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CHALLENGING HOSPITAL VBAC BANS THROUGH TORT LIABILITY

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INTRODUCTION

Births by cesarean section surgery (or c-sections) rose by 50 percent from 1996 to 2006 in the United States.¹ More than 30 percent of U.S. women who give birth at the present time do so by c-section;² which means that of the more than 4 million births per year, 1.2 million are c-sections.³ Because a woman experiences increased medical risk with each cesarean birth,⁴ the question of whether she may choose vaginal birth after a previous cesarean (VBAC) has entered

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1. CAROL SAKALA & MAUREEN P. CORRY, EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE 41 (Milbank Memorial Fund 2008), available at <http://milbank.org/uploads/documents/0809MaternityCare/0809MaternityCare.html>.

2. Joyce A. Martin et al., *Births: Final Data for 2010*, 61 NAT'L VITAL STATISTICS REPORT 1, 2, 9 (Aug. 28, 2012), available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01.pdf#table02.

3. *Id.* at 54 (looking at births from 2004 to 2010).

4. Roger W. Harms, *Repeat C-Sections: Is There a Limit?*, MAYO CLINIC, <http://www.mayoclinic.com/health/c-sections/AN02070> (last visited Jan. 10, 2014).

the policy debate.⁵ Prior to the 1980s, women with previous c-sections usually repeated the surgery for subsequent babies.⁶ Scarring on the uterus from the first surgery generally led physicians to prefer surgery to vaginal birth out of fear that scarring would increase the risk of uterine rupture (a rare but potentially devastating condition that can happen during labor).⁷ But as surgical birth techniques improved, a different type of incision reduced the effects of scarring.⁸ In the 1980s, the National Institute of Health determined that women with previous c-sections could safely undergo labor and, provided they had received the appropriate type of incision in their earlier surgery, would be able to deliver subsequent children vaginally.⁹

Despite these findings, many hospitals have enacted policies prohibiting VBAC.¹⁰ Women seek legal options to challenge these bans, because such policies represent barriers to informed consent and the right to choose to give birth vaginally.¹¹ This Article explores various tort theories of recovery and how they might be applied to the hospital VBAC ban scenario.

A typical VBAC ban scenario might unfold in the following manner: *Ana lives about five minutes away from St. Catherine's Hospital, which is located in a medium-sized town three hours drive from a major metropolitan area. For her second pregnancy, Ana is seeing Dr. Gayatri, a family physician in private practice who also attends births. The pregnancy is progressing well. Ana is considered low risk, except for the scar from her previous cesarean, which she underwent after a healthy first pregnancy when labor failed to progress.*

Dr. Gayatri agrees that since Ana's scar is of the low transverse variety, the baby is well positioned, and Ana lacks any other risk factors, Ana is well suited for a trial of labor and will probably be able to give birth vaginally. After learning the relative risks and benefits of VBAC and Elective Repeat Cesarean (ERCB), Ana and her

5. C.F. Chavez et al., *Vaginal Birth After Cesarean Birth—California 1996–2000*, 51(44) CDC MORBIDITY & MORTALITY WKLY REP. 996–98 (Nov. 8, 2002), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5144a3.htm>.

6. *Id.*; see also Bruce L. Flamm, *Once a Cesarean, Always a Controversy*, 90(2) OBSTETRICS & GYNECOLOGY 312 (Aug. 1997).

7. Chavez, *supra* note 5; Kevin S. Toppenberg & William A. Block, *Uterine Rupture: What Family Physicians Need to Know*, 66 AM. FAM. PHYSICIAN 832, 826–27 (2002).

8. Toppenberg & Block, *supra* note 7, at 823–24.

9. NAT'L INST. OF HEALTH, *Cesarean Childbirth: NIH Consensus Development Conference Statement* (Sept. 1980), available at <http://consensus.nih.gov/1980/1980Cesarean027html.htm>.

10. *Your Right to Refuse: What to Do If Your Hospital Has "Banned" VBAC Q & A*, INT'L CESAREAN AWARENESS NETWORK, http://www.fwhc.org/health/pdf_about_vbac.pdf (last visited Jan. 10, 2014) [hereinafter ICAN].

11. *Id.*

family opt for a “trial of labor” and vaginal delivery. Dr. Gayatri agrees with that decision and does not recommend an ECRB—until she discovers that the hospital recently instituted a policy prohibiting VBAC.

When Dr. Gayatri investigates, she learns that the hospital re-evaluated its capacity to accommodate VBACs after the American Association of Obstetricians and Gynecologists (ACOG) adopted a standard recommending VBACs be allowed only in hospitals staffed for immediate emergency cesareans.¹² After a *New England Journal of Medicine (NEJM)* study made headlines about the danger of uterine rupture during VBAC, the hospital decided VBAC was appropriate only for hospitals with round-the-clock surgical staff and St. Catherine’s pool of on-call anesthesiologists did not suffice.¹³

Dr. Gayatri had just moved from a nearby metropolitan area where she had attended many VBACs and had never encountered professional concern or prohibitive policies. Based on a review of the *NEJM* article, she felt the hospital’s concern to be misplaced. Dr. Gayatri was disappointed to deliver news of the hospital’s restrictive policy to Ana and her family. When they asked about their options, Dr. Gayatri had no answer: she did not have admitting privileges at the other hospital in town, there were no out-of-hospital birth centers within three hours, and Ana’s family did not want a home birth. When pushed by Dr. Gayatri, hospital administrators were unwilling to change the policy, insisting that most people preferred ERCB anyway.

When Ana arrived at the hospital in labor, hoping to be far enough along that she would be permitted to give birth vaginally, she was chastised by a nurse and the on-call physician for waiting so long to come to the hospital and for “risking your life and the life of your baby.” They immediately attached an electronic fetal monitor, which showed reassuring fetal heart tones, installed an IV, and presented Ana with a number of forms to sign. When Ana asked for Dr. Gayatri, the attending physician insisted that it was too late to summon Dr. Gayatri and that the cesarean had to be performed immediately. Ana was frustrated. While being given an epidural to

12. ACOG Practice Bulletin No. 115, *Vaginal Birth After Previous Cesarean Deliver*, 116 *OBSTETRICS & GYNECOLOGY* 450, 458 (Aug. 2010) (“ . . . [T]he College recommends that TOLAC be undertaken in facilities with staff immediately available to provide emergency care. When resources for immediate cesarean delivery are not available, the College recommends that health care providers and patients considering TOLAC discuss the hospital’s resources and availability of obstetric, pediatric, anesthetic, and operating room staffs. Respect for patient autonomy supports that patients should be allowed to accept increased levels of risk, however, patients should be clearly informed of such potential increase in risk and management alternatives.”).

13. Jill MacCorkle, *Fighting VBAC-Lash: Critiquing Current Research*, *MOTHERING MAGAZINE*, Jan./Feb. 2002, available at <http://www.mothering.com/community/a/fighting-vbac-lash-critiquing-current-research>.

numb the region, she insisted, "I don't want a cesarean. I can give birth to this baby myself." The attending physician ignored Ana's protests, repeating the policy that patients with previous cesareans could not give birth vaginally and demanded that Ana sign the consent form. Ana felt pressured in the midst of her contractions and did not know what else to do; she consented and the surgery was performed. Ana was too groggy afterwards to hold her healthy newborn, but she did remember Dr. Gayatri visiting and saying, "I'm sorry you didn't get to give birth vaginally as you wanted, but at least you're both healthy."

Of course Ana was happy to have her baby with her, safe and healthy. But she couldn't shake the feeling that something went wrong. Dr. Gayatri outwardly maintained a professional attitude, not wishing to undermine her patient's trust in the hospital; however, she privately felt that Ana could have given birth vaginally and should have been able to try.

This scenario is not uncommon. With millions of women experiencing primary c-sections every year,¹⁴ millions more face repeat surgery for subsequent births. Because of hospital anti-VBAC policies, many of these women will have no option to give birth vaginally. In the past decade, hospitals have increasingly instituted such bans. The International Cesarean Awareness Network has identified over 800 hospitals across the U.S. with such policies.¹⁵ This represents a large portion of the approximately 4900 hospitals in the country, especially when considering the distribution of hospitals across the country.¹⁶

The medical standard of care went from automatic repeat cesarean to a trial of labor for a vaginal birth after a cesarean and is now caught between the two.¹⁷ While public health officials are working to increase VBACs, some hospitals are prohibiting VBACs.¹⁸ Some hospitals that ban VBACs have done so in response to a statement from the ACOG and a 2001 study that boosted fears about VBAC risks.¹⁹ Women like Ana are caught in the middle of this

14. Martin, *supra* note 2, at 54.

15. ICAN, *supra* note 10.

16. *Total Hospitals: 2010*, THE HENRY J. KAISER FAMILY FOUNDATION, <http://www.statehealthfacts.org/comparemaptable.jsp?cat=8&ind=382> (last visited Jan. 10, 2014).

17. See *supra* text accompanying notes 5–10.

18. SAKALA & CORRY, *supra* note 1, at 16, 41–42 (addressing the national health objectives for 2010 and reporting that in 2005 92% of people who had a previous cesarean had a subsequent one).

19. MacCorkle, *supra* note 13, at 19 (citing Mona Lydon-Rochelle et al., *Risk of Uterine Rupture during Labor Among Women with a Prior Cesarean Delivery*, 345 NEW ENG. J. MED. 3 (2001); Michael F. Greene, *Vaginal Delivery after Cesarean Section: Is the Risk Acceptable?*, 345 NEW ENG. J. MED. 54 (2001)).

dispute, desiring more options for themselves and others, and seeking justice when their autonomy has been harmed by these policies.²⁰ In a search for legal solutions to Ana's impasse, the law of torts provides particularly fertile ground: medical malpractice liability, with its hefty influence on hospital policy and medical decision-making, may present the powerful lever needed to move policies in Ana's direction.²¹ This Article will explore possible tort claims against the hospital with a VBAC ban, from corporate negligence to vicarious liability, and the feasibility of bringing those claims.

I. THE TORTS THEORY OF RECOVERY

The law of torts provides compensation for harms.²² An overarching theme to these remedies is that conduct which is socially unreasonable will lead to liability.²³ Torts are "directed toward the compensation of individuals, rather than the public, for losses which they have suffered within the scope of their legally recognized interests generally . . . where the law considers that compensation is required."²⁴ Torts uses economic remedies to symbolically make the plaintiff whole again.²⁵

Before modern negligence doctrine, physicians could be sued through a contract theory based on their failure to satisfy an express promise.²⁶ Later, the doctrine of common callings established

20. See ICAN, *supra* note 10; see also *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999); *In re Baby Boy Doe*, 632 N.E.2d 326, 326 (Ill. App. Ct. 1994).

21. It is not, however, the only place to look. It is beyond the scope of this Article to consider the constitutional issues relating to the right to refuse unwanted medical treatment (as a Free Expression and Privacy interest). *But see In re A.C.*, 573 A.2d 1235 (D.C. 1990); *Pemberton*, 66 F. Supp. at 1247; *In re Fetus Brown*, 689 N.E.2d 397 (Ill. App. Ct. 1997); *Baby Boy Doe*, 632 N.E.2d at 326. See also April L. Cherry, *The Free Exercise Rights of Pregnant Women Who Refuse Medical Treatment*, 69 TENN. L. REV. 563 (2002). Nor is it possible here to discuss the right to make parenting decisions (even when the state believes it could make better ones than the parents). See *Moore v. City of E. Cleveland*, 431 U.S. 494 (1977) ("[T]he Constitution prevents East Cleveland from standardizing its children—and its adults—by forcing all to live in certain narrowly defined family patterns."); *Troxel v. Granville*, 530 U.S. 57 (2000) ("[T]he Due Process Clause does not permit a State to infringe on the fundamental right of parents to make child rearing decisions simply because a state judge believes a 'better' decision could be made."). Although there are some compelling cases on point, that discussion has been covered to some extent in other places. Nonetheless, further discussion of the constitutional issues are definitely warranted, especially in light of this tort analysis.

22. W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* 5–6 (5th ed. 1984).

23. *Id.* at 5.

24. *Id.* at 5–6.

25. *Id.*

26. Theodore Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 WIS. L. REV. 1193, 1196–97 (1992).

a general duty of care for practitioners, regardless of whether they had made express promises.²⁷ Liability that initially derived from express agreements expanded to general principles of reasonableness: conduct was reasonable depending on circumstances, unreasonable if the risks outweighed the benefits.²⁸ A physician who was hired to remove a spleen, but who also removed a cancerous mass, would be considered reasonable under the circumstances, despite the express agreement to remove only the spleen.²⁹ A physician's standard of care was "reasonable and ordinary care and diligence in the exertion of his skill and the application of his knowledge, to accomplish the purpose for which he is employed."³⁰ Eventually this concept expanded to encompass what we now know as negligence.³¹

During this period of change, hospitals were evolving from religious institutions to humanitarian charities, and later, to centers of surgery and technology.³² At first, hospital liability was significantly limited by the doctrine of charitable immunity and the fact that individual physicians made clinical decisions, not hospitals as institutions.³³ Charitable immunity is based on "the special status of the defendant" in order to protect social values, such as providing hospital services, that are deemed more important than the potential harms of negligently providing such services.³⁴ As hospitals have increasingly developed into businesses, charitable immunity has shifted, making room for hospital liability.³⁵

Many jurisdictions now recognize the doctrine of corporate liability, equating hospitals with other corporations as entities that can be sued for negligence.³⁶ Corporate liability doctrine serves to establish a direct duty of care between hospital and patient.³⁷ Yet courts have found that the medical decisions involved require expertise that could be given only by physicians and not by corporate

27. *Id.*

28. *Id.* at 1197, 1201, 1216–17.

29. *See, e.g., Sanderson v. Bryan*, 594 A.2d 353 (Pa Super. Ct. 1991) (finding a doctor who removed excess scar tissue during back surgery to ensure the surgery's success without explicit permission for removal of the scar tissue not liable because "waiting until appellants' express consent for the particular procedure could be obtained would have had a seriously adverse effect on husband to the material detriment of his health").

30. Silver, *supra* note 26, at 1209 (quoting *Leighton v. Sargent*, 27 N.H. 460, 471 (1863)).

31. *Id.* at 1211.

32. *See* GUENTER B. RISSE, *MENDING BODIES, SAVING SOULS: A HISTORY OF HOSPITALS* 675–77 (1999).

33. Shelley S. Fraser, *Hospital Liability: Drawing a Fine Line with Informed Consent in Today's Evolving Health Care Arena*, 1 *IND. HEALTH L. REV.* 253, 255 (2004).

34. KEETON, *supra* note 22, at 1032.

35. *Id.* at 1070.

36. Fraser, *supra* note 33, at 255.

37. *Id.*

agents, and as a result have resisted treating hospitals the same as other corporations.³⁸ Further complicating hospital liability, some states have enacted legislation to protect hospitals from such legal culpability.³⁹

While VBAC bans are the perfect example of hospital decision-making that is generally protected as clinical, it is also an example of hospital policies that contribute to the trend of *increased* hospital liability.⁴⁰ Since no cases have yet arisen against a hospital for a VBAC ban, it is not clear whether a court would be willing to find a hospital liable under a tort theory of recovery. The following sections of this Article will explore the two main avenues for making a claim against a hospital for VBAC bans: corporate negligence and vicarious liability.

A corporate negligence claim against a hospital would, of necessity, focus on the VBAC ban itself, because the hospital as an institution uses physicians to perform the surgery rather than performing surgeries directly.⁴¹ The claim would have to establish that the policy itself was negligently made or enacted.⁴² The hospital could be liable through vicarious liability only for surgeries that resulted from the ban.⁴³

Vicarious liability claims can involve hospitals in medical malpractice actions through principles of *respondeat superior* (rarely used against hospitals in the case of a physician's negligence, since physicians tend to be independent contractors), non-delegable duty, or apparent/ostensible agency.⁴⁴ All of these arise from agency doctrine, which allows for secondary liability in a third party who has some degree of control over the person with immediate liability.⁴⁵ These principles allow courts to hold hospitals liable when a hospital's agent or employee has breached *his own* standard of care; the court must find the agent negligent before it can find the hospital liable.⁴⁶ Under vicarious liability the hospital wouldn't be directly liable for the policy, but rather, would be liable for negligence resulting from

38. *Darling v. Charleston Cmty. Hosp.*, 211 N.E.2d 253, 256 (Ill. 1965) (quoting from the defendant's brief, "[i]t is a fundamental rule of law that only an individual properly educated and licensed, and not a corporation, may practice medicine.").

39. *See, e.g.*, *Jackson v. Power*, 743 P.2d 1376, 1385 (Alaska 1987) (finding that hospitals have a non-delegable duty when it comes to the emergency room superseded by codified hospital immunity).

40. *See Fraser, supra* note 33, at 255 (discussing the evolution of hospital liability).

41. *Id.*

42. *Id.* at 256.

43. *Id.* at 260–61.

44. *Id.* at 260–69.

45. *Id.* at 277–78.

46. *See Fraser, supra* note 33, at 255.

the policy. The following sections will explore corporate negligence and vicarious liability in turn.

II. CORPORATE NEGLIGENCE

The basic elements of negligence (duty, breach, causation, and damages)⁴⁷ remain the same regardless of the type of defendant, although the structures for establishing each element may vary. In medical malpractice, for example, expert testimony may be required to establish breach, while for some forms of hospital liability, breach can be established by what any reasonable person would do under the circumstances.⁴⁸ Regardless of this variance, the heart of negligence is the standard of care.⁴⁹ The question is whether the hospital has a specialized duty that only an expert would understand, or whether the hospital has a common-sense duty that anyone could understand.⁵⁰

A general negligence claim against the hospital would employ the doctrine of corporate liability to point out that duties between hospitals and patients do exist and that the creation of a VBAC ban is a breach because a reasonable person, under the circumstances, would not determine that the risks of a mandatory surgery outweigh the benefits.⁵¹

The doctrine of corporate negligence creates a direct duty of care between hospital and patient as a result of the special relationship between the two.⁵² Many of these duties are drawn from generally recognized negligence principles, like premises liability and *respondeat superior*, but corporate negligence theory is more expansive as it recognizes “some form of systemic negligence by the hospital” rather than vicarious liability alone.⁵³ Jurisdictions that recognize this theory of recovery also disagree about whether the standard of care requires expert testimony or whether it is based on what a reasonable person would do under the circumstances.⁵⁴

The case of *Darling v. Charleston Community Memorial Hospital* was one of the first to establish a direct duty of care owed by a hospital

47. *Elements of a Negligence Case*, FINDLAW, <http://injury.findlaw.com/accident-injury-law/elements-of-a-negligence-case.html> (last visited Jan. 10, 2014).

48. Andrea G. Nadel, *Hospital's Liability for Negligence in Failing to Review or Supervise Treatment Given by Doctor, or to Require Consultation*, 12 A.L.R.4th 57 (1982).

49. Sonja Larsen, *Hospitals and Asylums*, in 40A AM. JUR. § 26 (2d ed. 2013).

50. See Nadel, *supra* note 48, at 63–64.

51. Sylvia A. Law, *Childbirth: An Opportunity for Choice that Should Be Supported*, 32 N.Y.U. REV. L. & SOC. CHANGE 345, 358–59 (2008).

52. See Nadel, *supra* note 48, at 64.

53. *Stroud v. Abington Mem'l Hosp.*, 546 F. Supp. 2d 238, 245 (E.D. Pa. 2008).

54. Fraser, *supra* note 33, at 257.

to a patient, independent of the physician.⁵⁵ The court in *Darling* recognized the changes in hospital care and agreed that changes in liability should follow.⁵⁶ The court articulated several important points: first, “the conception that the hospital does not undertake to treat the patient . . . no longer reflects the fact[s],” and second, that “[p]resent-day hospitals . . . do far more than furnish facilities for treatment.”⁵⁷ The court also noted: “[t]he Standards for Hospital Accreditation, the state licensing regulations and the defendant’s bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.”⁵⁸ Many authorities agree that the duties recognized under corporate liability theory include a) the duty to provide safe and adequate equipment and facilities; b) the duty to select and retain staff physicians properly; and c) the duty to oversee medical care, and promulgate rules and policies to ensure quality care.⁵⁹

The duty to provide equipment and facilities would be applicable only in a VBAC ban case where a physician or patient sought access to hospital facilities for a vaginal delivery after a previous c-section and was refused on that account. The duty to select and supervise physicians is also not likely to be applicable in a VBAC ban case. The selection and supervision of physicians by hospitals is a complex matter. Historically, hospitals have given physicians wide latitude to go about their work unhindered.⁶⁰ But because contemporary corporate structures sometimes cause physicians and hospitals to be in direct competition in the healthcare market, traditional selection and supervision practices are eroding.⁶¹ VBAC bans are an excellent example of how the wide latitude hospitals previously allowed physicians has been replaced by policies in which hospitals deliberately attempt to influence medical decisions.⁶²

55. *Darling v. Charleston Cmty. Hosp.*, 211 N.E.2d 253 (Ill. 1965) (establishing a direct duty of care between hospital and patient).

56. *See Fraser*, *supra* note 33, at 255.

57. *Darling*, 211 N.E.2d at 257.

58. *Id.*

59. Larsen, *supra* note 49; *see also* David H. Rutchik, *The Emerging Trend of Corporate Liability: Courts’ Uneven Treatment of Hospital Standards Leaves Hospitals Uncertain and Exposed*, 47 VAND. L. REV. 535, 540–48 (1994).

60. Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, DUKE L.J. 1071, 1074–75 (1984).

61. *Id.* at 1075–76; *see also* John D. Blum, *Beyond the Bylaws: Hospital-Physician Relationships, Economics and Conflicting Agendas*, 53 BUFF. L. REV. 459, 460 (2005); Nadel, *supra* note 48.

62. *See* Havighurst, *supra* note 60, at 1075.

The duties to oversee medical care and promulgate rules and policies to ensure quality care are all implicated by the enactment of a VBAC ban, which is in essence a policy requiring that all patients who come to the hospital in labor have surgery if they had a previous cesarean.⁶³ The question is whether enacting the policy is sufficient to trigger a duty directly between a plaintiff and the hospital. Three kinds of cases address this question: cases where the hospital enacted a policy, cases where the hospital failed to enact a policy or enacted a deficient policy, and cases where the hospital voluntarily undertook an action that carried with it a special duty to the patient.⁶⁴

III. WHEN THE HOSPITAL ENACTS A POLICY

One harm resulting from VBAC bans is the lack of informed consent; by establishing a blanket refusal to VBACs, the hospital makes a clinical decision for every patient, regardless of her consent or refusal.⁶⁵ Therefore, it would be helpful to find case law establishing that hospitals have a duty to ensure that patients give informed consent for every procedure. In theory, if a hospital enacts an informed consent policy, they assume an implied duty to protect the patient from lack of consent (the kind of harm warned against in the policy). But the case law has not supported this theory.⁶⁶ In the cases involving hospitals that enacted informed consent policies, courts have held that the presence of a policy generally *does not* create a duty on the part of the hospital to oversee the informed consent process or ensure that it took place.⁶⁷

In *Campbell v. Pitt County Memorial Hospital*, the hospital was found to have a direct informed consent duty; however, since the decision was split, it bears no precedential value.⁶⁸ The court's

63. See Law, *supra* note 51, at 357.

64. See *infra* Part III.

65. Heather Joy Baker, "We Don't Want to Scare the Ladies": An Investigation of Maternal Rights and Informed Consent Throughout the Birth Process, 31 WOMEN'S RTS. L. REP. 4, 583.

66. *Petriello v. Kalman*, 576 A.2d 474, 475 (Conn. 1990) (finding no hospital duty for non-employee physician's violation of hospital informed consent policy); see also *Mele v. Sherman Hosp.*, 838 F.2d 923, 925 (7th Cir. 1988) (finding that hospital bylaws and consent forms are not a voluntary assumption of duty); *Kelly v. Methodist Hosp.*, 664 A.2d 148, 151 (Pa. Super. Ct. 1995) (finding that a regulation requiring doctors to get informed consent did not create a duty in the hospital to have policies and procedures to ensure informed consent).

67. *Mele*, 838 F.2d at 925.

68. *Campbell v. Pitt Cnty. Mem'l Hosp.*, 352 S.E.2d 902, 907 (N.C. Ct. App. 1987), *aff'd*, 362 S.E.2d 273 (N.C. 1987).

majority determined that the general duty a hospital has to “oversee the treatment” included “the specific duty, under the particular facts and circumstances of this case” to ensure informed consent and create procedures for reporting dangerous treatment.⁶⁹ While this case is an outlier, it does illustrate both that “specific facts and circumstances” can lead to novel outcomes and that courts may be open to recognizing an informed consent duty in the hospital.⁷⁰

However, the facts in *Campbell* were unlike those in the VBAC ban scenario in many ways: the *Campbell* patient was harmed by a lack of *disclosure* instead of a lack of consent, that deficiency resulted in a vaginal delivery instead of a cesarean, and there was harm to the infant instead of the mother.⁷¹ VBAC bans pose a slightly different question about the extent to which the act of creating policies establishes a duty of care between hospital and patient. VBAC bans injure patients by forcing them to have surgery and abrogating their right of refusal.⁷² The question is whether hospitals with conflicting policies, both VBAC bans and informed consent rules, could be liable for violating their own standard of care.

The difficulty of this approach is that even when courts have recognized that “violation of an employer’s work rules can be viewed as evidence of negligence,” they have also been clear that “hospital rules, regulations and policies do not themselves establish the standard of care.”⁷³ Thus, *Campbell* does not provide much in the way of analogy or precedent, while emphasizing how duty flows away from the hospital and toward the physician.⁷⁴

If a physician flouts a hospital VBAC ban and experiences a bad birth outcome, the failure to follow the VBAC ban policy (“violation of employer’s work rules”) could be used as evidence of the physician’s negligence.⁷⁵ This tension between the respective duties of hospital and physician creates an incentive for the physician to follow the policy, even when doing so is at odds with her professional judgment, and creates no corresponding disincentive for the hospital to maintain such a policy.

69. *Id.* at 908.

70. *Id.* at 907.

71. *Id.* at 904.

72. See Law, *supra* note 51, at 358–59.

73. See *Petriello v. Kalman*, 576 A.2d 474, 479 (Conn. 1990) (quoting *Van Steensburg v. Lawrence & Mem’l Hosp.*, 481 A.2d 750 (Conn. 1984)).

74. *Campbell v. Pitt Cnty. Mem’l Hosp.*, 352 S.E.2d 902, 908 (N.C. Ct. App. 1987), *aff’d*, 362 S.E.2d 273 (N.C. 1987).

75. *Petriello*, 576 A.2d at 479.

A. When Hospital Policy Is Absent or Deficient

Cases in which there is a failure to create a policy or a deficient policy exists are better analogies to the VBAC ban because they suggest that the hospital's policy-making function itself may be negligent.⁷⁶ In these cases, courts identify the hospital policy-making function itself as deficient because managerial control of the process could have prevented injury.⁷⁷ The plaintiffs in both *Jennison v. Providence St. Vincent Medical Center* and *Edwards v. Brandywine Hospital* were exposed to egregious negligence in the hospital, resulting from a series of unfortunate events and missed opportunities, including having a central line negligently inserted and left unchecked and having a heparin lock left in place for three days.⁷⁸ Injury could have been avoided had the hospital exerted more managerial control, by having policies for tending to central lines after insertion or limiting the use of heparin locks.⁷⁹ These two cases stand for the hospital's duty to create policies that ensure quality care, and triggering liability for the injuries resulting from negligent care.⁸⁰

In the case of VBAC bans, however, the problem is too much managerial control or managerial control that is negligently blind to relevant facts (e.g., the needs of specific bodies, or the authority of individuals to conduct their own risk analysis).⁸¹ VBAC bans are deficient policies because in contrast to a policy that would be beneficial to all patients (e.g., tending to a central line after insertion), they expose some patients to unnecessary risk.⁸² This argument, however, does not find easy traction within the existing construction of the law. In *Jennison* and *Edwards* the injuries were a result of negligent medical care.⁸³ The injuries were not a direct result of deficient policies; deficient policies just made the negligent care more possible.⁸⁴ Ironically, VBAC bans make negligent care *necessary* for

76. See *Jennison v. Providence St. Vincent Med. Ctr.*, 25 P.3d 358, 367 (Or. App. 2001) (finding that signing a consent form implies a policy or procedure for follow-through regarding the treatment consented to and when such a policy is missing, liability may flow, but deciding the case on apparent agency grounds); *Edwards v. Brandywine Hosp.*, 652 A.2d 1382, 1388 (Pa. Super. Ct. 1995) (finding that having a deficient standard leaves the hospital open to liability).

77. *Id.*

78. See *Jennison*, 25 P.3d at 362; *Edwards*, 652 A.2d at 1385.

79. See *Jennison*, 25 P.3d at 367; *Edwards*, 652 A.2d at 1388.

80. See *Jennison*, 25 P.3d at 363; *Edwards*, 652 A.2d at 1388.

81. See MacCorkle, *supra* note 13, at 19.

82. *Id.*

83. *Jennison v. Providence St. Vincent Med. Ctr.*, 25 P.3d 358, 362 (Or. App. 2001); *Edwards v. Brandywine Hosp.*, 652 A.2d 1382, 1385 (Pa. Super. Ct. 1995).

84. *Id.*

some patients.⁸⁵ Sadly, the law is ill equipped to address this kind of systemic negligence.⁸⁶

B. When Hospital Acts Create Certain Duties

A few exceptional cases recognize a hospital's duty to ensure informed consent.⁸⁷ These cases arise in the specific context of a hospital that has agreed to participate in a clinical trial regulated by the federal government, with governmental imposition of certain informed consent requirements as part of the study.⁸⁸ In these cases courts acknowledge that informed consent is a duty that usually attaches exclusively to the physician, but here expands to the hospital based on the hospital's acceptance of the informed consent duty as imposed by federal regulation.⁸⁹

The plaintiff in *Friter v. Iolab Corporation* had cataract surgery and a synthetic lens implanted.⁹⁰ The plaintiff did not know that the lens was experimental nor that he was taking part in a clinical study, that was under FDA regulation which required extensive informed consent procedures.⁹¹ The court acknowledged that informed consent, duty, and battery actions usually attached to the physician, but that the facts of this case were so different that both actions could attach to the hospital. When the hospital agreed to provide an experimental procedure that was then performed without the required consent, the hospital could be liable for battery.⁹²

The facts in *Friter* supported the plaintiff because the hospital knew of the informed consent requirement and had medical information that the plaintiff did not have; namely, that the procedure was experimental.⁹³ Perhaps a VBAC ban plaintiff could use the *Friter* case as an analogy: the hospital knows that there is a general informed consent requirement, but withholds that duty for all patients with prior c-sections. Though giving birth is not the same as signing up to participate in a clinical trial, the unique facts of a VBAC ban case might allow a court to accept the *Friter* analogy.

85. See MacCorkle, *supra* note 13, at 19.

86. See *Friter v. Iolab Corp.*, 607 A.2d 1111, 1113 (Pa. Super. Ct. 1992).

87. *Id.* at 1116; *Boyd v. Somerset*, 24 Pa. D. & C. 4th 564, 572 (Pa. Ct. Com. Pl. 1993).

88. *Friter*, 607 A.2d at 1116.

89. *Id.*

90. *Id.* at 1111 (finding that judgment *non obstante vertico* was improper where the facts allow for a hospital informed consent duty and battery cause of action); see also *Boyd*, 24 Pa. D. & C. 4th at 572.

91. *Id.* at 1111–12.

92. *Friter*, 607 A.2d at 1113.

93. *Id.* at 1111–12.

VBAC bans, in such an analogy, would be equivalent to experimental trials without an “opt-out” provision.

C. Limits of the Doctrine of Corporate Negligence for VBAC Bans

Instead of acting as a deterrent to VBAC bans, the law creates incentives for hospitals to create such policies and for physicians to uphold them. Almost every cesarean versus vaginal delivery case involves liability on a physician’s part for delaying or failing to perform a cesarean.⁹⁴ Very few cases can be found of physicians or hospitals being sued for unnecessary cesareans; when they exist, the defendants are generally not held liable.⁹⁵ In fact, medical defendants are more often held liable for “performing” a vaginal delivery.⁹⁶ A large margin of error in judgment exists regarding which patients require cesareans. If cesareans do more harm than good over a rate of fifteen percent, then at least fifteen to twenty percent of all cesareans performed in this country are statistically unnecessary or do more harm than good,⁹⁷ yet this fact has not led to a significant risk of liability.⁹⁸ In addition, the law customarily gives deference to medical decision-making and limits hospital duties as described above.⁹⁹ Although the duty to oversee medical care and promulgate rules and policies to ensure quality care is relevant to VBAC bans, they do not amount to the creation of a duty to ensure informed consent, prevent unwanted medical treatment, or a duty to create policies that are not negligent medical decisions when applied to certain patients.¹⁰⁰

IV. VICARIOUS LIABILITY

In the alternative, to make a claim against the hospital based on the surgery itself and not the VBAC ban, vicarious liability is required, since it was through the surgeon that the cesarean was

94. See Beomsoo Kim, *Current Research on Medical Malpractice Liability: The Impact of Malpractice Risk on the Use of Obstetrics Procedures*, 36 J. LEGAL STUD. S79, S82 (2007).

95. *Id.*

96. *Id.*

97. Fernando Althabe & Jose Belizan, *Caesarean Section: The Paradox*, 368 LANCET 1472, 1472–73 (Oct. 28, 2006).

98. See Jay Zitter, *Liability of Hospital, Physician, or Other Medical Personnel for Death or Injury to Mother or Child Caused by Improper Choice Between, or Timing Of, Vaginal or Cesarean Delivery*, 4 A.L.R.5th 171 (John A. Glenn ed., 1992) (examining cases that overwhelmingly find liability when vaginal delivery was chosen over surgical, and not when surgical was chosen over vaginal, unless some other negligence was involved).

99. *Id.* at 208.

100. See *id.* at 208–09.

performed.¹⁰¹ The same rules of negligence apply: duty, breach, causation and damages,¹⁰² but the focus is on the acts of the physician and the relationship between physician and hospital. Vicarious liability establishes that, “by reason of some relation existing between A and B, the negligence of A is to be charged against B, although B has played no part in it.”¹⁰³ Vicarious liability allows the hospital to be implicated through the physician’s duty and standard of care; the hospital’s liability depends on whether the claim comes from *respondeat superior*, a non-delegable duty, or apparent agency.¹⁰⁴

The control analysis of vicarious liability is especially appropriate in the case of VBAC bans, where the hospital dictates the course of treatment to all patients in a certain category and to all physicians as well. Under a VBAC ban, even though the physician is performing the cesarean, she cannot be said to be acting independently based on her own medical judgment.¹⁰⁵ Nonetheless, vicarious liability requires the negligence to be located in the actions of the physician.¹⁰⁶ This presents a problem in the VBAC ban scenario: the harm is not that the cesarean section was performed negligently, but rather that it was performed against the principles of informed consent.¹⁰⁷ To challenge the VBAC ban and resulting surgery under a vicarious liability theory requires proving that lack of informed refusal is negligent based on the physician’s duty to secure informed consent.¹⁰⁸

A. Informed Consent Doctrine

Informed consent developed as a cause of action for patients injured as a result of unauthorized medical treatment.¹⁰⁹ It arises from a duty to disclose information material to treatment and refrain from treatment until consent is given.¹¹⁰ The doctrine is based on Justice Cardozo’s 1914 finding that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.”¹¹¹ Informed consent has consistently been

101. See KEETON, *supra* note 22, at 499.

102. *Id.*

103. *Id.*

104. *Id.* at 499–508.

105. *Id.* at 501–02.

106. *Id.* at 499.

107. KEETON, *supra* note 22, at 502–03.

108. *Id.* at 499, 502–03.

109. See Robert Gatter, *The Mysterious Survival of the Policy Against Informed Consent Liability for Hospitals*, 81 NOTRE DAME L. REV. 1203, 1208 (2006).

110. *Id.* at 1208–09.

111. Fraser, *supra* note 33, at 257 (citing *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92 (N.Y. 1914) (describing facts in which a patient contends that while she had

held to be the exclusive duty of the physician,¹¹² precluding hospital liability in all but a few cases where the treating physician was an employee or agent of the hospital, or when the hospital housed medical research, as discussed above in *Friter*.¹¹³ Exceptions evolved at common law, but some states have codified in statute the physician's informed consent duty.¹¹⁴

Informed consent generally comprises two parts: disclosure of information and abstention from treatment until the patient consents.¹¹⁵ The disclosure element constrains the scope of information to be conveyed to that which is "material."¹¹⁶ Jurisdictions are split on the standard of materiality between what a "reasonable medical practitioner" would disclose and what a "reasonable patient" would want to know.¹¹⁷ Breach of disclosure also requires causation: that a reasonable person would not have consented to the treatment had material information been conveyed, and that the treatment caused the harm.¹¹⁸ When the physician fails to abstain from treatment, the elements are usually that of battery: harmful or offensive contact intended to set a force in motion that causes the contact.¹¹⁹ Battery recognizes the integrity of the person and the right to be free from intentional unpermitted contact.¹²⁰

Both parts of the informed consent doctrine prove inadequate in the VBAC ban scenario. The plaintiff's complaint is rarely a failure of disclosure, since such plaintiffs are usually highly educated about the risks and benefits of cesareans, and even when it is, it's not the lack of disclosure that causes the harm.¹²¹ The physician's failure to abstain from treatment is due to a policy to which both the physician and patient are held. Ultimately, plaintiffs like Ana formally consent to treatment even when they do not really have a choice; and this is the crux of the problem. Consent becomes meaningless when it does not accompany choice.

expressly refused surgery, it was nevertheless performed while she was unconscious. Nonetheless, the court established that a hospital could not be liable for the physician's breach of informed consent duty), *abrogated by* *Bing v. Thunig*, 2 N.Y.2d 656 (1957).

112. Gatter, *supra* note 109, at 1207.

113. *Friter v. Iolab Corp.*, 607 A.2d 1111, 1114–16 (Pa. Super. Ct. 1992).

114. Suzanne K. Ketler, *The Rebirth of Informed Consent: A Cultural Analysis of the Informed Consent Doctrine After Schreiber v. Physicians Insurance Co. of Wisconsin*, 95 NW. U. L. REV. 1029, 1035–36 (2001).

115. *See, e.g.*, Gatter, *supra* note 109, at 1208–09.

116. *Id.*

117. Ketler, *supra* note 114, at 1035–36; *see also* *Canterbury v. Spence*, 464 F.2d 772, 786 (D.C. Cir. 1972) (establishing the reasonable patient standard).

118. Gatter, *supra* note 109, at 1209–10.

119. KEETON, *supra* note 22, at 39.

120. *Id.*

121. *See* ICAN, *supra* note 10 (showing an example of resources available to women about challenging hospital VBAC bans).

B. *Informed Consent Under Respondeat Superior*

Respondeat superior is the legal doctrine specifying that a master is liable for the acts of his servant.¹²² This is most straightforward when the medical care provider is an employee of the hospital and the employee is subject to control by the hospital. This issue of control is based on several elements, including the skill required, supplier of the place and instrumentality, method of payment, length of the relationship, dictator of the details of the work, kind of occupation, and customs as to supervision.¹²³ Generally, physicians are considered independent contractors under the law and hospitals are consequently not considered to have the requisite control over physicians to create institutional liability.¹²⁴

Protection of the independence of physicians and the special physician-patient relationship is so strong that cases finding hospital liability even for employee physicians' failure to disclose material information are the exception rather than the rule.¹²⁵ Cases involving employee physicians generally find that the physician-patient relationship is so delicate, and the medical and individual information so nuanced, that the hospital should not and does not have sufficient control of the informed consent process to warrant liability.¹²⁶

122. See KEETON, *supra* note 22, at 499.

123. *Id.* at 501.

124. See, e.g., Valles v. Albert Einstein Med. Ctr., 805 A.2d 1232, 1238 (Pa. 2002) (holding the hospital lacked control over the manner a doctor performed his duty, which then precluded vicarious liability for informed consent).

125. See, e.g., Gotlin v. Lederman, 367 F. Supp. 2d 349, 362 (E.D.N.Y. 2005) (overturning dismissal of informed consent claim against hospital, where the complaint alleged vicarious liability for breach of the duty of disclosure by physicians alleged to be the employees or agents of the hospital); Burnet v. Spokane Ambulance, 772 P.2d 1027, 1031 (Wash. Ct. App. 1989) (holding a hospital can be vicariously liable for its physicians' breach of the duty of disclosure, but only where it is established that the physician was employed by the hospital).

126. See Valles, 805 A.2d at 1238–39; Fiorentino v. Wenger, 272 N.Y.S.2d 557 (App. Div. 1966) (mem.), *rev'd*, 227 N.E.2d 296, 300 (N.Y. 1967) (finding that hospitals do not have an obligation to oversee physicians and make sure they fulfill their disclosure duties, because the doctor-patient relationship is one of great delicacy and third parties should not interfere). Some courts have found vicarious liability based on the nurse's informed consent duty, but this is also rare. See Campbell v. Pitt Cnty. Mem'l Hosp., 352 S.E.2d 902, 908 (N.C. Ct. App. 1987), *aff'd*, 362 S.E.2d 273 (N.C. 1987) (containing testimony about nurse standard of care that includes "assuring that the patient had an explanation."). *But see* Butler v. S. Fulton Med. Ctr., Inc., 452 S.E.2d 768, 772 (Ga. Ct. App. 1994) ("In obtaining a consent form, a nurse is not acting as a 'borrowed servant' of the doctor."); Marsh v. Crawford Long Hosp. of Emory Univ., 444 S.E.2d 357, 358 (Ga. Ct. App. 1994) (holding that a nurse performing a ministerial task of recording a patient's consent on a form is not a "borrowed servant"); Ritter v. Delaney, 790 S.W.2d 29, 32 (Tex. 1990) (holding that when a hospital relinquishes control of nurse to physician it does not create a duty in the hospital).

In the case of VBAC bans, the hospital clearly has sufficient control of the acts of the surgeon and the nurses directly through the VBAC policy.¹²⁷ This control may prove that the physicians were employees, but it still does not establish that the informed consent duty can flow to the hospital.¹²⁸ In addition, while the law is more fully developed in cases where there is a lack of disclosure, here the other prong is violated.¹²⁹ A plaintiff like Ana *may* be able to argue that VBAC bans turn the surgeon into an agent of the hospital and therefore the hospital should be liable for not providing the corollary of informed consent, *i.e.*, informed refusal.

C. Informed Consent as a Non-Delegable Duty

The non-delegable duty principal circumvents the traditional lack of hospital-physician control based on the idea that the particular duty is so significant, that even when the hospital delegates it to another, the hospital can still be held liable.¹³⁰ When courts have identified a non-delegable duty, their analysis often resembles the corporate liability analysis described above, positing that “a person or entity entrusted with important duties in certain circumstances may not assign those duties to someone else and then expect to walk away unscathed when things go wrong.”¹³¹ The challenge with the VBAC ban scenario is that both the “wrong” and the non-delegable duty are the same thing: lack of consent and lack of informed refusal.¹³²

To successfully challenge the VBAC ban as a non-delegable duty, one would have to establish, counter to precedent, that informed consent is an important duty originating with the hospital and delegated to the physician.¹³³ A plaintiff would also have to prove the physician was negligent because he violated the informed consent standard of care by not allowing for refusal.¹³⁴ The physician was negligent in a non-delegable duty (informed consent), so the hospital would then be liable.¹³⁵ However, even where hospitals take overt

127. See SAKALA & CORRY, *supra* note 1 (describing how many women are unable to find physicians who will perform VBACs due to hospital bans).

128. See Valles, 805 A.2d at 1239.

129. *Id.*

130. KEETON, *supra* note 22, at 511.

131. *Simmons v. Tuomey Reg'l Med. Ctr.*, 533 S.E.2d 312 (S.C. 2000) (establishing that hospitals can be liable for their non-employee E.R. doctors through the doctrine of non-delegable duty); see also *Jackson v. Power*, 743 P.2d 1276, 1384–87 (Alaska 1987).

132. See *Simmons*, 533 S.E.2d at 317–23.

133. See Valles v. Albert Einstein Med. Ctr., 805 A.2d 1232, 1238 (Pa. 2002).

134. See *Fritter v. Iolab Corp.*, 607 A.2d 1111, 1114–16 (Pa. Super. Ct. 1992).

135. See *Simmons*, 533 S.E.2d at 317, 320.

steps in the informed consent process by providing consent to treat forms, for example, or having informed consent policies, those acts rarely amount to an informed consent duty (as discussed above).¹³⁶

D. Informed Consent and Apparent Agency

The doctrine of apparent agency confronts the barrier of physicians' traditional independence from the hospital, by asserting that certain representations make the physician appear to be acting for the hospital, thus leading the patient to believe the hospital is really in control.¹³⁷ For the sake of liability, the physician is either an independent contractor and the hospital is not liable, or the physician is an apparent agent and the hospital is liable.¹³⁸

In many cases, informed consent forms provide notice of a physician's independent contractor status, with the intent of protecting the hospital from liability under an apparent agency theory.¹³⁹ These forms confuse the purpose of informed consent, making it an issue of notice rather than of decision-making autonomy.¹⁴⁰ This misdirection creates a legal imperative on the part of hospitals to provide notice as to the physician-hospital relationship, but does not create a duty on the part of hospitals to disclose material information, abstain from treatment without consent, assure that physicians disclose material information, document consent, or prevent treatment from being given without consent.¹⁴¹

In the absence of these latter duties, even the substantial apparent agency arguments present in the VBAC ban scenario have nowhere to go. In the evolving field of hospital liability it is possible that the existence of the VBAC ban could help establish that the physicians were agents of the hospital, as the hospital controls the medical decisions of physicians through the VBAC policy.¹⁴² But

136. *Id.* at 320.

137. KEETON, *supra* note 22, at 508 (explaining that apparent agency is also referred to as *ostensible agency*; sometimes apparent agency is confused with *agency by estoppel* which is not a negligence theory but rather arises out of agency law, but is ultimately similar and often conflated).

138. *See, e.g.*, Fraser, *supra* note 33, at 260, 264.

139. *See, e.g.*, Brown *ex rel.* Brown v. St. Vincent's Hosp., 899 So.2d 227, 240, 242 (Ala. 2004); Sword v. NKC Hospitals, Inc., 714 N.E.2d 142, 152–53 (Ind. 1999); Burless v. W. Va. Univ. Hosp., Inc., 601 S.E.2d 85, 96–98 (W.Va. 2004) (noting that consent forms identifying the doctors as independent contractors may or may not be sufficient to establish or overcome agency).

140. *See, e.g.*, Fraser, *supra* note 33, at 273.

141. *See* Fiorentino v. Wenger, 227 N.E.2d 296, 300 (N.Y. 1967) (Rabin, J., concurring) (finding no duty to assure consent); Newell v. Trident Med. Ctr., 597 S.E.2d 776, 781 (S.C. 2004) (finding no hospital duty based on lack of agency relationship).

142. *See, e.g.*, Fraser, *supra* note 33, at 265.

even if physicians are agents of the hospital, there is a valid complaint against the hospital only if the physicians had a duty and breached a standard of care.¹⁴³

Does this mean physicians have a duty to violate hospital policy in order to provide informed consent? This could expand physician liability, and still fails to address the hospital's role: by putting physicians in this compromising position the hospital creates a risk that demands a duty and a heightened standard of care.¹⁴⁴

E. Physician's Duty to Accept Refusal

When a patient explicitly refuses to consent to care, the physician's duty to abstain from treatment is substantial.¹⁴⁵ In the case of a VBAC ban, it would seem obvious that this duty should take precedence over hospital policy, so that someone like Ana could simply refuse the cesarean, despite the policy. However, the pregnancy context complicates this rule as a result of precedent in both law and culture for curtailing women's rights during labor.¹⁴⁶ Even though the Constitution supports the right of refusal,¹⁴⁷ cultural disagreement abounds on this point,¹⁴⁸ as does substantial potential for liability when there is harm to a newborn.¹⁴⁹ The refusal standard is muddy when it comes to the practice of obstetrics, in which many procedures are performed without consent *as a matter of course*.¹⁵⁰

143. *Id.* at 264.

144. *Id.* at 253–55.

145. *See, e.g.,* Curtis v. Jaskey, 759 N.E.2d 962, 968 (2001) (finding summary judgment improper where there was material fact as to the patient's refusal).

146. *See* Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., 66 F. Supp. 2d 1247, 1256–57 (N.D. Fla. 1999) (finding that a court-ordered cesarean section did not violate the mother's rights); People v. Rosburg, 805 P.2d 432, 437–40 (Colo. 1991) (holding that the state may proscribe the unlicensed practice of midwifery without violating the due process of pregnant women who want to give birth at home); *In re Fetus Brown*, 689 N.E.2d 397, 400, 405–06 (Ill. App. Ct. 1997); *In re Baby Boy Doe*, 632 N.E.2d 326, 332–35 (Ill. App. Ct. 1994) (finding that labor interventions against the mother's will did violate her constitutional rights); *see also In re A.C.*, 573 A.2d 1235, 1243, 1252–53 (D.C. 1990) (explaining that even though the court ultimately found for A.C., it might have been okay to perform surgery without her consent); Stallman v. Youngquist, 531 N.E.2d 335, 359–61 (Ill. 1988) (rejecting maternal liability for harm to the fetus since mother and child in this context are not adversaries); John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 437–58, 463–64 (1983) (arguing that women accept additional duties and relinquish certain rights when pregnant); Katherine A. Taylor, *Compelling Pregnancy at Death's Door*, 7 COLUM. J. GENDER & L. 85, 87, 93–99 (1997) (explaining that most states have living will restrictions for pregnant women).

147. *See Baby Boy Doe*, 632 N.E.2d at 331.

148. *Id.* at 331–32.

149. *See, e.g.* Robertson, *supra* note 146, at 438–42 (an extreme example of potential liability).

150. Zitter, *supra* note 98, at § 2(a).

In *Curtis v. Jaskey*,¹⁵¹ a pregnant woman started seeing a physician for prenatal care and expressly refused to have an episiotomy during labor. She reminded the physician of this on subsequent visits.¹⁵² When she was admitted for an induction of labor, she signed consent forms, crossing out the consent to episiotomy.¹⁵³ Labor progressed quickly; in the final stages of labor her perineum began to tear and the physician performed an episiotomy.¹⁵⁴ The trial court granted summary judgment for the hospital based on expert testimony that the procedure was an emergency and consent was impractical.¹⁵⁵ The court of appeals found that there was a question of fact as to the plaintiff's refusal and remanded the case.¹⁵⁶ The court also clarified that the emergency exception, based on the doctrine of implied consent, did not apply where there was an express refusal on record.¹⁵⁷ At the very least this case emphasizes the importance of express refusal in the childbirth context.

Protection of the "delicate" physician-patient informed consent process is one of the biggest barriers to hospitals' vicarious liability in the VBAC ban scenario.¹⁵⁸ Despite the fact that hospitals exert obvious and substantial control over the process, the weight of precedent protects hospitals from informed consent duties.¹⁵⁹

CONCLUSION

I echo other scholars when I insist that in childbirth there is more than one "right" or "reasonable" way.¹⁶⁰ Thus, any advocacy for childbirth via relevant law should be directed at expanding the field to account for different cultures and ideas about what is reasonable or unreasonable. Tort liability provides opportunities and challenges for this proposal. The challenges include the history of hospital immunity, the limits of corporate liability theory, the informed consent doctrine, and the fact that hospitals typically bring more resources to litigation than plaintiffs can afford.¹⁶¹ Opportunities include making

151. *Curtis v. Jaskey*, 759 N.E.2d 962, 963 (Ill. App. Ct. 2001).

152. *Id.*

153. *Id.*

154. *Id.*

155. *Id.*

156. *Id.*

157. *Curtis v. Jaskey*, 759 N.E.2d 962, 968 (Ill. App. Ct. 2001).

158. See Ketler, *supra* note 114, at 1052–56.

159. This is one reason why scholars who advocate strongly for doctor-patient informed consent might want to expand their analysis. See, e.g., Ketler, *supra* note 114, at 1036–37.

160. Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 549 (1993–1994); see also Law, *supra* note 51, at 349–52.

161. See Fraser, *supra* note 33, at 255–58, 276–77.

inroads where medical malpractice is rooted, expanding the definitions of reasonableness, and calling into question the institutional reasons for VBAC bans.¹⁶²

Establishing hospital liability for VBAC bans would require the right set of facts in the right jurisdiction—facts I would not wish on anyone—such as a plaintiff who was severely injured by a forced cesarean or whose baby was injured as well. Such facts could tip the scales in favor of novel legal arguments or new ways of applying established doctrine.

Physicians and nurse midwives may be better situated than their patients to challenge such policies as they have the proven ability to organize and leverage their power toward their professional interests.¹⁶³ VBAC ban policies put providers in a very precarious position, compromise their ethical duties, and open them up to increased liability; lobbying against these policies could also serve their own bottom line.¹⁶⁴ The fact that they could also challenge these policies as violations of the informed consent standard of care and of the medical standard of care adds strength to their argument.¹⁶⁵ Certified Nurse Midwives and family physicians, like Dr. Gayatri, may even be entitled to an antitrust claim, since requiring VBAC also gives obstetricians a monopoly over all patients with a previous cesarean.¹⁶⁶ In general, when hospital care providers are educated about the law and develop an analysis about how it operates to constrain and protect them, they are better positioned to become advocates not only in the area of VBAC bans, but also with other policies that limit the field in pregnancy and birth.¹⁶⁷

Administrative law relating to hospital regulations is another area that warrants further exploration. The requirements for participation set forth by the Centers for Medicare and Medicaid Services include informed consent provisions and this creates the possibility of challenging VBAC bans through administrative channels.¹⁶⁸ Since many hospitals rely on federal funds they must be responsive to Medicaid regulations thus opening up the possibility of a petition for

162. See Law, *supra* note 51, at 362–71.

163. See Daniel W. Srsic, *Collective Bargaining by Physicians in the United States and Canada*, 15 COMP. LAB. L.J. 89 (1993); Elizabeth Thompson Beckley, *Strength in Numbers: Employed Physicians Enlist Unions for Bargaining Clout*, MODERN PHYSICIAN (Feb. 26, 2001), http://www.modernphysician.com/article/20010226/modernphysician/102260353/&template=printpicart_mp.

164. See Law, *supra* note 51, at 369, 371, 377–79.

165. *Id.* at 369–70.

166. See Havighurst, *supra* note 60, at 1149–50.

167. Law, *supra* note 51, at 371 (suggesting such a challenge to the use of electronic fetal monitors).

168. 42 C.F.R. § 482.24(c)(2)(v) (2012).

a rule-making that requires right of refusal provisions in all facilities that receive Medicaid funds, or even more explicitly, one that requires VBAC be available in all such facilities.¹⁶⁹ Alternately, one could petition for an interpretive rule determining whether the informed consent and right of refusal provisions create a hospital duty of informed consent.

An immediate strategy available to maternity care consumers to challenge VBAC bans is to give birth at home or in birth centers; vaginal birth is within the expertise and accessibility of most pregnant women.¹⁷⁰ At the same time, I recognize that for many this course of action is not an option for a variety of reasons: the responsibility of giving birth outside the hospital is significant, many places do not have birth centers, many home birth midwives may not legally attend VBACs—or in places, *any* births—at home, many insurance companies resist reimbursing families for home birth and birth center services, and finally, such a commitment requires a fundamental challenge that many are not prepared to face.¹⁷¹

Beyond the act of giving birth, other social and legal action can work to make sure that birth centers and home births are viable options. Ultimately, it will take effort on all these fronts using multiple strategies to change not only VBAC bans, but the underlying structures that make such bans possible.

169. See Eleanor A. Kinney, *Rule and Policy making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 860, 869–72 (1990); Elizabeth Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN. ST. L. REV. 955, 977–78 (2010).

170. See Kukura, *supra* note 169, at 984; Paul C. E. Torio, *Nature Versus Suture: Why VBAC Should Still Be in Vogue*, 31 WOMEN'S RTS. L. REP. 487, 512 (2010).

171. Baker, *supra* note 65, at 583, 587.