources are forced to choose to either have the surgery or go without care.⁹

Even when money is not a factor, women seeking VBAC frequently have no medical options because of increasingly restrictive, voluntary hospital policies and legislative requirements.¹⁰ Currently, approximately thirty percent of U.S. hospitals have policies that prohibit VBAC.¹¹ Moreover, women who seek alternatives discover that they are also not able to give birth at home or in a birth center, due to state laws and regulations that restrict care providers from legally attending to women who have had a prior cesarean.¹² Despite the widely

4. Elizabeth Cohen, *Mom Fights, Gets the Delivery She Wants*, CNN (Dec. 17, 2009), <http://www.cnn.com/2009/HEALTH/12/17/birth.plan.tips/index.html>.

5. Michael L. Socol & Donna K. Socol, *How Do We Deal With the Legal Risks*, 55 CLINICAL OBSTETRICS AND GYNECOLOGY 1014, 1015 (2012) (citing a recent survey of obstetricians that showed 25.9 percent had stopped offering VBAC because of fear of litigation).

6. Cunningham, *supra* note 2, at 1290 ("[T]he woman's preference should be honored"); *Vaginal Birth after Previous Cesarean Delivery*, PRACTICE BULLETIN: THE AM. C. OF OBSTETRICIANS AND GYNECOLOGISTS, Aug. 2010, at 7 ("[T]he ultimate decision to undergo TOLAC or a repeat cesarean delivery should be made by the patient.").

7. *VBAC Policies in U.S. Hospitals*, INT. CESAREAN AWARENESS NETWORK (ICAN), <http://www.ican-online.org/vbac-ban-info> (last visited Nov. 3, 2013) [hereinafter ICAN Hospital Survey].

8. In an interview with ICAN, Joy estimates the cost to travel to another city for her birth was more than \$1,500. Joy Szabo, *Don't Roll Over and Take It*, ICAN BLOG (Dec. 18, 2009), <http://blog.ican-online.org/2009/12/18/joy-szabo-dont-roll-over-and-take-it/>.

9. Rixa Ann Spencer Freeze, *Born Free: Unassisted Childbirth in North America* 273 (Dec. 2008) (unpublished Ph.D. dissertation, University of Iowa), available at <http://ir.uiowa.edu/etd/202> ("Some unassisted births would not occur if certain obstacles were eliminated, such as VBAC bans, restrictive hospital practices, [and] prohibition of home birth midwifery . . .").

10. Rita Rubin, *Battle Lines Drawn Over C-Sections*, USA TODAY (Aug. 23, 2005), http://usatoday30.usatoday.com/news/health/2005-08-23-csection-battle_x.htm.

11. See ICAN Hospital Survey, *supra* note 7.

12. Marian F. MacDorman et al., *Trends and Characteristics of Home Vaginal Birth After Cesarean Delivery in the United States and Selected States*, 119 OBSTETRICS & GYNECOLOGY 737, 741 (2012) (stating an increase in the number of VBACs in home birth and a decrease in hospital VBAC is likely attributable to women choosing alternative care due to hospital restrictions, and acknowledging that home birth VBAC is still rare).

accepted knowledge that VBAC is medically safe and viable,¹³ women who have had a prior cesarean are often excluded from any meaningful care options, forcing them to either consent to an unwanted and unnecessary surgery or forgo prenatal and delivery care altogether.¹⁴

When hospitals adopt policies that prohibit VBAC and state laws restrict VBAC at home or in a birth center, women and their fetuses are placed at an unnecessary risk.¹⁵ Eliminating patient choice at labor and delivery also means that women are forced out of the maternity care delivery system; in most instances the provider who handles the delivery also provides prenatal and postnatal care.¹⁶ When a woman endeavors to do what she believes is in her and the fetus's best interest, she must either globally opt in or opt out of medical care, even if that is not in her best interest.

This dilemma should be a staggering public health concern. One-third of women who give birth will deliver by cesarean, precluding more than one million women annually from most birth options because of laws and policies that prohibit VBAC.¹⁷ Certain minority populations are disparately impacted because of their disproportionately higher than average cesarean rate.¹⁸

When a hospital refuses to allow VBAC, the hospital has not eliminated one risky delivery method for a risk-free method.¹⁹ In light of this consideration, a pregnant woman should be the one determining which set of risks are acceptable.²⁰ Part I of this Article will discuss the history of VBAC and the emergence of VBAC bans, examine the

13. PRACTICE BULLETIN, *supra* note 6, at 8.

14. MacDorman, *supra* note 12, at 741.

15. Carol Sakala et al., *Maternity Care and Liability: Pressing Problems, Substantive Solutions*, CHILDBIRTH CONNECTION 34 (2013), available at <http://transform.childbirthconnection.org/wp-content/uploads/2013/02/Maternity-Care-and-Liability.pdf> (explaining the practice of defensive medicine harms patients and limits access).

16. Freeze, *supra* note 9, at 25.

17. *Why You Don't Want a C-Section*, FIT PREGNANCY, <http://www.fitpregnancy.com/pregnancy/labor-delivery/why-you-dont-want-c-section> (last visited Nov. 3, 2013).

18. Bonnie Rochman, *C-Sections on the Rise, Especially for Black Moms*, TIME (Dec. 20, 2010), <http://healthland.time.com/2010/12/20/c-sections-on-the-rise-especially-for-black-moms/>.

19. The purpose of this Article is not to argue the pros and cons of which delivery method is safer or should be preferred. Unfortunately, there is no risk-free method of child-birth; both vaginal birth and surgical births carry risk to both mother and fetus. *NIH VBAC Consensus Conference*, *supra* note 2 (follow hyperlink Archived Webcasts Day 1 and Day 2) (demonstrating there are risks and benefits to both a planned cesarean and a planned vaginal birth, and concluding the patient's preferences should be honored).

20. Anne Drapkin Lyerly & Margaret Olivia Little, *Toward an Ethically Responsible Approach to Vaginal Birth After Cesarean*, 34 SEMINARS IN PERINATOLOGY 337, 338 (2010) (“[M]any of the trade-offs have to do with extramedical, highly qualitative considerations about the process of birth, which are often poorly captured by traditional measures or risk-benefit analyses.”).

medical research, and review the relevant legal framework. Part II will present how voluntary policies and laws restrict access to VBAC. Part III will explore the impact the restrictions have on women.

I. THE RISE AND FALL OF VBAC

The motivation to prohibit VBAC in hospitals stems from a fear of legal liability, rather than a concern for patient safety.²¹ Prohibiting access to care for women who desire a VBAC, either in the hospital or outside of the hospital, is not supported by public policy,²² current medical research,²³ or legal precedent.²⁴

A. *The History of the VBAC Movement*

Cesareans were once regarded as a life-saving measure for the fetus when the mother's demise was imminent.²⁵ As advances were made in surgical technology, coupled with the use of blood products and increased knowledge about sanitation, the procedure was able to be performed without taking the mother's life.²⁶ The phrase "once a cesarean always a cesarean" was commonly used prior to the 1970s, when cesarean sections were a very rare occurrence.²⁷ In the 1980s, after research demonstrated a low rate of complications, hospitals started offering VBAC in response to concerns over the rising cesarean rate and to increased consumer demand.²⁸ Eventually, insurance companies, concerned about the high cost of cesareans, required women who had previously delivered by cesarean to deliver by VBAC in subsequent deliveries, regardless of individual risk factors.²⁹ Consequently, women were not given true informed consent on the risks of VBAC, and those who suffered adverse outcomes brought malpractice claims against the doctors and hospitals.³⁰ In response to an increased malpractice climate, ACOG released more restrictive VBAC guidelines in 1999, stating the circumstances under which women should be

21. Lisa L. Chalidze, *Misinformed Consent: Non-Medical Bases for American Birth Recommendations as a Human Rights Issue*, 54 N.Y.L. SCH. L. REV. 59, 82, 100 (2009).

22. *Id.* at 73.

23. *Id.* at 75.

24. *Id.* at 78.

25. COHEN & ESTNER, *supra* note 2, at 10; Clarissa Bonanno et al., *VBAC: A Medicolegal Perspective*, 38 CLINICAL PERINATOLOGY 217, 217–18 (2011) [hereinafter *VBAC History*] (giving a brief history of cesareans and VBAC).

26. *Id.*

27. *VBAC History*, *supra* note 25.

28. COHEN & ESTNER, *supra* note 2, at 21.

29. *VBAC History*, *supra* note 25, at 219.

30. *Id.* at 221.

offered a VBAC, including having anesthesia immediately available.³¹ Concerned with the ability to meet the new guidelines, hospitals gradually stopped offering VBAC, until the VBAC rate dropped to 8.5 percent in 2006, an all-time low.³²

During this time, many states were passing licensing laws for midwives who attended home births. Many of these laws prohibited the midwife from attending VBACs at home, or created restrictions on the circumstances under which the midwife could attend a VBAC at home.³³ Additionally, birth centers, which were a relatively new concept in maternity care delivery, were also being licensed by some states and, in some instances, prohibited from attending VBACs.³⁴ Some birth centers, like some hospitals, were also electing not to offer VBACs even if they were not prohibited by law from doing so.³⁵

Policies that force women to have a repeat cesarean section carry the echoes of the old mandatory VBAC policies. Once again women are not being told of the risks,³⁶ this time the risks of cesarean section, and they are not being given the opportunity to refuse the procedure.³⁷ Moreover, women are not able to seek alternative care outside of a hospital setting due to state laws prohibiting VBACs at home or in birth centers.³⁸

B. Current Medical Research on the Safety of VBAC

In 2010, NIH held a consensus conference on the medical research for VBAC. That conference presented information that cesareans carried more risk to the mother, but that a vaginal birth carried more

31. *Id.* at 218.

32. *Id.*

33. There are two different types of midwives in the United States: direct-entry midwives and Certified Nurse-Midwives. A Certified Nurse-Midwife (CNM) is a midwife who obtained a nursing degree and then a Masters degree in midwifery. Direct-entry midwives do not possess a nursing degree or license; instead they attend midwifery training from a direct-entry midwifery school or through an apprenticeship. There is not a consistent title or credential for direct entry midwives. Each state establishes their own nomenclature: Certified Professional Midwife, Registered Midwife, Certified Midwife, Licensed Midwife, Lay Midwife, or Direct-Entry Midwife. MIDWIVES ALLIANCE NORTH AM., *What is a Midwife?*, <http://www.mana.org/about-midwives/what-is-a-midwife> (last visited Nov. 3, 2013) (explaining the different types of midwives); *The Push Chart*, THE BIG PUSH FOR MIDWIVES CAMPAIGN (May 17, 2013), <http://pushformidwives.org/2012/04/29/pushchart/> (last visited Nov. 3, 2013) (showing what year each state passed legislation to license direct entry midwives); *see also infra* Section II.B.

34. NANCY WAINER COHEN, OPEN SEASON, A SURVIVAL GUIDE FOR NATURAL CHILDBIRTH AND VBAC IN THE 90S, at 195 (Bergin & Garvey 1991).

35. *Id.*

36. *Id.* at 312.

37. Rubin, *supra* note 10, at 4.

38. *See infra* Section II, discussing decreased access in home and birth center settings.

risks for the fetus.³⁹ In either situation, the panel concluded that the risks were still incredibly small, and that VBAC was an option women should be offered.⁴⁰ Furthermore, in evaluating safety considerations, the panel concluded that one cannot make a decision on whether to have a VBAC based only on the risks and benefits of having a vaginal birth; one must also evaluate the short and long term risks and benefits of a repeat cesarean.⁴¹ The risks associated with a VBAC are similar to risks of any first-time birth.⁴² The only major increased risk is uterine rupture.⁴³ However, the increase is very small at less than one percent in women who have a low transverse scar.⁴⁴ Even at the higher risks, there is still a ninety-nine percent chance that her uterus will not tear.⁴⁵ Research on the outcomes for cesarean surgery in general, and repeat cesareans specifically, do show a decreased risk of uterine rupture, but rupture is not the only outcome consideration.⁴⁶ Babies born by cesarean spend more time in the NICU, and have other long term complications, such as asthma.⁴⁷ Each delivery option has risks and benefits, and women will choose different risks to accept, but that determination should be made by the woman whose life, health, and baby will be affected, not by hospital policies.

C. Legal Framework

The question of whether a woman has the right to decline cesarean surgery may be addressed through long-standing legal doctrines concerning patients' rights. Deeply rooted in common law, a competent individual has the right to refuse any or all unwanted medical treatment, even life-saving treatment.⁴⁸ Further, the doctrine of informed

39. *NIH VBAC Consensus Conference*, *supra* note 2, at 1283, 1286 (showing the death rate for women from VBAC is 4 per 100,000 and from cesarean is 13 per 100,000, but for the fetus the death rate from VBAC is 130 per 100,000 and from cesarean is 50 per 100,000).

40. *Id.* at 1289–90.

41. *Id.* at 1290.

42. *Id.*

43. JENNIFER BLOCK, *PUSHED* 116 (2007). A “uterine rupture” is a tear in the uterus. It is a life-threatening complication to both the mother and fetus. Uterine rupture can occur in any vaginal delivery, not just after a prior cesarean.

44. *NIH VBAC Consensus Conference*, *supra* note 2 (showing rupture rate is less than one percent).

45. *Id.*

46. *See* Lyerly & Little, *supra* note 20.

47. *NIH VBAC Consensus Conference*, *supra* note 2.

48. “No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.” *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891); “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for

consent, and the corollary doctrine of informed refusal, bolster this right by providing a patient with the information on which to base her treatment decisions, after being informed of the risks and benefits, as well as the alternatives to the proposed treatment.⁴⁹ Additionally, established doctrine states that one cannot be compelled to undergo treatment for the benefit of a third party,⁵⁰ and that there are limits on whether a hospital or physician may force a woman to undergo a cesarean. Finally, case law clearly supports the premise that pregnancy does not void a woman's constitutional right to make her own treatment decisions, nor does it diminish her right to informed consent.⁵¹

Some would suggest that pregnancy is a special circumstance that involves two patients, both of whom possess equal rights and equal consideration with regard to a decision to pursue a VBAC.⁵² However, this special category of personhood cannot logically or legally support forced cesarean. In order for the fetus to receive treatment, in this case a surgical delivery, one must cut through the woman's body, compelling her to submit to treatment that benefits a third party, the fetus, and to address the rights of the fetus, it must invariably mean addressing the individual rights of the woman. Certainly a fetus has an interest in what delivery options the woman chooses. However, those interests do not trump the woman's rights.⁵³

Whether to perceive the mother and baby as two separate patients or as one does not change the analysis. First, if the mother and baby are indeed two separate patients, the mother has the right to not

which he is liable in damages." *Schloendorff v. Soc'y of New York Hosp.*, 105 N.E. 92, 93 (1914); *Cruzan v. Dir., Missouri Dept. of Health*, 497 U.S. 261, 279 (1990).

49. Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 1970 (1986) ("[I]nformed consent doctrine illustrates two salient features of American law. First, it shows the extent to which patient autonomy is respected and highlights how nonconsensual surgery deviates sharply from [that and] it shows that risk-benefit judgments about medical treatment are the patient's to make, and not the doctor's . . . The informed consent requirement would be meaningless if patients had no choice but to obey doctors' orders.").

50. *McFall v. Shimp*, 10 Pa. D.& C.3d 90, 91 (1978) (considering if Shimp should be compelled to give life sustaining bone marrow to his cousin, the court stated, "one human being is under no legal compulsion to give aid or to take action to save that human being or to rescue.").

51. *In re A.C.*, 573 A.2d 1235, 1244, 1247 (D.C. 1990), *rev'd en banc*, 533 A.2d 611 (D.C. 1987).

52. Margo Kaplan, *A "Special Class of Persons": Pregnant Women's Right to Refuse Medical Treatment After Gonzales v. Carhart*, 13 PA. J. CONST. L. 145, 192 (2010). Judge Belson's dissent in the *In re A.C.* case describes pregnant women as a "unique category of persons." *Id.*

53. Elselijn Kingma, *The Lancet's Risky Ideas: Rights, Interests, and Home Birth*, 65 INT. J. OF CLINICAL PRAC. 918, 919 (2011) (distinguishing between "rights" and "interests" in birth).

be compelled to undergo treatment for a third party, in this case the fetus. Because of doctrine governing patient refusals, she has the right to refuse the surgery, even if it poses a greater risk to the fetus. If, alternatively, the mother and baby are considered one patient, the mother decides for herself what treatment to refuse or accept. The decision whether to attempt a VBAC rests solely with the mother.

Finally, it is important to note that attempting a VBAC is not a *de facto* abortion and cases that attempt to apply abortion case law to compel a cesarean are misplaced.⁵⁴ In the situation where a woman contests a hospital or doctor's determination to prohibit VBAC, the mother is disagreeing with the doctor on the manner in which to deliver the baby. There is no reason to believe that she intends to terminate the pregnancy or to terminate the potential life of the fetus prior to delivery.⁵⁵

Any legal theory that presumes the maternal choice to pursue a VBAC involves harm to the fetus, or even a competition of interests between mother and fetus, is flawed. This comparison assumes that VBAC is inherently risky, so much so, that the likelihood of death or harm to the fetus is almost certain, but the medical literature does not support this assertion.⁵⁶

II. LAWS AND POLICIES THAT RESTRICT VBAC

There have been several student written articles on possible legal challenges to hospital policies that prohibit VBAC, however none have examined the lack of access outside of a hospital.⁵⁷ This is an

54. Rhoden, *supra* note 49, at 1953 (“*Roe* merely allows states to prohibit intentional fetal destruction after viability, unless abortion is needed to protect the woman’s life It says nothing about whether the state may require invasive medical procedures to *promote* fetal health.”).

55. Kaplan, *supra* note 52, at 169–70 (“One of the limitations of applying abortion jurisprudence to compelled treatment is that the state interest in fetal life is not implicated in the same manner in compelled treatment cases. In the context of abortion, fetal life will certainly be terminated; this is one of the purposes of abortion. However, medical treatment cases do not involve the purposeful termination of fetal life. Instead, they concern differences of opinion in how to achieve a live birth.”).

56. *NIH VBAC Consensus Conference*, *supra* note 2 (presenting current research on VBAC’s safety).

57. The National Advocates for Pregnant Women (NAPW) held a student essay contest on potential legal challenges for hospital VBAC policies. NAPW, CONGRATULATIONS TO THE 2008–2009 CONTEST WINNERS! (Oct. 22, 2009), http://advocatesforpregnantwomen.org/main/events/napw_writing_contest/congratulations_to_our_winners.php. See Krista Stone-Manista, “*In the Manner Prescribed By the State*: Potential Challenges to State-Enforced Hospital Limitations on Childbirth Options, 16 CARDOZO WOMEN’S L.J. 469 (May 2010); Elizabeth Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN ST. L. REV. 955 (2010); Paul Christopher Estaris Torio, *Nature Versus Suture: Why VBAC Should Still Be in Vogue*; L. Indra Lusero, *Challenging Hospital VBAC Bans Through Tort Liability: Reasonableness and the Limits of Informed Consent*, 20 WM. & MARY J. WOMEN & L. (forthcoming 2014).

important public policy consideration when contemplating legal challenges to restrictive VBAC policies: women whom are restricted by law from having an out-of-hospital birth are then prohibited from having a VBAC in a hospital, the only birth setting legally available to them.

A. Hospital Policies That Prohibit VBAC

No state or federal law prohibits a woman from having a VBAC in a hospital or with a doctor.⁵⁸ Hospital policies that ban VBAC are therefore voluntary and self-determined. Hospital VBAC refusals have two forms: (1) the hospital has a formal policy that does not permit a woman to have a VBAC in their hospital and prohibit doctors who have privileges there from attending a VBAC⁵⁹ or, (2) the hospital may not have a formal policy on VBAC, but all of the doctors who have privileges at the hospital refuse to attend VBAC patients.⁶⁰ The origin of the policy may be different, but the result is the same: no access to hospital care for those women who desire a VBAC.⁶¹

In 2009, to determine how widespread these policies were, the International Cesarean Awareness Network (ICAN) conducted a telephone survey of 2,875 hospitals.⁶² Their survey found that only 1,645 hospitals allowed VBAC, 824 prohibited VBAC formally, and 388 did not have even one doctor willing to support a VBAC, thus creating a *de facto* ban.⁶³ The survey conducted by ICAN did not identify hospitals that affirmatively encourage VBAC,⁶⁴ and the results should not be interpreted to support that conclusion. The survey focused on facility level policy, therefore, a hospital was included in the “allowed”

58. ICAN Hospital Survey, *supra* note 7.

59. *Id.*

60. *Id.*

61. The National Institutes of Health convened a consensus conference in 2006 on the issue of maternal request cesareans. Advocates and researchers disputed the idea that women were asking for this procedure. When the NIH panel was questioned on what data they were basing the conclusion that women were in fact the driving force behind cesareans without any indications, the panelists could not state one specific study. The conference unintentionally highlighted a concerning trend: if women are not demanding elective cesareans over a VBAC then there must be some external factor that is forcing that decision. Thanks to ICAN's survey, we know that hospital and doctor policies are one external factor. Video, *NIH State-of-the-Science Conference: Cesarean Delivery on Maternal Request*, NAT'L INST. OF HEALTH (Mar. 27–29, 2006), <http://consensus.nih.gov/2006/cesarean.htm> (follow hyperlink Archived Videocasts Day 1, Day 2, and Day 3) (last visited Nov. 3, 2013).

62. ICAN's telephone survey was designed to simulate what a pregnant woman would be told if she contacted the hospital and asked their policy on VBAC. Industry surveys show a slightly lower rate (one-third) of hospitals no longer offering VBAC. See ICAN Hospital Survey, *supra* note 7.

63. *Id.*

64. *Id.*

category even if only one doctor there would permit a VBAC.⁶⁵ In total, 1,212 hospitals, or forty-two percent, prohibit VBAC.⁶⁶

B. Midwifery Laws and Regulations That Prohibit or Restrict VBAC

The significant impediment for women seeking VBAC caused by the number of hospitals limiting or prohibiting VBAC is further exacerbated by heightened regulation in recent years of midwifery practice.⁶⁷ States have the authority to license midwives and promulgate rules under which they must practice.⁶⁸ In doing so, many states have restricted or entirely prohibited midwives from providing care to women who have had a prior cesarean.⁶⁹ A survey of state laws and regulations conducted by the author reveals how many states prohibit or restrict access to VBAC at home with direct-entry midwives.⁷⁰ Only five states have no restrictions on women seeking home birth for VBACs (Delaware,⁷¹ Tennessee,⁷² Minnesota,⁷³ New York,⁷⁴ and

65. *Id.*

66. *Id.*

67. ISSUE BRIEF: CERTIFIED PROFESSIONAL MIDWIVES IN THE UNITED STATES 3 (Midwives Alliance of North America 2008), available at <http://mana.org/pdfs/CPMIssueBrief.pdf>.

68. It is an important distinction to note that laws restricting access to home birth midwives are restricting the midwife's scope of practice and not a woman's right to give birth at home. A midwife cannot practice outside the scope of her licensing regulations, but a woman who hires a midwife is not breaking any law, even if the midwife is acting outside the scope of her practice. Some states have included informed refusal clauses affirming parents' right to refuse treatment. Although these clauses may permit the parents to refuse treatment or procedures the midwife is required to perform (a right they already possess), it does not permit the midwife to practice outside of her scope of practice. *See id.*

69. This Article examines licensing laws for direct-entry midwives who are considered experts on out of hospital birth. ISSUE BRIEF, *supra* note 67, at 2–3 (stating Certified Professional Midwives have “particular expertise in out of hospital settings”). According to the Centers for Disease Control (CDC), 73 percent of home births were attended by non-nurse or direct-entry midwives, only 27 percent by CNMs, 7.6 percent by physicians, and the remaining births were attended by family or others. CTRS. FOR DISEASE CONTROL, TRENDS AND CHARACTERISTICS OF HOME AND OTHER OUT-OF-HOSPITAL BIRTHS IN THE UNITED STATES, 1990–2006 (2010), available at http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_11.pdf.

70. The purpose of this research is to provide facility level data on policies that restrict access for women who desire a VBAC. To that end, I did not survey individual midwives to determine their personal policy. Instead, I researched state laws and regulations governing a midwife's ability to accept VBACs or not. In addition to state laws that prohibit or restrict midwives from attending VBAC, some midwives choose not to attend VBACs, however, it is beyond the scope of this Article to determine the actual number of midwives who do or do not attend VBACs.

71. DEL. CODE ANN. tit. 16, § 122 (2011); 16-4000–4106 DEL. CODE REGS. § 4.3 (LexisNexis 2013).

72. TENN. CODE ANN. § 63-29-101 (2013); TENN. COMP. R. & REGS. 1050-5-.02 (2013).

73. MINN. STAT. § 147D.01 (2013).

74. N.Y. EDUC. L. § 6951 (2012); N.Y. COMP. CODES R. & REGS. tit. 8, § 79-5, tit. 10, § 85.36 (2013).

Washington⁷⁵). Four states prohibit VBAC in home births (Alaska,⁷⁶ Arizona,⁷⁷ Arkansas,⁷⁸ and South Carolina⁷⁹). Sixteen states impose restrictions that limit or prohibit VBAC, such as requiring an enhanced informed consent process,⁸⁰ a physician consult,⁸¹ at least eighteen months between pregnancies,⁸² or limiting it to secondary VBACs.⁸³ (California,⁸⁴ Colorado,⁸⁵ Florida,⁸⁶ Idaho,⁸⁷ Louisiana,⁸⁸ Montana,⁸⁹ New Hampshire,⁹⁰ New Jersey,⁹¹ New Mexico,⁹² Oregon,⁹³

75. WASH. REV. CODE ANN. § 18.50.003 (West 2011); WASH. ADMIN. CODE § 246-834-010 (2013).

76. ALASKA STAT. § 08.65.140(d)(15) (2011).

77. ARIZ. ADMIN. CODE § R9-16-108(A)(1) (2013).

78. 007-13-92 ARK. CODE R. § 406.1(1) (LexisNexis 2008).

79. S.C. CODE ANN. § 44-89-60(1) (2011) (stating the licensed midwife may provide care to low-risk women). “It is the Department’s position that the care of patients desiring VBAC is not low-risk and therefore is outside the scope of practice for Licensed Midwives.” Letter from South Carolina’s Department of Health and Environmental Control (DHEC) . . . to Licensed Midwives (Mar. 27, 2006), available at <http://www.scdhec.gov/health/licen/vbac-lmw20060327.pdf>.

80. An enhanced informed consent process can include signing an acknowledgement of increased risks, providing the client with ACOG’s VBAC guidelines, information on physicians to whom the client could transfer care, or current medical research on risks and benefits of VBAC and documenting the process in the client’s chart. This level of disclosure is generally not required for other conditions that may pose an increased risk, and creates an additional burden on the midwife to uniquely document the informed consent process for VBAC.

81. On its face, statutes requiring a doctor consultation, collaboration, or sign-off clauses appear to allow VBAC, but there are very few doctors who will provide these consultations, effectively reducing or eliminating access for women seeking VBACs. See *Rhode Island: Status of Midwifery*, CITIZENS FOR MIDWIFERY (2005), <http://cfmidwifery.org/states/states.aspx?ST=RI> (last visited Nov. 3, 2013) (describing how changes to the Rhode Island midwifery law that required consultation with a doctor limited midwives’ ability to practice).

82. IDAPA 24.26.01, “Rules of the Idaho Board of Midwifery.” r.356.02(b)(i), 356.04(b) (2010).

83. A “secondary VBAC” is a VBAC after a woman has previously had a successful VBAC.

84. CAL. CODE REGS. tit. 16, § 1379.19 (2010).

85. 4 COLO. CODE REGS. § 739-1:12 (LexisNexis 2011).

86. Florida has a unique point system for assessing risk criteria. When a client’s risk factor adds up to three, the midwife is required to refer the client to a physician for a consultation and sign off. If a woman has had a prior cesarean and has never had a vaginal delivery the risk score is three points; if she has had a VBAC previously the risk score is two points. FLA. ADMIN. CODE ANN. r. 64B24-7.004 (2011).

87. IDAPA 24.26.01, “Rules of the Idaho Board of Midwifery.” r. 356.02(b)(i), 356.04(b) (3-29-10); IDAHO CODE ANN. § 54-5501(i)(5) (2012).

88. LA. ADMIN. CODE tit. 46, § 5361(B)(1) (2013).

89. MONT. ADMIN. R. 24.111.612 (2013).

90. N.H. CODE ADMIN. R. ANN. MID. 503.02, 503.04–05 (2013).

91. N.J. ADMIN. CODE § 13:35-2A.9 (2011).

92. N.M. CODE R. § 16.11.3.3(A) (LexisNexis 2001); PRACTICE GUIDELINES FOR NEW MEXICO MIDWIVES 2008 EDITION 88, 93, 95 (New Mexico Midwives Assoc. ed. 2008), available at <http://www.health.state.nm.us/PHD/midwife/NMMA%202008%20practice%20guidelines.pdf>.

93. OR. ADMIN. R. 332-025-0021 (2013).

Texas,⁹⁴ Utah,⁹⁵ Vermont,⁹⁶ Virginia,⁹⁷ Wisconsin,⁹⁸ and Wyoming⁹⁹). The remaining states¹⁰⁰ do not license home birth midwives.¹⁰¹

Unlike hospital policies, restrictions limiting VBACs in home birth settings are laws. Despite the presumptive public policy justification to promote the welfare of citizens, there is no evidence that prohibiting VBAC at home promotes safer conditions for mothers preferring a VBAC.¹⁰² These restrictions have the paradoxical effect of creating greater risks for pregnant women. If the servicing hospital prohibits VBAC, and the state places limitations on VBAC for midwifery assisted births, women either submit to cesarean surgery or pursue VBAC with no choice in care providers.¹⁰³ Policy makers need to reevaluate the scheme under which midwives can legally practice without unnecessarily limiting VBAC, and to amend current laws to eliminate restrictions.

C. Birth Center Laws, Regulations, and Policies Against VBAC

Similarly, policy and legal restrictions on birth center environments significantly restrict, or eliminate, a woman's ability to choose a VBAC. Birth centers' VBAC policies were evaluated by both researching state law and conducting a survey similar to ICAN's hospital survey. Birth center policy for VBAC is influenced both by state law and by institutional or provider preferences.¹⁰⁴ Some states

94. 22 TEX. ADMIN. CODE §§ 831.52, 831.60(b)(9), (c)(8) (2013).

95. UTAH ADMIN. CODE R. 58-77-204(4)(b)(v)-(ix) (2011).

96. 04-030-360 VT. CODE R. § 3.14.2.1 (2012).

97. VA. CODE ANN. § 54.1-2957.9(IV) (2009).

98. WIS. ADMIN. CODE RL § 182.02 (2011).

99. WYO. STAT. ANN. § 33-46-103(j)(i)(A)(V), (C)(II) (2011).

100. Alabama, Connecticut, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, and West Virginia. Indiana passed a licensing law in 2013, but at the time of publication, the rules were not promulgated, therefore, the author was unable to determine if VBAC was permitted. IND. CODE § 25-23.4-6-1 (2013).

101. Some states do not license direct-entry midwives. In most of the states that do not license midwives, direct-entry midwifery is not legal because it violates the state's medical practice act. However, some states provide for an exemption to the medical practice act for midwifery, making the practice legal, but they do not promulgate regulations to govern the practice of those midwives. In either case, there is no specific restriction on VBAC and those states were not included in the analysis. Whether or not midwifery is legal in states that do not license direct-entry midwives is beyond the scope of this Article.

102. Amy V. Haas, *Homebirth after Cesarean: The Myth and the Reality*, MIDWIFERY TODAY (2008), <http://www.midwiferytoday.com/articles/homebirthaftercesarean.asp>.

103. Freeze, *supra* note 9, at 11.

104. Jen Kamel, *Is VBAC Illegal? Is Homebirth Illegal?*, VBAC FACTS, <http://vbacfacts.com/2009/02/28/is-vbac-illegal/> (last visited Nov. 3, 2013).

prohibit VBAC under the birth center licensing laws.¹⁰⁵ The author conducted an email survey of birth centers to determine how many offer VBAC in the states that do not prohibit VBAC in birth centers.¹⁰⁶ The survey consisted of one simple question: “Do you offer VBAC at your birth center?”, with four possible answer choices: (A) “No,” (B) “Yes, in the birth center,” (C) “Yes, in the hospital,” (D) “Yes, at home.” Respondents could choose more than one answer, if, for example, they offered VBAC in the hospital and in the birth center they could choose response “B” and response “C”. The answer choices were designed to isolate births that actually take place in the birth centers, because many birth center midwives will also attend deliveries at home or in hospitals. For deliveries that take place in locations outside of the birth center, home birth laws or hospital policies control whether the midwife could attend a VBAC. The survey assumes that birth centers in states that prohibit VBAC do not, in fact, offer VBAC in their centers, and were automatically classified as “prohibited.” The survey was emailed to 227 birth centers, and the following are the results: thirty-eight responded (B) “Yes, in the birth center”; twenty-eight responded (A) “No”; sixty-three were prohibited by law; fifty-four did not respond; and forty-three email addresses were returned as undeliverable.¹⁰⁷ In total, only twenty-nine percent of birth centers surveyed offer VBAC. The findings reveal that the trend to restrict VBAC in hospital and home birth settings is paralleled in birth centers. With significant restrictions in many jurisdictions against VBAC in all birth setting options, it means that women seeking VBAC are effectively prohibited from having the option to pursue VBAC, and must either submit to a repeat cesarean or opt to not seek prenatal and birth care from a health care provider.

III. THE CHILLING EFFECT VBAC BANS HAVE ON WOMEN’S RIGHTS

Hospital policies prohibiting VBAC have a chilling effect¹⁰⁸ on a pregnant woman’s medical rights. Women anticipating birth in a

105. *Id.*

106. These policies can be affected by local hospital policy or the policy of the collaborating physician. As there does not seem to be a pattern of birth center policy corresponding with hospital policy, some midwives who responded to the survey stated that they did not offer VBAC anymore because their collaborating physician or the hospital to which they would transfer did not allow it. This information was volunteered in addition to the survey response, however, and was not part of the survey. Similarly, the factors that drive birth center policies are beyond the scope of this Article.

107. Survey results are on file with author.

108. In First Amendment legal doctrine, a “chilling effect” is “when any behavior safeguarded by the Constitution is unduly discouraged.” Frank Schauer, *Fear, Risk and the First Amendment: Unraveling the Chilling Effect*, 58 B.U.L. REV. 689, 690 (1978).

hospital prohibiting VBAC are often unaware of their right to refuse the surgery, or they do not know how to assert those rights.¹⁰⁹ Prior to widespread policies prohibiting VBAC, some hospitals attempted to force women to have cesareans by court order.¹¹⁰ After a favorable appellate ruling for women's rights, the efforts to use this legal strategy subsided and hospitals abandoned this approach in favor of internal policies prohibiting VBAC. Though these policies are likely not legally enforceable,¹¹¹ they persist because of the unequal bargaining positions of the doctor-patient relationship, and through the use of coercion and intimidation.¹¹²

The imbalance in the doctor-patient relationship is a significant factor impacting women's rights in birth choices, and an important reason why informed consent is such a critical component in the delivery of health care. The doctor-patient relationship is an asymmetrical one, with the doctor in the position of authority as the one who holds the special knowledge and skills the patient needs or wants.¹¹³ It is this "competence gap" that tips the power in the physician's favor, and without balanced informed consent, requires the patient to acquiesce to the doctor's recommendations.¹¹⁴ The problem is that, even if women are given information on alternatives, when a hospital adopts a policy to eliminate VBAC there is often nowhere else to seek care, except from another hospital or doctor who will require a cesarean section.¹¹⁵ In these situations where a hospital prohibits VBAC, the woman appears to be consenting to surgery, but this consent is given

109. Jen Kamel, *Options for Mom Who Will Be "Forced" to Have a Repeat Cesarean*, VBAC FACTS, <http://vbacfacts.com/2012/03/02/options-mom-forced-repeat-cs/> (last visited Nov. 3, 2013); Jen Kamel, *VBAC Bans, Exercising Your Rights, and When to Contact an Attorney*, VBAC FACTS, <http://vbacfacts.com/2012/08/24/vbac-bans-exercising-your-rights-and-when-to-contact-an-attorney/> (last visited Nov. 3, 2013) (featuring a question from a reader questioning what her rights are to refuse a cesarean); Lisa Pratt, Conference Presentation at the National VBAC summit: A Legal Guide to VBAC: Rights, Effective Communication, and Remedies (Aug. 18, 2011), available at <https://www.dropbox.com/sh/ps4p2crkz22kqe9/EgyojNUtdE?n=18138270> (speaking on a woman's right to refuse treatment and how to effectively assert those rights).

110. Rhoden, *supra* note 49, at 1951.

111. See NAPW, *supra* note 57, at 1; Stone-Manista, *supra* note 57, at 477; Kukura, *supra* note 57, at 999; Torio, *supra* note 57, at 19; Lusero, *supra* note 57, at 3.

112. Susan Irwin & Brigitte Jordan, *Knowledge, Practice, and Power: Court-Ordered Cesarean Sections*, 1 MED. ANTHROPOLOGY Q. 319, 319–34, (1987) (discussing forced cesareans "stem from a particular definition of authoritative medical knowledge—in this instance, the technical skills attributed to obstetricians that legitimate their control of birthing and discredit the individual and collective expertise of birthing women.").

113. *Id.* at 319.

114. Lu-in Wang, *Race as Proxy: Situational Racism and Self-Fulfilling Stereotypes*, 53 DEPAUL L. REV. 1013, 1097 (2004).

115. See Szabo, *supra* note 8 (stating that the woman traveled hundreds of miles to a hospital that would permit VBAC).

under extreme duress.¹¹⁶ The choice posed to a woman is that she either has surgery or she goes without care. But few women want to give birth without any medical care.¹¹⁷ Some women will navigate around hospital policies and choose an out of hospital birth in order to have a VBAC.

Laura Pemberton is an example of a woman attempting to navigate a VBAC ban by seeking care outside of the hospital system, and highlights how in-hospital policies affect women even when they choose to opt out of that system.¹¹⁸ She had planned a home birth after a previous cesarean, but during her labor she became dehydrated and went to the hospital to get IV fluids. Once at the hospital, she was denied the fluids she needed unless she agreed to have a cesarean surgery, which she refused.¹¹⁹ The hospital was granted an order for her to be returned to the hospital by police force and submit to the operation.¹²⁰ This trial level decision appears to be an outlier; if the case had been properly appealed, it is likely the Florida court would have followed the persuasive authority of *In re A.C.*¹²¹

Relatively few cases of court ordered cesareans have been published, even fewer involve a woman with a prior cesarean refusing a repeat surgery. After the *In re A.C.* decision, doctors and hospitals stopped pursuing court-ordered cesareans and now attempt to gain compliance in more covert ways. Rather than involving the court to compel the doctor's orders, they have resorted to coercion to wear down the woman until she relents.¹²² Women have been threatened that the doctor will report her to Child Protective Services (CPS) if she did not agree to a cesarean.¹²³ For example, a woman from Florida posted to an email forum looking for advice after her doctor informed her he would call CPS if she did not schedule a cesarean, or if she did

116. Laura Pemberton, Speech at the National Summit to Ensure the Health and Humanity of Pregnant and Birthing Women (Jan. 20, 2007), available at <http://vimeo.com/4895023>. The hospital withheld critical IV fluids she needed for dehydration, unless she consented to a cesarean. She refused and left without receiving any treatment.

117. See Freeze, *supra* note 9, at 8–9 (estimating the number of unassisted births in the U.S. to be between a few hundred and 8000, but due to the “off-grid” nature of unassisted births, the number is difficult to estimate).

118. See Pemberton, *supra* note 116; see also Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., 66 F. Supp. 2d 1247, 1249 (N.D. Fla. 1999).

119. Pemberton, 66 F. Supp. 2d at 1249.

120. Torio, *supra* note 57.

121. Laura Pemberton's Talk From NAPW's 2007 Summit Now Available Online, NAPW, http://advocatesforpregnantwomen.org/featured/laura_pembertons_talk_from_napws_2007_summit_now_available_online.php (last updated July 6, 2009) (commenting on the Pemberton case).

122. See Pemberton, *supra* note 116.

123. *Informed Consent in Childbirth: Making Rights into Reality*, IMPROVINGBIRTH.ORG (July 9, 2013), <http://www.improvingbirth.org/2013/07/informed-consent-in-childbirth/>.

not show up for the scheduled surgery.¹²⁴ More recently, a woman contacted popular blogger Jen Kamel at VBACFacts.com looking for advice after her doctor threatened to drop her from care if she did not consent to a cesarean. With Ms. Kamel's help, she contacted several advocacy groups who were able to convince the doctor and hospital to back down without court intervention.¹²⁵

A recent decision in New Jersey highlights this egregious method taken to an extreme.¹²⁶ While in labor, V.M. refused to sign a blanket consent form for a cesarean, even though there was no indication she needed one, and a psychologist was called in to evaluate her mental condition.¹²⁷ The psychologist who examined her concluded she was competent and entitled to informed consent.¹²⁸ Not content with the first psychologist's conclusion, the hospital brought in a second doctor to evaluate V.M.¹²⁹ The interview was cut short when V.M. vaginally delivered her baby. Despite the competent evaluation from the first doctor and the fact that she delivered a healthy baby without the refused surgery, CPS was called in to investigate, based on her refusal to submit to the surgery.¹³⁰ Ultimately V.M. prevailed, a victory for pregnant woman but bittersweet for V.M., who was needlessly separated from her baby for four years while the case was adjudicated.¹³¹ It is this type of case that presents a chilling effect on women's rights in child birth. Even when a woman knows her rights, she will abandon her rights rather than risk having her baby removed after a retaliatory CPS investigation.

This decision touches on an important public policy consideration: punishing a woman for not agreeing to a recommended treatment, particularly major surgery,¹³² will only discourage women from seeking medical care. Prenatal care is vital to a healthy pregnancy.¹³³

124. Postings of Lily Beck (July 24, 2009 & Aug. 14, 2009) (on file with author).

125. See Kamel, *Options*, *supra* note 109, at 5; see also Kamel, *VBAC Bans*, *supra* note 109, at 2.

126. See Jessica L. Waters, *In Whose Best Interest? New Jersey Division of Youth and Family Services v. V.M. & B.G. and the Next Wave of Court-Controlled Pregnancies*, 34 HARV. J. L. & GENDER 81, 82 (2011); see also N.J. Div. of Youth & Family Servs. v. V.M. (*In re* Guardianship of J.M.G.), Nos. A-2649-08T4, 10 (N.J. Super. Ct. App. Div., Aug. 6, 2010) (per curiam), available at <http://advocatesforpregnantwomen.org/blog/FGopinion.pdf>.

127. Waters, *supra* note 126, at 84.

128. *Id.* at 85.

129. *Id.*

130. *Id.* at 86.

131. *Superior Court of New Jersey has ruled in favor of V.M.*, NAT'L ADVOC. FOR PREGNANT WOMEN (Aug. 6, 2010), advocatesforwomen.org/blog/2010/08/post.php.

132. Waters, *supra* note 126, at 111.

133. AMNESTY INT'L, DEADLY DELIVERY 6 (2010), available at <http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf> ("Women who do not receive prenatal care are three to four times more likely to die [of pregnancy-related complications] than women who do.").

States should support policies that encourage women to seek this important care, not create barriers and disincentives for accessing it. Women do not choose VBAC for safety reasons only, and these other factors are a pertinent piece of why VBAC should not be prohibited.¹³⁴

And yet, paradoxically, safety should be of utmost concern for expecting women, especially in a hospital setting. According to a recent Amnesty International report, the United States has a worse maternal mortality rate than forty other industrialized nations.¹³⁵ African American women have a much higher mortality and morbidity rate, as well as higher cesarean rates and lower VBAC rates, than other racial and ethnic groups.¹³⁶ This already vulnerable population is even more affected by such policies.¹³⁷ With this in mind, unlike countries where women do not have adequate nutrition and give birth in areas with poor sanitation and limited or no access to health care, the United States still has a relatively low number of maternal deaths.¹³⁸ Although the maternal death rate in this country is higher than it should be, it is not high enough to justify eviscerating the medical rights of pregnant women by forcing them into unwanted procedures under the guise of increased safety.

CONCLUSION

It is often stated that “all that matters is a healthy mom and healthy baby.” This oversimplification does a disservice to women and babies. A healthy outcome is the goal, but how we achieve the desired results is really what matters. It matters that all women are treated with respect and dignity during labor. To insure integrity in the process, women must be full participants in their pregnancies, anything less would undermine informed consent, and compromise

134. See Lyerly & Little, *supra* note 20, at 341 (discussing extramedical reasons women consider in choosing between VBAC and an elective repeat cesarean).

135. AMNESTY INT'L, *supra* note 133, at 1 (stating the U.S. has higher maternal mortality rates than 40 other industrialized countries and estimating the rate could be double the published rate due to no requirements for hospitals to report maternal deaths).

136. Margaret Harper et al., *Racial Disparity In Pregnancy-Related Mortality Following A Live Birth Outcome*, 14 ANNALS OF EPIDEMIOLOGY 274, 278 (2004); Susan Gennaro, *Overview Of Current State Of Research On Maternity Outcomes In Minority Populations*, 192 AM. J. OF OBSTETRICS & GYNECOLOGY S3, S4 (2005); Camara Phyllis Jones, *Levels Of Racism: A Theoretic Framework and a Gardener's Tale*, 90 AM. J. OF PUB. HEALTH 1212, 1212 (2000); Michael Lu, *Racial And Ethnic Disparities In Birth Outcomes: A Life-Course Perspective*, 7 MATERNAL AND CHILD HEALTH J. 13, 13 (2003).

137. Jones, *supra* note 136, at 1212.

138. PREGNANCY-RELATED DEATHS, CTRES. FOR DISEASE CONTROL & PREVENTION (2013), available at <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm> (last visited Nov. 3, 2013) (stating there are approximately 650 pregnancy-related maternal deaths per year in the U.S.).

the manner in which we attain the stated goal. Everyone agrees that healthy moms and healthy babies are important, but that goal must be carried out in a manner that acknowledges that the process is as important as the end result.

Prohibitions on VBAC are generating a public health crisis. A record-high cesarean rate coupled with the lack of available VBAC options puts a burden on the healthcare system, puts women at unnecessary risk, and limits patient choice. Putting profits and the desire for liability protection over women's health is not adequate justification to reduce women's rights in pregnancy. In addition to changing hospital policies, a change is needed to laws for home birth and birth centers to remove barriers and prohibitions to VBAC.