NOTE

CESAREAN SECTION EPIDEMIC: DEFINING THE PROBLEM—APPROACHING SOLUTIONS*

"I live within a mile of several large maternity hospitals. All day long I hear them cutting."
-Rose (Massachusetts)[1]

I. INTRODUCTION

The complex problem of physicians performing forced and unnecessary cesarean sections on pregnant women has generated national concern. As recently as December of 1993, state officials in Cook County, Illinois challenged in court a pregnant woman's decision to refuse a cesarean section.[2] The woman trusted that her religion would preserve the safety of her baby during childbirth.[3] A lawyer for the hospital claimed that without the surgery, the baby would "almost assuredly . . . be born dead or brain damaged."[4] Despite the woman's religious beliefs, the public guardian in Cook County sought to obtain a court order to override her refusal.[5]

The trial court ruled that the state could not force the woman to submit to a cesarean.[6] The Illinois Appellate Court unanimously affirmed.[7] In one of the strongest opinions upholding the right of a woman to refuse a cesarean section, the appellate court held that "a woman's competent choice in refusing . . . a

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[1] NANCY W. COHEN & LOIS J. ESTNER, SILENT KNIFE 50 (1983).

[2] Doe v. Doe, 260 Ill. App. 3d 392 (1994). *See also* Don Terry, *Legal Fight Over Caesarean Pits Mother Against Fetus*, N.Y. TIMES, Dec. 14, 1993, at A22.

[3] *Doe*, 260 Ill. App. 3d at 393. The woman and her husband are Pentecostal Christians. Terry, *supra* note 2, at A22.

[4] Terry, *supra* note 2, at A22.

[5] *Doe*, 260 Ill. App. 3d at 395.

[6] *Id.* at 396.

[7] *Id.* at 406.

cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus."[8] Not long after the court's decision, the woman delivered a healthy baby boy through natural childbirth.[9]

The cesarean section rate in the United States has reached epidemic proportions. The rate is currently the second highest in the world.[10] Studies show that one in four pregnant women will receive a cesarean section in her lifetime.[11] In 1968, only five percent of American deliveries were by cesarean section;[12] by the end of 1989, the rate increased to twenty-three percent.[13] Health advocates have defined the cesarean explosion as a health issue and a legal difficulty.[14]

Since 1990, the cesarean section rate has decreased slightly. A recent study shows that the rate inched downward to 22.7% in 1990.[15] Despite this downward trend, more than half of these procedures are still medically unnecessary.[16] Physicians believe that the high incident of cesarean section rates in this country can be attributed to: threat of malpractice suits, obstetrical policy of repeat cesarean sections, obstetrical training, belief that cesarean sections result in healthier babies, financial factors, fetal technology, birth weight, and severe medical conditions.[17]

This Note analyzes the historical background of cesarean sections in the United States and the reasons for the rise in forced and unnecessary cesarean sections. It also examines legal, legislative, and medical solutions to this increasingly important problem. If the legal and medical community forge a strong partnership to solve this crisis, creative, comprehensive, and workable solutions can be developed.

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[8] *Doe*, 260 Ill. App. 3d at 398. The Illinois Supreme Court rejected the public guardian's petition to re-hear the case. Ronald Brownstein & Tracy Shryer, *Refusal to Undergo Cesarean Supported; Supreme Court: Justices Clear Way for Pentecostalist to Await Natural Labor. Doctors Say Fetus is Endangered*, L.A. TIMES, Dec. 19, 1993, at A24.

[9] Brownstein & Shryer, *supra* note 8, at A24.

[10] Francis C. Notzon, *International Differences in the Use of Obstetric Interventions*, 263 JAMA 3286 (1990).

[11] *Id.* at 3289.

[12] COHEN & ESTNER, *supra* note 1, at 8.

[13] *Caesarean Births Fall, Group Says*, BOSTON GLOBE, May 13, 1992, at 17.

[14] *Id.* at introduction.

[15] PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, UNNECESSARY CESAREAN SECTIONS: HALTING A NATIONAL EPIDEMIC 2 (1992). A mere three-tenths percent, however, does not represent a substantial decline in the cesarean section rate.

[16] In 1990, out of the 982,000 cesareans performed in the United States, 480,520 procedures were found unnecessary. *Id.* at 40. *See* section II, *infra*, for a discussion of why cesarean sections may be medically unnecessary.

[17] *See* Hilary E. Berkman, Note, *A Discussion of Medical Malpractice and Cesarean Section*, 70 OR. L. REV. 629 (1991).

A. *The Historical Origins of Cesarean Sections and Their Prevention in the United States*

Contrary to popular belief, the name "cesarean" does not derive from the birth of Julius Caesar by cesarean section.[18] The name developed from Roman law, *lex caesarea*, which required that physicians cut open a woman dying in childbirth to remove the child.[19] In 1827, Dr. John Richmond of Newton, Ohio performed the first documented cesarean section in the United States.[20] At the time, cesareans were performed only in emergencies.[21]

By the 1920s, surgical techniques improved and cesarean sections became more common.[22] The rate increased in the Post-World War II era with the development of antibiotics and an increase in the number of blood banks.[23] It was not until the late 1970s, however, that health care professionals and the government began to focus on the need to reduce the cesarean section rate.[24] Between 1968 and 1977, the rate tripled, making cesarean delivery the tenth most common surgical procedure.[25] The National Institute of Health, a division of the Department of Health and Human Services, responded to the crisis by organizing a conference of scientists, physicians, and consumers to generate recommendations for halting the rising rate.[26]

Over the last twenty years, organizations such as the International Cesarean Awareness Network have launched great efforts to decrease the rate of unnecessary cesareans by educating hospitals, legislators, and the general public about the problem.[27]

B. *The Cesarean Procedure*

A cesarean section constitutes major surgery.[28] It is two to five times more

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[18] BRUCE L. FLAMM, BIRTH AFTER CESAREAN: THE MEDICAL FACTS 17 (1990).

[19] CHRISTOPHER NORWOOD, HOW TO AVOID A CESAREAN SECTION 21 (1984).

[20] FLAMM, *supra* note 18, at 16. There is some speculation, however, that the first cesarean section in the United States was performed as early as 1794 by Jesse Bennett, a doctor in Staunton, Vermont who performed the operation on his wife. NORWOOD, *supra* note 19, at 21.

[21] FLAMM, *supra* note 18, at 16.

[22] NORWOOD, *supra* note 19, at 21-22.

[23] *Id.* at 22.

[24] NATIONAL INSTITUTE OF HEALTH. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. CESAREAN CHILDBIRTH 38-40 (1981).

[25] *Id.* at iii.

[26] *Id.* Conference participants recommended the development of comprehensive hospital programs and legal incentives to perform natural childbirth as an approach to the cesarean section problem. *Id.* at 9-26.

[27] PUBLIC CITIZEN'S RESEARCH GROUP, *supra* note 15, at 53-56. This organization was formerly known as the "Cesarean Prevention Movement." *Id.* at 66. The group publishes a newsletter and has approximately eighty chapters across the country. *Id.*

[28] FLAMM, *supra* note 18, at 7 (1990). Major surgery involves any surgical procedure that requires general anesthesia or assistance in respiration. DICTIONARY OF MEDICAL

likely to result in maternal death than natural childbirth.[29] The doctor first administers an anesthetic, drains the woman's bladder, and scrubs her skin.[30] The doctor then opens the abdomen using a low "bikini" incision and peels the bladder away from the uterus.[31] The physician is able to remove the baby after making an additional incision to the uterus and applying the requisite pressure.[32]

Finally, the physician removes the placenta, sews the bladder back into place, and closes the "bikini" incision with six or seven layers of stitching.[33] Most women spend an average of four days in the hospital recovering from the surgery.[34] Many women feel weakened from the impact of the anesthesia and surgical stress for weeks or months after they go home.[35] In addition, half of these women experience depression, discomfort, and infections.[36]

C. *The Women Who Have Refused Cesareans*

Most pregnant women would do anything to ensure the safety of their babies, including accepting medical procedures recommended by their obstetrician. However, some women reasonably decide to forgo a cesarean section based on the substantial danger of maternal death, to avoid repeat cesarean sections, or to adhere to sincerely held religious, cultural, or moral beliefs.[37]

In cases where a woman refuses a cesarean section and the fetus appears at risk, the hospital charged with her care can seek a court order to override her refusal. To determine the appropriateness of the order, courts have adopted a balancing test that weighs the rights of the pregnant woman to privacy and bodily integrity against the state's interest in protecting potential life.[38] Judges, however, often defer to the physician's conclusion that surgery is necessary because they lack the medical expertise or factual information to render an adequate judgment.

From 1981 to 1986, fifteen court orders were sought in the United States to

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TERMS 268 (2d ed. 1989).

[29] Terry, *supra* note 2, at A22. Some health professionals claim that the maternal morbidity rate is actually twelve times that for natural delivery. Lorna McBarnette, *Women and Poverty: The Effects on Reproductive Status*, 12 WOMEN & HEALTH 55, 72 (1988).

[30] NORWOOD, *supra* note 19, at 20.

[31] *Id.*

[32] *Id.*

[33] *Id.* at 21.

[34] PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, *supra* note 15, at 38.

[35] NORWOOD, *supra* note 19, at 21.

[36] *Id.* at 21-23. Feelings of anger, depression, and inadequacy are commonly expressed by new mothers. Some women feel that having a cesarean baby detracts from the natural childbirth process. COHEN & ESTNER, *supra* note 1, at 33.

[37] *See* the discussion in section II.A, *infra*.

[38] Brophy v. New England Sinai Hosp., 497 N.E.2d 626, 635 (Mass. 1986).

authorize cesarean sections against women who refused them.[39] Courts granted thirteen of the fifteen orders.[40] Too often, however, physicians perform cesareans even where the risk of harm to the fetus or the mother is merely speculative.[41] In several cases where pregnant women have refused surgery in violation of a court order, the women have delivered healthy babies through natural childbirth.[42]

In *Jefferson v. Griffin Spalding County Hospital Authority*,[43] the hospital obtained a court order to perform a cesarean section against the wishes of a pregnant woman who refused the surgery based on her religious beliefs. The doctor diagnosed a ninety-nine percent chance that the fetus would not survive natural delivery and a fifty percent chance that the mother would not survive without a cesarean section.[44] The court, under the guise of protecting the fetus, authorized the procedure despite the woman's adamant refusal.[45] A few days later, however, Mrs. Jefferson left the hospital environment and delivered a healthy child from vaginal childbirth.[46]

1. The impact of forced and unnecessary cesarean sections on low-income women and women of color

As the epidemic of unnecessary cesarean sections continues to spread, poor women and women of color[47] inevitably will constitute the greatest number of victims.[48] There is a disproportionate impact of court-ordered obstetrical inter-

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[39] Michael Phillips, *Maternal Rights v. Fetal Rights: Court-Ordered Cesareans*, 56 MO. L. REV. 411 (1991).

[40] *Id.*

[41] Physician predictions of fetal harm are often incorrect. George J. Annas, *Forced Cesareans: The Most Unkindest Cut of All*, HASTINGS CENTER REPORT, June 1982, at 17.

[42] Doe v. Doe, No. 93-7437, 1994 U.S. Lexis 1988, at *1 (U.S. Feb. 28, 1994); Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981). The courts have also created unfortunate results by ordering women to submit to cesarean sections. For example, in the case of *In re A.C.*, 573 A.2d 1235 (D.C. 1990), the trial court ordered a terminally ill pregnant woman to have a cesarean section, and both the baby and the woman died. *Id.* at 1238. *See* discussion in section II.B.2, *infra*.

[43] 274 S.E.2d 457 (Ga. 1981).

[44] *Id.* at 458.

[45] *Id.* at 460.

[46] Annas, *supra* note 41, at 16. The legal issues presented in *Jefferson* are examined in section II.B.2, *infra*.

[47] The term "women of color" will be used to denote Native-American, Latina, Asian-American, and African-American women. The terms "women of color" and "minority women" signify the same group for purposes of this Note.

[48] African-American women have high infant and maternal mortality rates. JANE S. LIN-FU, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, SPECIAL CONCERNS OF ETHNIC MINORITY WOMEN 12 (1987). African-American women are three times more likely as white women to die in childbirth. McBarnette, *supra* note 29, at 72. A study in California revealed that African-American women give birth to low weight babies

ventions on low-income women and women of color.[49] Similar to the episodes of sterilization abuse affecting women two decades ago, poor and minority women will experience significant infringements of their reproductive liberties with the ascendancy of the cesarean section rate.[50]

During the 1970s, there was a dramatic increase in the use of sterilization as a method of contraception.[51] Government funding made sterilization widely available to poor and minority women.[52] Health care scholars expressed deep concern that the government was specifically targeting poor and minority women, especially welfare recipients, for reproductive control.[53]

The increase in cesarean sections performed on poor and minority women has caused similar concern. A recent national study found that eighty percent of the patients who received court-ordered cesarean sections were African-American, African, Asian, and Latina.[54] Nearly half of the court-ordered procedures impacted African-American women.[55] Half of the women were unmarried, and over one-fourth did not speak English as their primary language.[56]

The health care providers in this study agreed that poor women and women of color cannot be trusted to make decisions regarding their own body. The study revealed that forty-six percent of the directors of fellowship programs in maternal and fetal medicine believed that mothers who refused medical advice when their fetuses were in danger required detention in hospitals or other

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2.3 times more often than white women. Ruth E. Zambrana, *A Research Agenda on Issues Affecting Poor and Minority Women: A Model for Understanding Their Health Needs*, 12 WOMEN & HEALTH 137, 145 (1988).

Young Mexican-American women have a higher percentage of deaths from pregnancy complications than their white peers. *Id.* at 145. The birthweight for Latino children is significantly lower than that of white children. *Id.* These statistics can be attributed to the lack of early detection of diseases and preventative health care in minority communities, poor living conditions, and inadequate access to prenatal health care. *Id.* at 142.

[49] Veronika E.B. Kolder et al., *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192 (1987) (obstetrical interventions included cesarean sections, hospital detentions and intrauterine transfusions). *Id.*

[50] McBarnette, *supra* note 29, at 69.

[51] *Id.* Sterilization, also known as "tubal ligation," is a procedure in which a woman's fallopian tubes are tied in two places and the intervening space is removed or crushed so that the tube is effectively blocked and conception cannot occur. DICTIONARY OF MEDICAL TERMS 452 (2d ed. 1989).

[52] McBarnette, *supra* note 29, at 69.

[53] *Id.*

[54] Kolder, *supra* note 49, at 1193. The study involved patients receiving care from a teaching hospital and patients receiving public assistance. *Id.* at 1192. The study designates the particular ethnic groups.

[55] *Id.* (This figure does not include African women, who were counted along with Asians as representing 33% of those receiving forced cesareans.)

[56] *Id.*

facilities until compliance with the advice could be obtained.[57]

The health care community cannot afford to overlook the link of racism and classism to the incidence of cesarean sections. Health care providers who maintain racist and classist beliefs about their patients, whether conscious or subconscious, contribute to the social subordination and medical inequality of certain groups in society.[58] Solutions to the cesarean section crisis must include proposals for addressing racism and classism in the health care system.

II. DEFINING THE PROBLEM

The health care and legal systems share equal responsibility for the rising cesarean section rate.[59] The following section discusses the role of the medical industry and the legal system in encouraging the practice of forced and unnecessary cesarean sections. It explores the reasons for the increase, examining the incentives in the health care industry to perform cesarean sections, the legal context in which they are performed, and the crucial issue of medical malpractice. Any adequate solution to the problem must address these causes.

A. *Medical Reasons*

1. Doctors encourage their colleagues to perform repeat cesarean sections

In 1916, Dr. Edwin B. Cragin, speaking at a medical engagement in New York City announced the well-known dictum, "a prudent obstetrician should adopt a philosophy of once a cesarean, always a cesarean."[60] Today, repeat cesarean sections account for 35.6% of all cesarean sections.[61] Studies show that eighty-two percent of American women who have had the procedure must repeat the surgery for subsequent deliveries.[62]

In 1982, the American College of Obstetricians and Gynecologists (ACOG) approved the use of trial labor[63] for mothers who had previous cesarean sections.[64] Recently, ACOG found that eighty percent of all women who have

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[57] *Id.* Approximately one-quarter of them supported state surveillance of women in the third trimester of pregnancy. *Id.* at 1193-94.

[58] McBarnette, *supra* note 29, at 69.

[59] Berkman, *supra* note 17, at 619.

[60] PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, *supra* note 15, at 18. Historically, cesarean sections left large scars capable of rupture, creating an emergency for both mother and infant if natural labor was attempted in a subsequent delivery. NORWOOD, *supra* note 19, at 40-41. Modern medicine, however, has perfected a new incision that rarely results in rupture. *Id.*

[61] PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, *supra* note 15, at ii.

[62] Lisa L. Ryckman, *Must One Cesarean Section Lead to Another? The VBAC Mothers Say No*, L.A. TIMES, Jan. 26, 1991, at A13.

[63] Trial labor is defined as the process by which doctors permit labor to continue long enough to determine if natural childbirth is possible. TABERS CYCLOPEDIC MEDICAL DICTIONARY 787 (14th ed. 1981).

[64] NORWOOD, *supra* note 19, at 41-42.

had cesareans are capable of having natural childbirth in the future.[65] Most obstetricians, however, are not trained to perform trial labor and are unwilling to change their procedures to accommodate this method.[66]

2. Financial incentives

Physicians and hospitals have financial incentives to perform cesarean sections. A study of California hospitals revealed that women covered by private insurance, Medicaid, and other forms of public insurance are more likely to receive cesareans than uninsured women.[67] In addition, physicians can charge more for cesarean sections than for natural childbirth. An analysis of insurance claims in 1986 found that physician fees were sixty-eight percent higher for cesarean sections than for natural delivery.[68] In the same year, insurance claims for hospital charges were ninety-two percent higher for cesarean sections compared with natural delivery.[69]

The data suggest that financial factors and type of insurance coverage may influence a physician or hospital to perform unnecessary cesareans. Thus, pregnant women and their insurers may be paying more for unnecessary surgery. A recent report estimates that a one percent drop in the national cesarean rate would save this country $1.3 million annually.[70]

3. The influence of medical technology

Studies have established a link between the rise in incidence of cesarean sections and the use of electronic fetal heart rate monitors.[71] In 1989, the diagnosis of fetal distress accounted for 9.9% of all cesarean sections per-

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[65] Ryckman, *supra* note 62, at A13.

[66] NORWOOD, *supra* note 19, at 42.

[67] Randall S. Stafford, *Alternative Strategies for Controlling Rising Cesarean Section Rates*, 263 JAMA 683, 685 (1990).

[68] *Id.*

[69] *Id.* Hospital charges are more expensive because cesarean patients stay in the hospital two to three more days than patients who deliver by natural childbirth. PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, *supra* note 15, at 38.

[70] PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, *supra* note 15, at 40 (this amount is based on the fact that 480,520 unnecessary cesarean sections were performed in 1990).

[71] *Id.* at 31. Fetal monitors are a form of technology used during pregnancy, labor, and childbirth to observe the fetal heart rate and maternal uterine contractions. DICTIONARY OF MEDICAL TERMS 173 (2d ed. 1989).

The monitor is either strapped to the mother's abdomen or attached to the baby's scalp through an electrode after the mother's water has broken. PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, *supra* note 15, at 31. Fetal heartbeats can also be measured through periodic use of a fetoscope which is similar to a stethoscope. *Id.* A stethoscope is a simple instrument that can be used by a nurse or physician to listen to body sounds produced by the heart or lungs. DICTIONARY OF MEDICAL TERMS 421 (2d ed. 1989).

formed that year.[72] Fetal monitors can be extremely helpful to many obstetricians in detecting fetal harm. However, some physicians perform cesareans at the first indication of deviation on the monitor to avoid a suit for negligence.[73] Such doctors are concerned about the possibility of a lawsuit based on failure to perform a necessary cesarean section.[74] This practice of performing procedures or tests to avoid suit, commonly called "defensive medicine," constitutes a serious problem, particularly because of studies showing that a fetal monitor can produce false signals at a rate of forty percent.[75]

A recent study in Germany noted that seventeen percent of low-risk and thirty-five percent of high-risk women experienced alarming signals on the electronic fetal monitor during labor.[76] However, after fetal blood testing, the study found that only four percent of the women's infants were in actual danger.[77] The study found that for every infant with real fetal distress, three infants showed false signals of distress.[78] The authors of the study concluded that the intermittent use of a stethoscope was safer than electronic fetal monitoring because it prevented unnecessary cesarean sections.[79]

The Germany study confirms the findings of an American study performed in 1976.[80] In the American study, high risk mothers in labor were randomly assigned to an electronically monitored group or to a group cared for by nurses with stethoscopes.[81] Infants from both groups proved healthy upon delivery.[82] However, cesarean sections were performed at a rate of 16.5% for the electronically monitored group, while for the nurse monitored group, the rate was only 6.6%.[83] This finding reinforces the notion that medical technology may influence a physician's decision to perform an unnecessary cesarean section.

4. Physician ideology

Research in the area of cesarean childbirth rarely focuses on the subjective factors such as cultural ideology and fetal protectionist beliefs that may influence doctors to perform forced cesarean sections. Physician ideology, however,

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[72] PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, *supra* note 15, at 31.

[73] NORWOOD, *supra* note 19, at 47.

[74] *See, e.g.*, Williams v. Lallie Kemp Charity Hosp., 428 So. 2d 1000 (1st Cir. 1983); Labate v. Plotkin, 600 N.Y.S.2d 144 (1993); Holt v. Nelson, 523 P.2d 211 (Wash. 1974), *rev. denied*, 84 Wash. 2d 1008 (1974).

[75] PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, *supra* note 15, at 31.

[76] *Id.*

[77] *Id.*

[78] *Id.*

[79] *Id.*

[80] *See* Susan A. Doering, *Unnecessary Cesareans: Doctor's Choice, Patient's Dilemma*, *in* 1 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 177, 178 (NAPSAC ed., 1979).

[81] *Id.*

[82] *Id.*

[83] *Id.*

may play an important role in determining when the procedure will be performed.

a. Cultural ideology

Certain doctors express hostility towards women who refuse a cesarean section based on cultural or religious values.[84] Some doctors view these women as irresponsible, irrational, or callous.[85] Some doctors may also believe that a woman who refuses the surgery in an emergency situation does not care about the life of her child.[86]

In one case, for example, doctors forcibly restrained a Nigerian woman who vigorously opposed a cesarean section to her hospital bed, and removed her husband from the delivery room. They then proceeded to perform surgery on her after placing her wrists and ankles in leather cuffs.[87] In another case, doctors characterized a Bedouin woman, who rejected the procedure because she feared she would die, as ignorant and incapable of "arriving at an intelligent decision."[88]

Data confirm the theory that doctors may impose surgery on women based on cultural or socio-economic factors.[89] Health care providers and consumer groups should evaluate the influence of cultural ideology on the cesarean section rate.

b. Religious and personal views on fetal protection

As a medical professional, the obstetrician has a duty to try and minimize the risks to both mother and fetus in the labor room. In many respects, the doctor has two patients, the mother and the fetus. At one time, the mother was viewed as the primary patient, through whom the fetus was indirectly treated. Advances in fetal physiology and monitoring, however, have enabled physicians to develop a more direct medical relationship with the fetus. Overall, this relationship enhances the childbirth process. In some cases, however, doctors subordinate the interests and rights of the mother in favor of fetal survival and perform unwanted cesarean sections.

Some doctors believe that it is medically necessary to perform surgery to protect the life of the fetus. Others feel that the mother's rejection of surgery when the fetus appears at risk constitutes a decision to have an abortion. These doctors may interpret a mother's decision to refuse a cesarean section as

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[84] Deborah J. Krauss, *Regulating Women's Bodies: The Adverse Effect of Fetal Rights Theory on Childbirth Decisions and Women of Color*, 26 HARV. C.R.-C.L. L. REV. 523, 532 (1991).

[85] *Id.*

[86] COHEN & ESTNER, *supra* note 1, at 13.

[87] Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong With Fetal Rights*, 10 HARV. WOMEN'S L.J. 9, 9-10 (1987).

[88] Krauss, *supra* note 84, at 532.

[89] *See* discussion in part I.C.1, *supra*.

a conscious decision to destroy her fetus given the magnitude of the risks posed to the fetus. If the doctor does not support abortion or restrictions on fetal life because of her own personal moral or religious views, she may interpret a mother's refusal of a cesarean to be cruel or ignorant. Thus, when deciding whether to override the woman's consent, the doctor may feel obliged to perform the procedure. One doctor revealed:

> By and large, I think American obstetrics has become so preoccupied with apparatus and possible fetal injury that the mothers are increasingly being considered solely as vehicles. In many instances, small and uncertain gain for the infant is purchased at the price of a small but grave risk to the mother.[90]

The ethical questions that a physician must face when deciding to override a pregnant mother's consent are extremely difficult. The mother and her fetus are valued patients of the doctor, and no physician wants to jeopardize the life of either. In making the decision whether or not to perform surgery, the physician must balance the rights of the mother against the interests in promoting fetal survival. Unfortunately, this decision may result in either limiting the personal autonomy of the mother, or in endangering the fetus. The moral and philosophical debate surrounding forced cesarean sections makes it particularly hard for the medical community and the courts to resolve this issue with absolute neutrality.

B. *Legal Reasons*

1. Informed consent doctrine

The doctrine of informed consent, as applied in the context of childbirth, creates a duty of disclosure upon a physician to present her patient with information on not only the material risks involved in undergoing natural childbirth, but also the risks associated with having a cesarean section.[91] The physician must assist the patient in determining the costs and benefits, economic or otherwise, of various childbirth procedures. An open discussion regarding the patient's personal choices is critical to enabling her to make an informed decision concerning her choice of childbirth method.

In the childbirth context, physicians are not complying with their duty to follow informed consent guidelines and requirements.[92] Their bias towards

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[90] COHEN & ESTNER, *supra* note 1, at 13.

[91] Physicians are required to disclose (1) the risks of a particular method of treatment; (2) alternative methods of treatment; (3) the risks relating to such alternative methods of treatment; and (4) the results likely to occur if the patient remains untreated. Canterbury v. Spence, 464 F.2d 772, 781-82 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972); Crain v. Allison, 443 A.2d 558, 561-62 (D.C. 1982); Holt v. Nelson, 523 P.2d 211, 217 (Wash. 1974).

[92] The American Medical Association's Council on Ethical and Judicial Affairs, concerned with physicians' lack of adherence to informed consent doctrine, issued the following statement in December 1993, shortly after a Chicago woman was faced with the

cesarean sections may influence their ability to provide adequate information about childbirth methods. Physicians who find it in their best interest to perform the surgery may reveal incomplete information to a patient deciding between a cesarean or natural childbirth. This practice violates the physician's fiduciary duty to her patient.

Moreover, the informed consent doctrine does not require a doctor to be culturally sensitive to patients who refuse the procedure.[93] Poor or religious women, for example, may require unique or additional information from physicians to make an informed decision about childbirth methods.[94] Physicians must be willing to fully inform the pregnant woman of her options, and to facilitate discussions regarding the patient's personal choices.

2. The reluctance of the Supreme Court to resolve the issue of forced cesarean sections

The lack of a judicial pronouncement by the Supreme Court on the issue of forced cesarean sections has left state courts with primary responsibility for resolving the tension between maternal and fetal rights in the childbirth set-

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choice of whether to have a cesarean section:

> Cases involving a trade-off between the woman's health and her fetus' health are among the most difficult, and at the same time tragic, dilemmas facing physicians, and all efforts must be made to ensure that the woman is fully informed about her treatment options and the risks and benefits of different [alternative methods of childbirth]. Physicians should do their utmost to assist the woman in her decision-making and help ensure that the best possible decision is made.
>
> However, the American Medical Association opposes forced cesarean sections. It is a fundamental ethical and legal principle that patients cannot be forced to accept a risk to health to benefit another, whether the other is a person, or a fetus. Even if a person is dying of leukemia, we do not force someone else to donate potentially life-saving bone marrow. While cesarean sections are generally very safe procedures, they are nevertheless invasive surgeries that carry a risk to the woman. The risk of death for the pregnant woman from a cesarean section is two-to-four times higher than from a vaginal delivery, and there is a significantly higher risk of infection, hemorrhage or other complications.
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> While pregnant woman routinely choose, and in our view, should take this risk for the benefit of their fetuses, they cannot be forced to do so.

Statement by American Medical Association on Forced Cesarean Section Court Case in Chicago, U.S. Newswire, Inc., Dec. 15, 1993, *available in* LEXIS, News Library, U.S. File.

[93] The standard for disclosure requires an objective inquiry. Canterbury, 464 F.2d at 787 ("[t]he scope of the standard is not subjective as to either the physician or the patient; it remains objective with due regard for the patient's informational needs and with suitable leeway for the physician's situation").

[94] For example, information concerning costs of the procedures and the possibility of blood transfusions in the course of childbirth. *See, e.g.*, Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 201 A.2d 537 (N.J. 1964) (woman refused blood transfusion because it was contrary to her religion).

ting. State courts have reached different results as to whether a forced cesarean constitutes an intrusion significant enough to outweigh possible harm to a fetus.[95] The Supreme Court has not resolved the conflict among the courts, although it was recently presented with the question.[96]

In *Jefferson v. Griffin Spalding County Authority*,[97] the hospital petitioned the trial court for an order authorizing it to perform a cesarean section on a woman who was likely to refuse surgery because of her religion. The examining physician determined that surgery prior to labor "would have an almost 100% chance of preserving the life of the distressed fetus."[98] An emergency hearing was held on the same day and an order was granted.[99]

On appeal, the Supreme Court of Georgia affirmed the lower court's holding and found that the state's interest in protecting the fetus outweighed the mother's interest in refusing the surgery.[100] Citing *Roe v. Wade*, the court noted that the state's interest in protecting a fetus from harm occurs at approximately twenty-eight weeks.[101] The court determined that it had ample authority to infringe upon the mother's right to refuse treatment, since the woman was thirty-nine weeks pregnant and the fetus appeared at great risk.[102] The court granted temporary custody of the fetus to the State of Georgia, giving it full authority to make all decisions concerning the birth of the child.[103]

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[95] This Note will address three published cases: *In re A.C.*, 573 A.2d 1235 (D.C. 1990), *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981), and *Doe v. Doe*, 632 N.E.2d 326 (Ill. 1994). There are several unpublished cases dealing with the issue of forced cesarean sections. *See* Annette Williams, *In re A.C.: Foreshadowing the Unfortunate Expansion of Court-Ordered Cesarean Sections*, 74 IOWA L. REV. 287 (1988), and Michael Phillips, *supra* note 39, at 411, for an account of these cases. The problem of coerced cesarean sections has not received the public attention and social commentary it deserves because of the lack of written decisions.

[96] Doe v. Doe, No. 93-7437, 1994 U.S. LEXIS 1988, at *1. (U.S. Feb. 28, 1994).

[97] 274 S.E.2d 457 (Ga. 1981).

[98] *Id.* at 458.

[99] *Id.* at 459-60.

[100] *Id.* at 460-61.

[101] *Id.* at 460 (quoting Roe v. Wade, 410 U.S. 113, 160-65 (1973)). *Roe* established a woman's fundamental right to obtain an abortion. Roe, 410 U.S. at 154-55. The right to an abortion is not absolute, but must be balanced against the state's interest in protecting potential life. *Id.* at 163. A state's interest becomes compelling when the fetus reaches the point of viability. *Id.*

[102] Jefferson, 274 S.E.2d at 460. *Cf.* Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 201 A.2d 537 (N.J. 1964) (blood transfusion ordered over the objections of a woman thirty-two weeks pregnant to save the life of her fetus); In re Jamaica Hosp., 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985) (blood transfusion ordered to save the life of a fetus despite objections of a woman who was only eighteen weeks pregnant). The *Jefferson* court relied on *Raleigh* for authority to order the cesarean section, although a blood transfusion is arguably not as intrusive as a cesarean section. Jefferson, 274 S.E.2d at 460.

[103] Jefferson, 274 S.E.2d at 459.

In the case of *In re A.C.*,[104] a physician informed Angela Carder, a dying cancer patient, that if she did not have a cesarean section, her health and her baby's life would be seriously endangered.[105] The hospital sought a declaratory order from the Superior Court to determine whether it should proceed with the procedure to save the life of the fetus.[106]

After a three hour hearing in Carder's hospital, the trial court ordered the performance of a cesarean section.[107] When Carder was informed of the decision, she ultimately refused.[108] Carder's counsel immediately requested a stay from the District of Columbia Court of Appeals, but the court denied the request.[109] The doctor performed the surgery, but tragically, Carder and her baby girl died shortly after the procedure.[110] The appellate court granted a petition for a rehearing *en banc*.[111] The appellate court vacated the trial court's order and held that a physician should defer to a competent pregnant woman's decision to accept or reject a cesarean section operation.[112] The court noted with great emphasis that "it would be an extraordinary case indeed in which a court might ever be justified in overriding the patient's wishes and authorizing a major surgical procedure such as a caesarean section."[113]

The court's regard for self-determination and bodily integrity in *In re A.C.* may represent a judicial trend to honor the rights of patients who refuse

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[104] 573 A.2d 1235 (D.C. 1990)(en banc).

[105] *Id.* at 1240-41. Angela Carder was close to twenty-seven weeks pregnant with a viable fetus. *Id.* at 1238.

[106] In re A.C., 533 A.2d 611, 612 (D.C. 1987), *vacated*, 539 A.2d 203 (D.C. 1988). The trial court appointed counsel for A.C. and the fetus. The District of Columbia was permitted to intervene on behalf of the fetus as *parens patriae*. 533 A.2d at 612.

[107] 533 A.2d at 612. The trial court expressly relied upon an earlier case in its jurisdiction to arrive at its conclusion. *See* In re Maydun, 114 Daily Wash. L. Rptr. 2233 (D.C. Sup. Ct. July 26, 1986) (woman's express refusal of a cesarean section was overridden to protect the fetus from apparent harm).

[108] In re A.C., 533 A.2d at 613. At one point, she told the physician that "she would agree to the surgery although she might not survive it." *Id.*

[109] In re A.C., 573 A.2d at 1238.

[110] *Id.* The child died within two and one-half hours of the procedure. The mother died two days later. *Id.*

[111] In re A.C., 539 A.2d at 203.

[112] In re A.C., 573 A.2d at 1237. The court, although willing to decide the case on its full merits, noted that it was not the proper forum for deciding this type of case. Judge Terry, writing for the majority, made a plea to the state legislature to create another tribunal capable of handling these decisions, with a limited opportunity for review. *Id.* at n.2.

[113] *Id.* at 1252. Unlike *Jefferson*, the court did not find *Roe v. Wade* dispositive. The court noted that, unlike Roe, who was seeking an abortion, Carder wanted to carry her pregnancy to full term and at no time wanted to terminate her pregnancy. *Id.* at 1245 n.9. The court stated that the issue before the court was not "whether A.C. (or any woman) should have a child but, rather, who should decide how that child should be delivered." *Id.* The court reserved the question of how *Roe* might apply in cases of forced cesarean sections to the Supreme Court. *Id.*

cesarean sections. One year after *In re A.C.*, the Supreme Court determined in *Cruzan v. Director, Missouri Dept. of Health*[114] that the Fourteenth Amendment stood for the principle that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."[115]

In *Cruzan*, the petitioner was rendered incompetent as a result of severe injuries sustained in a car accident.[116] Once her parents determined that she had virtually no chance of recovering her cognitive abilities, they asked hospital employees to terminate artificial feeding which would have kept her alive.[117] The employees refused to fulfill the parents' request without court authorization.[118] The parents obtained authorization from the lower court, however, the Supreme Court of Missouri reversed the court's decision.[119] On appeal, the United States Supreme Court held that the petitioner had a right to refuse medical treatment under the Fourteenth Amendment.[120]

Most recently, in *Doe v. Doe*,[121] the Illinois Appellate Court upheld a woman's decision to refuse a cesarean section given facts almost identical to *Jefferson v. Griffin Spalding County Authority*.[122] In *Doe*, a thirty-five week pregnant woman refused to submit to a cesarean section although her physician believed that surgery was necessary for a safe delivery.[123] The Cook County State's Attorney petitioned the circuit court to order Doe to undergo an immediate cesarean section.[124] The circuit court denied the request.[125] The appeals court affirmed and held that a physician must honor a woman's right to refuse a cesarean section.[126]

The appeals court explicitly rejected using a balancing test to determine the rights of the fetus.[127] Although the court relied primarily upon state court decisions and statutes to reach its conclusion, the court noted that *Cruzan* recognized a significant liberty interest in avoiding unwanted surgery.[128] The court refused to rely upon *Jefferson* as controlling law, stating that *Jefferson*

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[114] 497 U.S. 261 (1990).

[115] *Id.* at 278. The Court noted however, that this interest must be balanced against relevant state interests. *Id.* at 279.

[116] *Id.* at 266.

[117] *Id.* at 267.

[118] *Id.* at 268.

[119] *Id.*

[120] *Id.* at 279. To reach this conclusion, the Court had to determine whether the petitioner was competent when she expressed a desire to terminate artificial feeding should she be rendered significantly ill or injured. *Id.* at 280-87.

[121] 632 N.E.2d 326 (Ill. App. Ct. 1994).

[122] 274 S.E.2d 457 (Ga. 1981).

[123] 632 N.E.2d at 327. The physician concluded that the chances of the fetus surviving natural childbirth were close to zero. *Id.* at 328.

[124] *Id.* at 327.

[125] *Id.* at 328.

[126] *Id.* at 330.

[127] *Id.*

[128] *Id.* at 331.

failed to recognize "the constitutional dimension of the woman's right to refuse treatment, or the magnitude of that right."[129] The court dismissed the state's argument that *Roe* gives a viable fetus substantial rights over its mother's.[130] Judge DiVito, writing for the majority, stated that "*Roe* and its progeny . . . make it clear that, even in the context of abortion, the state's compelling interest in the potential life of the fetus is insufficient to override the woman's interest in preserving her health."[131]

Although the *Doe* court relied upon *Cruzan* to offer support for the contention that courts should respect the rights of pregnant patients who refuse medical treatment, *Cruzan* does not directly address the issue of when, if ever, a physician should be able to force a woman to submit to a cesarean section. In *Cruzan*, the Court was faced with the question of whether a competent individual can refuse medical treatment. The Court did not have to balance the state's interest in protecting the fetus against the rights of the mother because the plaintiff was not pregnant. Thus, the weight that courts should accord to *Cruzan* in cesarean section cases is unclear.

Physicians and patients need a well-defined and consistent judicial benchmark upon which to base their medical and personal decisions. The patchwork of current state decisions prevents the establishment of a coherent rule. The Supreme Court should resolve the issue of forced cesarean sections and clarify when, if ever, courts and the medical profession may legitimately override a woman's decision.

3. Medical malpractice liability

Physicians cite fear of malpractice suits as one of the major explanations for the rise in the cesarean section rate.[132] Physicians perform the procedure as a defensive measure to avoid malpractice liability.[133] Hospitals have encouraged this practice.[134] One doctor candidly explained this pressure: "If there's anything wrong with a baby, even when the surgery would have made no difference, the first question is always, Why didn't you do a cesarean? If you did a cesarean, the next question is, Why didn't you do it sooner?"[135]

The first major study on cesarean childbirth indicated that fear of malpractice suits may have contributed to the rise in cesarean sections.[136] As early as 1976, a study found that close to 100 percent of medical school department chairs, professors, and practicing obstetricians mentioned "fear of malpractice

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[129] *Id.* at 333.

[130] *Id.* at 334.

[131] *Id.*

[132] *See* Sara C. Charles et al., *Physicians' Self-Reports of Reactions to Malpractice Litigation*, 141 AM. J. PSYCHIATRY 563 (1984).

[133] *See* Berkman, *supra* note 17, at 629.

[134] NORWOOD, *supra* note 19, at 38.

[135] *Id.*

[136] NATIONAL INSTITUTE OF HEALTH, *supra* note 24, at iii.

suits" as a main reason for the increase.[137]

A 1984 study confirmed these findings.[138] In this study, more than 130 physicians revealed that "a malpractice suit was considered a serious and often devastating event in [a physician's] personal and professional [life]. . . ."[139] The study noted, however, that none of the respondents to the survey ever suffered an adverse trial verdict.[140]

Studies show that only one in ten legitimate malpractice incidents ever reaches the tort system.[141] Most claims are settled without any payment, and defendants win in the majority of litigated cases.[142] A recent study based on data from the Massachusetts Professional Insurance Association (MPIA)[143] found that doctors win ninety-one percent of medical negligence cases that go to trial.[144] The study also found that insurers paid no money in sixty-two percent of all malpractice claims filed, and settled thirty-seven percent of the suits, paying only modest settlements for negligence.[145]

Although these studies suggest that obstetricians' and gynecologists' fears of malpractice liability are largely unsubstantiated, physicians' fears still exist. These fears must be addressed in order to solve the cesarean section crisis.

Physicians may also perform cesarean sections to avoid increased malpractice insurance costs.[146] A 1988 study, based on medical practices in New York and Illinois, found that as the number of lawsuits multiply against physicians, and the number of claims paid rise, the costs of defense and insurance protection do, in fact, increase accordingly.[147] The study found a direct correlation between increased insurance rates and increased cesarean section rates.[148]

The fear of malpractice liability and increased payments on medical malpractice insurance may greatly impact a pregnant woman's choice of delivery

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[137] COMPULSORY HOSPITALIZATION, *supra* note 80, at 180-81.

[138] *See* Charles, *supra* note 132, at 563.

[139] *Id.* at 565. Approximately twenty percent of the physicians practiced in the field of obstetrics and gynecology. *Id.* at 563. Approximately forty-seven percent of the respondents had been sued only once, while the rest of the group had been sued more than once. *Id.* at 564.

[140] *Id.* at 565.

[141] Peter D. Jacobson, *Medical Malpractice and the Tort System*, 262 JAMA 3320, 3321 (1989).

[142] *Id.*

[143] The MPIA is the largest malpractice insurer in Massachusetts. *Malpractice in Massachusetts*, BOSTON GLOBE, Oct. 2, 1994, at A1, A30.

[144] *Id.*

[145] *Id.*

[146] Obstetricians and gynecologists make substantial insurance payments on their premiums to compensate for the cost of jury verdicts. Steven M. Rock, *Malpractice Premiums and Primary Cesarean Section Rates in New York and Illinois*, 103 PUBLIC HEALTH REPORTS 459, 461 (1988). Insurance companies often assess a surcharge for physicians with unfavorable malpractice claims experience. *Id.* at 461.

[147] *Id.*

[148] *Id.* at 460.

and thus the level of health care she receives. Some physicians admit to reducing care to high-risk patients and eliminating the performance of high-risk procedures from their practice because they do not want to accept the high cost of liability insurance.[149]

4. The absence of legislation

Congress and state legislatures have not passed legislation to curb the incidence of cesarean sections. Although health care reform was recently a national priority, the cesarean issue did not surface on the legislative agenda. Congress has preferred to leave this issue in the hands of organized medical groups.[150]

A few state legislatures have passed legislation requiring hospitals to report their cesarean section rates. Massachusetts and New York require hospitals to give every maternity patient prior to admission a pamphlet describing their annual cesarean section rate.[151] Although this type of legislation serves an important educational function, it fails to address the root causes of why unnecessary cesarean sections are performed in the first place, such as the influence of medical malpractice liability.

III. SOLUTIONS

In order to arrive at an adequate solution to the problem of forced and unnecessary cesarean sections, a unified effort by hospital administrators and staff, doctors, nurses, midwives, patients, consumer groups, medical societies, and the government must occur. As demonstrated in this Note, there is no single person or entity responsible for the cesarean epidemic.

The following section outlines possible strategies for reducing the rate of unnecessary and forced cesarean sections in the United States. These strategies include hospital programs, physician and patient education, changes in physician and hospital reimbursement rates, no-fault liability, and voluntary arbitration. These strategies, taken together, can provide a comprehensive solution to the cesarean epidemic.

A. *Hospital Initiatives*

Hospitals must take affirmative steps to reduce their cesarean section rate and encourage physicians to honor the wishes of pregnant women. Medical

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[149] Charles, *supra* note 132, at 564.

[150] A congressional aide for the Subcommittee on Children and Family has stated, "This is not something we would legislate, the issue is not in the legislative domain . . . well informed women is the real solution . . . we let the American College of Obstetricians and Gynecologists (ACOG) handle these things." Interview with Courtney Pastorfield, Legislative Aide, Senate Subcommittee on Children and Family, 1991.

[151] MASS. GEN. L. ch. 111, § 70E (1991); N.Y. PUB. HEALTH LAW § 2803-j (McKinney 1992).

institutions should follow the trend of hospitals that have implemented obstetrical programs specifically targeted at reducing cesarean rates. Several hospitals have successfully reduced their rate without jeopardizing the health of the mother or fetus.[152]

In 1987, the University Medical Center of Jacksonville, Florida, a teaching hospital serving primarily indigent clients, developed a program to address the problems most often associated with cesarean sections.[153] The hospital offered trial labor to patients who had previously delivered by cesarean section to decrease the rate of repeat cesareans.[154] Fetal monitor signals indicating fetal distress were confirmed by fetal scalp blood sampling.[155] The program also included weekly peer review of all cesarean sections.[156] The facility reduced its cesarean rate from twenty-eight percent in 1986, to eleven percent in 1989.[157]

In southern California, the Kaiser Permanente hospitals reduced their cesarean rate by approximately seven percent by instituting classes that stressed vaginal childbirth after a cesarean section.[158] These hospitals combine patient education with efforts by physician leadership to alter physician attitudes and practices towards repeat cesarean sections.[159] In New York City, the North Central Bronx Hospital has maintained a rate of twelve to thirteen percent by incorporating into the labor process midwives and their views on health care.[160]

Hospitals should evaluate their obstetrical programs and procedures to determine the necessity of reform. Strong participation and commitment from hospitals and medical schools can help alleviate the cesarean epidemic. Hospitals should require mandatory second opinions to confirm the necessity of the procedure. Medical institutions should also educate physicians to respect a family's religious choices and the effect of those choices on a mother's right to choose a particular method of childbirth. Continuing medical education should encourage doctors to perform natural childbirth and eliminate racist and classist prejudices that often cause physicians to disrespect the wishes of mothers. These prejudices should also be addressed in medical school

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[152] PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, *supra* note 15, at 43.

[153] *Id.*

[154] *Id.*

[155] *Id.* at 44. Fetal scalp blood testing can help clarify the true condition of an infant. It measures the acid-base status of fetal blood. Fewer than two percent of practicing physicians use fetal blood testing, and three percent or less of patients undergo this type of testing at major university hospitals. *Id.* at 32.

[156] *Id.* (peer review in this context involved physicians evaluating physician behavior).

[157] During this period, newborn complication rates remained the same while newborn deaths actually decreased. *Id.*

[158] *Id.* at 44.

[159] *Id.*

[160] *Id.* This hospital should be especially commended for its program, considering that seventy percent of its patients are at risk for pregnancy, labor, and delivery complications. *Id.*

curricula.

B. *Patient Education*

Pregnant women must no longer be afraid to ask pressing questions of hospitals and physicians about their childbirth practices. Before selecting a hospital or obstetrician, patients should educate themselves about different childbirth methods and the cesarean section rates for their hospital or physician.

It is important to determine in advance if the hospital or physician has a significant cesarean section rate, and if so, whether the hospital has any policies to reduce its rate. Most patients can obtain hospital rates from state agencies or reports by non-profit health organizations.[161] Women should not feel uncomfortable discussing their feelings and opinions about cesarean sections with their physicians. If a woman has strong feelings against the operation, she should enter into an agreement with her physician, stating the circumstances in which interventions will be used, and when, if at all, a cesarean would be acceptable.

C. *Reporting Statutes*

States should pass statutes requiring hospitals and physicians to disclose their cesarean section rates to maternity patients. As previously discussed, New York and Massachusetts currently have reporting statutes.[162] Although this Note contends earlier that reporting statutes do not address the root causes of the problem, they do serve the important educational function of giving families essential childbirth statistics. Reporting statutes can assist a mother in deciding the appropriate place to give birth to her child. They also provide incentives to hospitals and physicians with high cesarean section rates to lower their rates to meet the demands of patients.

D. *Changes in Physician Reimbursement*

Health care scholars have recommended changes in physician and hospital reimbursement to eliminate the financial incentive to perform cesarean sections.[163] A number of public and private payers have attempted to take the financial incentive out of the practice by equalizing physician fees for natural and cesarean deliveries.[164]

As of 1988, fourteen Medicaid programs had equal fees for both modes of delivery.[165] Blue Cross/Blue Shield of Kansas City found a fifty percent reduction in cesarean rates in its health maintenance organization plan when it

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[161] *See id.* at 1A.

[162] *See* section II.B.4, *infra.*

[163] Stafford, *supra* note 67, at 685.

[164] *Id.*

[165] *Id.*

charged equal fees for natural and cesarean section childbirth.[166] Equalized fees at Blue Cross of Massachusetts, however, did not reduce cesarean use.[167] Blue Cross/Blue Shield of Minnesota is considering instituting equal fee reimbursement.[168]

E. *No-Fault Liability*

To solve the problem of "defensive medicine" and the increase in malpractice insurance costs to obstetricians and gynecologists, physicians and lawyers have recommended implementing a "no-fault" system for babies born with birth defects.[169] John Freeman, a pediatric neurologist at Johns Hopkins School of Medicine, and his son Andrew Freeman, a Baltimore lawyer, have proposed a compensation scheme for children with cerebral palsy that could be applied in the cesarean section context.[170] The Freemans designed the scheme to compensate babies born with cerebral palsy resulting from a physician's failure to perform a cesarean.[171]

According to the Freeman proposal, a state could impose a tax on obstetricians for each baby delivered.[172] A pool derived from these taxes would compensate all babies who develop cerebral palsy for the medical and educational costs of their handicaps.[173] The plaintiff would not have to prove negligence.[174] In exchange, the proposal requires that families with handicapped children give up the right to sue for malpractice.[175] "A state board would investigate all cerebral palsy cases and discipline doctors who were found to be at fault."[176] The Freemans contend that their scheme is more equitable than the present system because only ten percent of cerebral palsy cases receive any compensation from lawsuits.[177] They also point to the fact that half the money awarded to successful plaintiffs goes to lawyers and court costs.[178]

Policymakers should formulate a program derived from taxes, similar to the

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[166] *Id.*

[167] *Id.*

[168] *Id.* at 686.

[169] *See* Susan Okie, *No Fault Awards Urged in Cerebral Palsy Cases; State Taxes on Obstetricians Seen as Way to Remedy High Malpractice Costs*, WASH. POST, Jan. 2, 1990, at A3.

[170] *Id.*

[171] *Id.* The Freemans targeted cerebral palsy because it is the birth defect that most frequently triggers malpractice claims. *Id.* A few states have recently adopted no-fault programs for birth-related injuries that are similar to the Freeman proposal. *See, e.g.*, FLA. STAT ch. 766.316 (1993); VA. CODE ANN. § 38.2-5000 (Michie 1993).

[172] Okie, *supra* note 169, at A3.

[173] *Id.*

[174] *Id.*

[175] *Id.*

[176] *Id.*

[177] *Id.*

[178] *Id.*

proposed cerebral palsy program, to compensate babies born with defects allegedly caused by a physician's failure to perform a cesarean section. Under such a scheme, the family would give up its right to sue, and instead, take its award from the pool.[179] Policymakers could determine the award based on the average cost of illness to a family over a lifetime.[180]

No-fault liability would ensure that a family received an award, while at the same time removing the stigma and costs associated with malpractice verdicts against obstetricians and gynecologists. The proposal addresses the fear of most obstetricians and gynecologists that they will be sued if they do not perform a cesarean section. By removing the unpredictable threat of malpractice liability, a no-fault plan would encourage physicians to perform natural childbirth more often.

Some might argue that removing the right to sue would deny babies born with defects the right to recover adequate damages. However, a recent study by the American College of Obstetricians and Gynecologists found that defendants won sixty-eight percent of all medical malpractice claims adjudicated by arbitration or jury verdict.[181] Thus, a no-fault plan would actually compensate some families who normally would not receive damages through arbitration or litigation in court.

F. *Voluntary Arbitration as a Solution*

In 1987, the Department of Health and Human Services Task Force on Medical Liability and Malpractice recommended that federal and state governments explore alternative dispute resolution mechanisms for resolving malpractice claims.[182] More recently, President Clinton, in his efforts to reform the health care system, has included in his health care legislation provisions for non-binding arbitration for all medical malpractice cases.[183] Arbitration proposals are gaining wide spread support from the health care industry and the legal community.[184]

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[179] Of course, this program would only be effective if the annual tax levied on obstetricians and gynecologists for abnormal deliveries is significantly less than the annual cost for malpractice insurance.

[180] Thus, some babies may receive more money than others depending on the severity of their handicaps and the cost of treatment.

[181] Jacobson, *supra* note 141, at 3322.

[182] *HHS Task Force Report Urges Reduction in Medical Malpractice Premiums*, (BNA) No. 152, at A-11 (Aug. 10, 1987).

[183] David G. Savage, *Doctors Seek Remedy for Lawsuits; Plan Offers Little to Curb High Damage Awards*, CHI. SUN-TIMES, Oct. 5, 1993, at 26. The bill limits the amount of attorneys' fees recoverable in arbitration to thirty-three percent. The bill does not support a limit on damages awards for non-economic damages such as pain and suffering. *Id.*

[184] *Id.* Arbitration can have many advantages over court adjudication. Arbitration proceedings are private in nature, the rules of procedure are more flexible, costs are lower, and parties can rely on obtaining a speedy resolution of their claims. Simplified

As an alternative to implementing no-fault plans, Congress or state legislatures could attempt to eliminate the medical malpractice concerns of physicians by adopting a form of non-binding voluntary arbitration for malpractice claims arising from a failure to perform a cesarean section.[185] Unlike no-fault plans, families would have the option of filing a malpractice claim in arbitration or in court. Legislatures could provide incentives to physicians to pursue arbitration by decreasing the amount of non-economic damages recoverable by a plaintiff in arbitration. To encourage plaintiffs to pursue arbitration, the legislation could eliminate proof of fault in arbitration and allow the plaintiff to recover unlimited damages in a court of law if the physician refuses to arbitrate the claim.[186]

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arbitration procedures, the lack of opportunity to appeal the arbitrator's decision, and the typical absence of discovery, account for the low cost of arbitration.

[185] The national debate on health care reform, cost containment, and medical malpractice liability has prompted legislators to introduce bills incorporating use of arbitration mechanisms for malpractice claims. *See, e.g.*, H.R. 834, 103d Cong., 1st Sess. (1993); H.R. 200, 103d Cong., 1st Sess. (1993); H.R. 196, 103d Cong., 1st Sess. (1993); H.R. 191, 103d Cong., 1st Sess. (1993); H.R. 101, 103d Cong., 1st Sess. (1993).

The state of California has adopted legislation providing for voluntary arbitration of medical malpractice claims. CAL. CIV. PROC. CODE § 1295 (1994).

[186] A proposal for arbitration in the cesarean section context could be drafted as follows:

1. *Offer to Arbitrate*: Patient and doctor can enter into a private agreement prior to treatment to handle all malpractice claims through arbitration. Either party may offer to arbitrate. Neither party has to accept use of the arbitration system.
2. *Recovery of Damages*: If the patient accepts the doctor's offer to arbitrate, the patient can recover an unlimited amount of economic damages (ie. loss of hospital and medical expenses, lost wages, lost employment, etc.). However, non-economic damages (i.e. pain and suffering and loss of companionship) cannot exceed $250,000.
3. *Refusal to Arbitrate*: If the patient refuses the doctor's offer of arbitration, non-economic damages cannot exceed $350,000 in a subsequent trial. If the doctor refuses arbitration, the patient can recover unlimited economic and non-economic damages in a subsequent trial.
4. *Arbitration Panels*: The arbitration panel will consist of three arbiters. The patient can choose one arbiter. The doctor can choose the second arbiter. Both arbiters can choose a third arbiter who will chair the panel. If they cannot decide on a third arbiter, they must request an impartial arbiter from the American Arbitration Association. Both parties must bear the cost of the arbitrators.
5. *Appeals to State Court and Standard of Review*: The parties may file an appeal with the court of appropriate jurisdiction of the state (as determined under state law) to vacate the decision of the panel if the party files a motion to appeal not later than 60 days after the panel renders its decision. A court reviewing the decision of an arbitration panel may not vacate unless it determines that the decision was *arbitrary and capricious.*
6. *Attorney's Fees*: A patient who agrees to arbitrate can recover attorney's fees

Although a patient might be able to obtain a greater amount of damages and attorney's fees in court, she still has an incentive to pursue arbitration because it is less costly and more expedient than adjudication. Moreover, the plaintiff can appeal the arbitration decision if she is dissatisfied with her award. Courts, however, should use an arbitrary and capricious standard upon review. This standard, albeit difficult to overcome, is necessary to ensure that courts give great weight to the decisions of the arbitration panel.

G. *Judicial Intervention*

Opponents of alternative forms of dispute resolution must rely on the courts to resolve the issue of forced and unnecessary cesarean sections. In many states, however, it is unclear when a woman's right to refuse a cesarean section should be upheld. Therefore, neither a pregnant woman nor her physician can rely on the courts for guidance in determining when a woman must submit to a cesarean to save the life of her fetus.

Although the Supreme Court is in the best position to resolve this conflict, it has denied certiorari on the issue several times.[187] The Court may be evading the issue so as not to consider the extent to which *Roe v. Wade* is controlling in the childbirth context. The abortion question, although not directly parallel

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up to a maximum of 25% of the total recovery. If the doctor refuses the offer to arbitrate, a patient can recover attorney's fees equal to 33% of the award at trial and prejudgment interest.

7. *Grants*: The Secretary of Health and Human Services ("Secretary") shall give out monetary grants to states who do one or more of the following: (1) improve or devise an arbitration system for medical malpractice claims, (2) conduct research on the cesarean section rate and medical malpractice concerns, (3) develop and implement mechanisms for monitoring the practices of obstetricians and gynecologists, (4) educate the public on childbirth methods and their safety or hazards, (5) develop faculty training programs and medical school curricula for educating health care professionals on the need to reduce the rate of unnecessary and forced cesarean sections.

Applicants must submit applications to the Secretary to receive grants. The Secretary shall solicit annual reports from all states to determine whether the state acts in compliance with the terms of the grants.

8. *Hotline and Pamphlets*: The Department of Health and Human Services (HHS) will make a pamphlet available to all hospitals for distribution to maternity patients which describes the arbitration process and the costs and benefits of pursuing arbitration or obtaining damages in a court of law. The Department will provide a toll-free telephone hotline for pregnant women to answer questions about the arbitration process and childbirth decisions.

9. *Annual Report*: HHS will report to Congress three years after the enactment of this legislation. Within a year of this report, Congress must hold a public hearing on the effectiveness of this proposal.

The proposal is based on H.R. 1004, 102d Cong., 1st Sess. (1991), and its companion bill, S. 489, 102d Cong., 1st Sess. (1991).

[187] *See* discussion in section II.B.2, *supra*.

to the issue of forced cesarean sections, may need to be revisited if the Court determines that an endangered fetus has plenary rights over a mother's right to refuse a cesarean. Regardless of this dilemma, the Supreme Court should accept its responsibility to adjudicate the issue and hand down a decision that clearly discusses the rights of the fetus and patient, and when a physician may exercise her medical judgment to perform unwanted cesarean sections.

IV. CONCLUSION

The complex issue of physicians performing forced and unnecessary cesarean sections on pregnant women must be defined as a national health and legal problem. Although recent studies reveal that the overall rate in the United States has begun to decrease, thousands of women still receive unnecessary cesarean sections every year, many of them without their consent.

The rate of forced and unnecessary cesarean sections has increased because of several medical and legal factors. These include repeat cesarean sections, financial incentives, fetal monitor technology, physician ideology, limitations of informed consent doctrine, Supreme Court inaction, medical malpractice concerns, and the absence of substantive legislation.

The health care sector and legal community must evaluate these factors to develop concrete solutions to the cesarean crisis. The first step toward rectifying a national problem of this magnitude is to research and analyze the root causes. This Note has attempted to provide an analysis of these medical and legal factors so that people genuinely concerned with the issue can formulate adequate solutions.

There are a myriad of ways to approach solving the cesarean section epidemic. This Note has outlined a number of solutions. Strategies such as individual hospital programs, physician and patient education, changes in physician and hospital reimbursement rates, no-fault liability plans, and voluntary arbitration can be employed to facilitate a decrease in cesarean section rates. These solutions offer promise to the thousands of courageous women in America who choose potentially dangerous and unnecessary surgery to improve the lives of their children.

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