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Enforcing and Promoting the Rights of Women Seeking Vaginal Birth After Cesarean (VBAC): A Primer

by Katherine Prown, Ph.D.

Part One: The Legal and Ethical Foundations of the Rights of Pregnant Women

Introduction

The growing trend among hospitals of mandating that pregnant women with prior uterine surgery must undergo cesarean sections in subsequent pregnancies is the latest in a series of maternity care practices that stand in direct violation of a wide body of law protecting the rights of patients, including pregnant and birthing women, to refuse treatment. The doctrine of informed consent/refusal is upheld by common law; case law; Constitutional law (the right to privacy and self determination protected by the 1st and 14th amendments); federal law (The Emergency Medical Treatment and Active Labor Act and The Patient Self-Determination Act); international tort law (which US courts sometimes cite); state law; state mandated medical ethics; and the ethical guidelines of the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG). The doctrine of informed consent/refusal upheld by these laws provides all patients, pregnant or not, with certain fundamental rights:

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- The right to exercise self-determination and autonomy in making all medical decisions, including the decision to refuse treatment.
- The right to bodily integrity; any form of non-consensual touching or treatment that occurs in a medical setting constitutes battery.
- The right to be provided with the necessary information on which to base medical decisions, including a diagnosis; recommended treatments and alternatives; the risks, benefits, discomforts, and potential disabilities of proposed medical treatments; realistic expectation of outcomes; the right to a second opinion, and any financial or research interests a physician may have in proposing certain treatments.
- The right to be informed of any potentially life threatening consequences of a proposed treatment, even if the likelihood of experiencing such an outcome is rare.
- The right to make medical decisions free from coercion or undue influence from physicians.
- The right to have informed medical decisions witnessed, signed and documented by the attending physician and another adult.
- The right to revoke consent to treatment at any time, either verbally or in writing.

The only exceptions to these rights occur when a patient is in an immediately life-threatening situation that demands treatment to preserve her life; when the physician determines that disclosure of all facts would have an adverse effect on the patient, though medical ethics dictate that this “therapeutic privilege” is rarely, if ever, justified; when a court orders a treatment, though it’s important to note that courts have upheld the right of pregnant women to decline treatment even in situations where the life of their fetus is threatened; when diagnostic tests are required by law enforcement agencies, such as drawing blood to test intoxication levels in impaired drivers.

The legal doctrine of informed consent/refusal developed from the laws on battery. In a medical setting battery is defined as touching or treatment that occurs without obtaining proper informed consent; medical treatments that are substantially different from the ones a patient consented to; treatment that exceeds the scope of consent; or treatment provided by a physician other than the physician who obtained the patient’s consent. As case law on informed consent/refusal evolved, however, the courts increasingly defined lack of proper consent as a matter of negligence. Negligence requires that

the lack of proper consent or failure to meet the standard of care resulted in emotional or physical harm worthy of monetary compensation. In certain circumstances in which monetary compensation is not an issue, though, the laws on battery may still apply.

Court Decisions and Case Law on the Rights of Pregnant Women

The courts have been an important ally in protecting the right to informed consent/refusal, particularly for pregnant women. Many people are under the impression that no physician has ever lost a malpractice suit for performing a cesarean. However, in *Meador v. Stahler and Gheridian* (<http://www.forensic-psych.com/articles/artAskexp02.php>), a jury awarded a \$1.5 million settlement to a Massachusetts woman and her husband for undergoing a medically unnecessary cesarean that she had made clear she didn't want.

The plaintiffs successfully claimed that the woman's obstetricians misrepresented the risks of alternative procedures, i.e. VBAC; ignored her expressed wishes for this alternative treatment; compelled her passive consent to surgery through emotional coercion; and that the failure to obtain proper consent constituted substandard and negligent medical care resulting in the development of post-traumatic stress disorder. Further, the plaintiff argued, and the jury agreed, that the loss of personal decision making power over her body, her health, and the birth of her child was both physically and emotionally disabling and deprived her husband of "consortium," i.e. sexual companionship. In addition, her husband argued that his loss of consortium was exacerbated by the physicians' failure to include him in the decision-making process, leaving him to feel powerless, and as a result nearly one-third of the total damages was awarded to him. While this case doesn't hold the same legal standing as appellate court rulings, it does establish a useful precedent for other women to refer to in pursuing malpractice suits alleging negligence related to failure to obtain proper consent.

In recent years physicians in various parts of the country began appealing to the courts when pregnant women refused to undergo treatment on behalf of their fetus. In the majority of cases, the courts sided with physicians and ordered women to undergo cesareans against their will. However, appellate decisions (which hold the force of law) have since upheld the right of pregnant women to refuse treatment, even in situations where their physician believes the life of the fetus to be threatened.

The most widely cited case, *In Re. A.C.*, involved Angela Carder, a pregnant cancer patient who refused to consent to a cesarean at 25 weeks gestation and stated that she wanted to undergo cancer treatment instead, which her doctors believed would kill her fetus. Officials at George Washington University Hospital intervened and obtained a court order to force her to undergo a cesarean that neither she nor her baby survived. Her estate appealed the decision and won.

The Court of Appeals upheld the right of pregnant women to make all medical decisions on behalf of themselves and their fetuses, arguing that to compel invasive treatment on pregnant women would give fetuses rights superior to those of the mother and diminish the rights of born children whose parents could not, by law, be forced to undergo surgery or donate organs on their behalf. The court further ruled that the viability of the fetus and any potential harm the mother might cause to it by refusing treatment could not override her fundamental right to bodily integrity and informed consent/refusal.

It's important for VBAC mothers to know that the Carder ruling has had a very chilling effect on the willingness of doctors or hospitals to use the courts to force women to undergo cesareans. Many continue to use the prospect of a court order as a threat to coerce women to consent, but hospitals, doctors, and their attorneys are well aware that, should they proceed and should the mother decide to appeal, they're looking at a long and expensive legal battle that they will lose in the end.

Any VBAC mother who's threatened with a court-ordered cesarean should inform staff that she knows that it's an empty threat, that case law is on her side, and that she plans to appeal the ruling all the way to the Supreme Court if need be.

Professional Standards and Ethical Guidelines on the Rights of Pregnant Women

In the aftermath of the Carder ruling—and more recent appellate rulings, such as *In Re. Fetus Brown* in which the Illinois Supreme Court upheld the right of a pregnant woman to refuse a blood transfusion—the AMA and ACOG issued ethical guidelines mandating that physicians must respect the autonomy of pregnant patients and declaring that using the courts to compel treatment is rarely, if ever, justified. ACOG's ethical guidelines regarding patient rights and maternal-fetal conflict state (http://www.acog.org/from_home/publications/ethics/): “

Occasionally, a woman's autonomous decision will seem not to promote beneficence-based obligations to the fetus. In this situation, where there is insufficient time to obtain transfer of care, the

obstetrician must respect the patient's autonomy, continue to care for the pregnant woman, and not intervene against the patient's wishes, regardless of the consequences." The guidelines conclude by reminding physicians that, even in the case of a court order, physical force is never justified. So even in instances where a woman's refusal to undergo surgery on behalf of her fetus will likely result in harm, professional standards of care require physicians to respect her autonomy in all but the rarest of circumstances.

In cases where a woman's refusal of treatment poses no substantial risk to her fetus, the ACOG Code of Professional Ethics (www.acog.org/from_home/publications/ethics/) and its Committee Opinion paper on informed refusal (www.greenjournal.org/cgi/reprint/104/6/1465) are even more adamant in protecting her right to refuse, declaring that patient autonomy in making medical decisions must be respected at all times; that physicians must obtain informed consent for any medical or surgical treatments; and that a patient's decision to forego treatment based on cultural or religious beliefs and personal preference or comfort must be honored.

While failing to meet the ethical guidelines required by their profession won't subject physicians to criminal prosecution, such violations are grounds for losing the right to remain licensed to practice or to become subject to assorted other disciplinary actions. As a whole, the body of state, federal, and case law makes it clear that hospital policies mandating cesarean section violate the legal rights of pregnant women and constitute violations of professional ethical standards as well. In fact, no physician has ever been sued or held liable for neglecting to appeal to the courts to order a cesarean that a patient has refused (see, "Jehovah's Witnesses, Pregnancy, and Blood Transfusions: A Paradigm for the Autonomy Rights of All Pregnant Women" https://www.aslme.org/aslmesecure/shop/show_product.php?prod_id=500)

Patient Bills of Rights

The federal government and a number of states have further articulated and protected the right to informed consent/refusal through patient bills of rights. The Patient Self Determination act mandates that hospitals must inform patients of their rights upon admission (<http://www.dgcenter.org/acp/pdf/psda.pdf>) and in states such as New York, federally protected patient rights are expanded on and reiterated through a statewide patient bill of rights that includes detailed stipulations regarding maternity care and outlines the various grievance procedures available to women whose hospitals fail to provide the care outlined in the statute (<http://www.health.state.ny.us/nysdoh/consumer/patient/patient.htm>).

In addition, a number of hospitals across the country have implemented private bills of rights that declare their own intention to uphold the law by respecting patient autonomy and the doctrine of informed consent/refusal. In the aftermath of *In Re. A.C.*, for example, George Washington University Hospital developed a bill of rights that spells out in no uncertain terms that physicians may not force patients to undergo treatment against their will and that requires all patients to be informed of their rights upon admission (<https://www.gwhospital.com/p126.html>).

Though hospital policies denying access to VBAC are already in violation of the law, having a clearly articulated patient bill of rights clarifying the parameters of decision making authority means a hospital will be far less likely to institute a non-VBAC policy or encourage physicians to coerce women into cesareans. Both the New York and the George Washington University Hospital patient bill of rights serve as useful models for activists in other states who wish to further promote and protect the right of women to refuse cesareans.

Patient Abandonment and the Right to Care

Many people are under the mistaken impression that in instances where they disagree with their physician about a course of treatment, their doctor has the right to discontinue care. However, professional ethical guidelines stipulate that a physician may only terminate care after reasonable notice and after providing for necessary interim or emergency care. Physicians who fail to meet these guidelines may be charged with patient abandonment, which is grounds for malpractice and constitutes a violation of ethical conduct that could result in loss of licensure. As a general rule, physicians who wish to discontinue care in a non-emergency situation must notify patients in writing, give 30 days' notice and offer a general referral to other physicians in the area. However, if ongoing care is required at the time the physician wishes to terminate care (certainly the case with pregnancy), then the physician must ensure that the patient is transferred to a specific provider.

Part Two: Strategies for Enforcing the Rights of Women Seeking VBAC

Before Labor Begins: Holding Your Hospital Accountable Under the Center for Medicare and Medicaid Service's Conditions of Participation

All hospitals that receive federal funding (approximately 80% of them do) must adhere to the Center for Medicare and Medicaid Service's (CMS) Conditions of Participation (CoP), which require hospitals to honor patient rights as defined by the Patient Self-Determination Act, the Consumer Bill of Rights and Responsibilities, the Emergency Medical Treatment and Active Labor Act (EMTALA), and the large body of case law upholding the right to refuse treatment, to be fully informed of the risks, benefits, and alternatives of any proposed treatment, and to participate in all treatment decisions. Hospitals that fail to adhere to the CoP are subject to heavy fines and risk losing their right to qualify for Medicare and Medicaid funding. In addition, the CoP require that hospitals institute an internal grievance process and give patients the information they need to know about how to file a complaint and where to appeal in the case of an unfavorable ruling.

You can read a summary of your rights under the CoP and how they're protected at: <http://www.hhs.gov/news/press/1999pres/990412.html>

You can read the CoP regulations by going to the Code of Federal Regulation's main page at: <http://www.gpoaccess.gov/cfr/index.html> Enter "42CFR482.13" into the search engine, which will bring up all of the CoP on patient rights and filing grievances. The patient rights CoP are also excerpted in the appendix.

Pregnant women who plan to give birth at a hospital that performs repeat cesareans on all VBAC mothers should start first by filing a complaint with the Chief Compliance Officer, whose job it is to ensure that the CoP are met. If the hospital has no Chief Compliance Officer, then call and ask to receive the necessary information to file a complaint for a violation of the Center for Medicare and Medicaid Service's Conditions of Participation.

The hospital must respond to an initial complaint within one week or else offer an explanation of the reasons for the delay and an estimated time frame for a response; failure to do so is in itself a violation of the CoP. If the hospital's Chief Compliance Officer or other designated agent issues an unfavorable ruling, then the next step is to appeal to the Office of the Inspector General at the Department of Health and Human Services. If HHS also rules in favor of the hospital, then you may appeal to the Department of Justice, which is authorized to bring litigation against hospitals on behalf of their patients.

Organizations representing deaf patients who were denied interpreters in violation of the CoP have successfully used this process to hold hospitals accountable for violating their rights under federal law. once VBAC mothers begin to do the same, they'll be

putting hospitals across the country on the alert, sending a strong message that women plan to start using the law to uphold their right to refuse surgery. Customizing Your Consent Forms: The New Birth Plan Many women who seeking a VBAC write birth plans stating their preferences for the treatments they wish to receive or decline while they're in the hospital. However, it's important to note here that birth plans are not legally binding documents. In fact, because they usually include a disclaimer declaring that the mother is willing to accept certain procedures in the event of medical necessity, in reality birth plans function as blanket consent forms that allow hospital staff to perform any procedures they deem "necessary."

While birth plans can be a useful tool for educating physicians and hospital staff about your wishes, a more effective means of enforcing your right to informed consent/refusal is to customize the hospital's blanket consent form. Physicians often fail to let patients know exactly how all encompassing these forms are, and many people sign them without a full understanding of their legal implications. Moreover, most patients are unaware that they are not, by law, required to sign the hospital's consent form or that they have the right to make it reflect their specific treatment wishes.

It's possible for people to either customize the form themselves or to write down their refusal to consent to treatment on any piece of paper and sign it. To customize the hospital's form, put a line through any listed procedure and then add your own list of routine procedures, including cesarean surgery, which you wish to refuse, initial each change or addition and make sure to include the required signatures. You can find a template for making your own informed refusal form at: <http://www.medlaw.com/healthlaw/EMTALA/formsample/index.shtml>

Customized consent/refusal forms legally document your refusal to accept treatment and alert staff that you understand and are prepared to protect your rights. In addition, such a document will require staff to obtain direct, verbal consent from you each time they want to do a procedure you've already declined in writing. Then you can decide at that time if a treatment is needed and if you should accept it or not. If possible, pre-register at the hospital no sooner than thirty days before your due date and take the forms home with you to review, add to, and sign. Be sure to keep personal copies of any forms you sign and ask your partner or doula to record any changes that were made during the course of your labor.

While many physicians will tell you that such forms do not protect them from lawsuits, in fact, as long as your refusal is documented, under US law it's very difficult, if not impossible, for hospitals or

physicians to be held liable for not doing a procedure a patient has refused.

Moreover, if your refusal is documented and you underwent a cesarean anyway, your doctor and hospital would be subject to criminal battery charges, regardless of whether your or your baby was harmed by the cesarean. The so-called malpractice crisis surrounding VBAC grew out of lawsuits brought by women whose doctors encouraged or, in some cases required, a trial of labor (often including the use of induction agents known to increase the risk of uterine rupture) without informing their patients that uterine rupture was a possible consequence. Doctors who lost those lawsuits did so because they neglected to provide adequate information about the risks, benefits, and alternatives to VBAC. The very same legal principles apply to doctors who neglect to inform patients that elective repeat cesareans also present a number of risks and that VBAC is a medically sound alternative. Women who've undergone repeat cesareans only because of hospital policies banning VBAC can sue for negligence if they or their babies experience any complication they weren't informed of prior to the surgery, particularly if they weren't informed that VBAC was an alternative.

During Labor: Holding Your Hospital Accountable Under The Emergency Medical Treatment and Active Labor Act

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to admit women in active labor, explain the risks, benefits, and alternatives of all proposed treatments, and to honor their treatment wishes, including the right to decline treatment. EMTALA was originally enacted to prevent "patient dumping" but has since been applied to require hospitals to admit, examine, and treat (or not, if a patient chooses to decline) anyone who requires emergency care, regardless of their ability to pay. Under the act, no patient who requires emergency care—which is defined to include laboring women—can be transferred to another hospital until after they've been "stabilized." In the case of women in labor, stabilization is defined as the delivery of both the baby and the placenta. You don't have to be admitted to the emergency room in order to be covered by EMTALA; in fact, it begins to apply once you set foot within 250 feet of the hospital building. EMTALA is widely enforced, and each violation carries a fine of up to \$50,000, so if you're admitted to the hospital and the nurses or physicians fail to inform you of the risks, benefits, and alternatives to cesarean section, that counts as one violation, and if they fail to honor your right to refuse a cesarean, that counts as an additional violation.

EMTALA is a particularly effective tool for VBAC mothers who've exhausted other options and plan to go into a hospital very late in labor. Any woman who finds herself in this situation should prepare to repeatedly use such phrases as, "It's my right under EMTALA (pronounced with a short "e" and a short "a") to decline a, b, or c," or "It's a violation of my rights under EMTALA to refuse any proposed treatment, including cesarean," and "If you perform a cesarean without my consent, I plan to file a complaint with the Center for Medicare and Medicaid Services for violating my rights under EMTALA" (CMS is in charge of enforcing the act).

To find out where to report an EMTALA violation in your state, go to: <http://www.medlaw.com/healthlaw/EMTALA/reporting/where-to-report-violation.shtml>

To read the EMTALA statute and regulations, and to get more information, go to: <http://www.medlaw.com/healthlaw/EMTALA/index.shtml>

Addressing Grievances After the Fact: Filing Complaints With the Board of Medicine

Given the fact that many states inadequately discipline physicians who commit malpractice and given how difficult it can be to bring malpractice suits to begin with, many people are under the impression that it's futile to pursue action against a physician who fails to obtain proper consent or who coerces them into consenting to a medically unnecessary cesarean. While it remains true that the primary trend in malpractice cases has been to sue physicians for neglecting to perform cesareans, the law certainly does provide recourse for women whose medically unnecessary cesareans resulted in physical or emotional harm. And though physicians may be held criminally liable only under very narrow circumstances, using any form of physical force to perform a medical procedure without a patient's consent constitutes grounds for battery (a criminal action) as well as for malpractice (a civil action). Lawsuits can cost a great deal of time and money and may not be the best means of addressing the issue of coerced cesareans, but until more women begin to pursue this route, physicians will continue to view cesareans as a no-fault course of treatment in virtually every clinical situation.

And despite the lack of adequate physician discipline in most states, filing a complaint to the medical board can be a very effective means of changing the birth climate in your state. Though few complaints actually result in loss of licensure, they can result in a range of lesser disciplinary actions that may threaten the ability of physicians to earn hospital privileges or to maintain certification through their professional credentialing organization. In addition, many states

maintain searchable databases of complaints, malpractice suits, and disciplinary actions against physicians, which can have financial repercussions. At the very least, filing a complaint to the medical board and to other interested parties (including your hospital and insurance company) establishes a record that can be referred to should other patients complain about the same physician (letters of complaint usually remain on file permanently). For more information on how to file complaints, see, "Unhappy With Your Maternity Care? File a Complaint!" (<http://www.cfmidwifery.org/Resources/item.aspx?ID=1>) and refer to the sample letters included in the Appendix.

Legislative Strategies for Protecting the Rights of Pregnant Women

Holding physicians accountable to the law and to their own ethical guidelines is just one part of the equation. Using legislation to more clearly outline the rights of pregnant women, particularly women seeking VBAC, is another means for guaranteeing that the right to informed consent/refusal is universally honored. Most states have a range of statutes that address the reproductive needs of women and clearly spell out instances in which informed consent/refusal becomes especially important. For example, Maryland has a statute dictating that physicians who treat women for breast cancer must inform them of reasonable alternatives and obtain consent for any course of treatment.

Though these obligations are already required by a range of federal and state laws, the breast cancer treatment act in Maryland includes a specific penalty for failure to meet those standards in the context of breast cancer treatment. Extending such requirements to inform women with prior uterine surgery of alternative treatments, i.e. VBAC, would certainly be a reasonable option that would appeal to liberal and conservative legislators alike.

Similarly, many states have abortion statutes that mandate exactly what kinds of information women must be provided with in order to consent to an abortion. In many cases, the state develops and publishes brochures outlining the assorted risks, benefits, and alternatives to abortion. Again, legislation requiring physicians to disclose very specific and detailed information to women considering cesarean sections could easily be modeled on such laws. Other states have statutes explicitly absolving physicians of liability in providing alternative treatments in instances where patients were fully informed of the risks and potential benefits of such treatment, while other states have laws directing the department of health to institute certain public health campaigns directed at pregnant women. In short, most states already have a number of statutes specifically regulating the provision

of reproductive healthcare and laying out clear instructions as to how to provide such care, in addition to the specific kinds of consent required to proceed. Using these laws as models for VBAC-centered legislation is another option for enhancing the rights of birthing women and for educating the public and healthcare providers about the need to do so.

It's also important for activists seeking to increase access to VBAC to monitor current legislative initiatives related to reproductive healthcare, particularly efforts to provide licensing for Certified Professional Midwives (CPMs). In states such as Oklahoma, where the primary liability insurance provider has refused to cover physicians who offer VBACs, CPMs provide the only reasonably accessible alternative. However, because state law defines midwifery as the practice of medicine, CPMs—particularly those who attend births the medical monopoly considers high risk—remain vulnerable to a range of criminal charges, from practicing medicine and nursing without a license, to manslaughter, child endangerment, and the unauthorized use of controlled substances. In a number of states where midwives are effectively illegal—such as Alabama, Illinois, Massachusetts, Ohio, Nebraska, North Carolina, South Dakota, Wisconsin, and Wyoming—legislative efforts are currently underway to license CPMs (for more information on midwifery legislation go to www.vbfree.org). In Oklahoma and certain other states where midwives remain vulnerable to prosecution, one of the primary obstacles is often lack of consumer support and involvement. ICAN and its membership are an underutilized resource both in states with current legislative efforts and those where midwives are reluctant to move forward due to lack of a strong grassroots network.

In certain states where CPMs are already legal—such as California, Florida, New Hampshire, New Mexico, Texas, Utah, and Virginia—the administrative rules governing their practice are either being developed or are under review. Many people are unaware of the fact that the regulatory process allows for input from the public, and as primary stakeholders in the issues surrounding access to VBAC, it's especially crucial for ICAN members to become educated about and involved in any regulations affecting the ability of CPMs to provide this service without having to risk losing their license. While it remains true that many states where midwives are legal have regulations restricting their ability to attend VBACs, this is because there's been little to no input or pressure from the public. In fact, there are a number of states where midwives are permitted to legally attend VBACs, as well as other states, such as Vermont, New Hampshire, and Wisconsin, where VBAC and other regulations involving all types of maternity care providers and institutions are currently under review. In short, there are a wide range of opportunities in most states for activists to

become involved in legislative and regulatory efforts to expand access to VBAC.

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