

**From “Not Allowed” to “This Is My Body”: Reproductive Justice Demands Supporting  
Informed Decisions for Labor After Cesarean**

by

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# **From “Not Allowed” to “This Is My Body”: Reproductive Justice Demands Supporting Informed Decisions for Labor After Cesarean**

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University of Pittsburgh, 2021

Determining the approach to delivery after a prior cesarean is an ethically complex and nuanced issue. This thesis analyzes the personal and external conditions impacting the decision-making process surrounding a chosen birth method that follows a previous cesarean delivery through the lens of both patient and physician. Patient birth narratives identify the individual, social, and systemic barriers to vaginal birth after cesarean (VBAC). After providing a historical context for the medicalization of pregnancy and the role of medical racism, this thesis argues that medical authority must be examined through the critical lens of history. Forced interventions and coercive obstetrics practices, long part of an established historical legacy of dismissing women's concerns in medicine, especially women of color, are documented and examined.

This thesis is critical of the maternal-fetal conflict (MFC) framework because it misrepresents the conflict that occurs when a pregnant woman goes against medical advice perceived to benefit the fetus, justifying violations to the mother's bodily autonomy for the sake of the fetus. Additionally, the MFC harmfully perpetuates normative expectations of maternal sacrifice, validating morally weighted language and blame against the mother. Patient autonomy, conceived as only respecting medical choices or expanding options, does not translate into enhanced reproductive autonomy for women. Given the lived experiences of disrespect and mistreatment in obstetrics practice, providers must recognize the added relational dimensions of autonomy and center the lived experience of pregnancy through the lens of reproductive justice.

This thesis argues that health providers are responsible for empowering pregnant women to make informed medical decisions, achieved by placing value in birthing experiences and actively seeking to understand the mother's choice. Labor after cesarean counseling that is inclusive, understanding, and respecting of the mother's experience, has the potential to replace a harmful adversarial relationship with one of mutual trust and respect.

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## Preface

I dedicate this project to the courageous women who have publicly shared their birthing stories online and inspired this work.

I am incredibly grateful to my advisor, Dr. Bridget Keown, for the countless hours she spent editing my drafts, providing thoughtful advice, and encouraging me to follow my convictions. I owe a special thank you to my committee members, Dr. Marielle Gross and Dr. Martha Terry, for their time, guidance, and inspiration in developing my thesis topic and the structure of my arguments.

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Last but certainly not least, I am grateful to my family for their love and support throughout this process.



## 1.0 Introduction

Pregnant women and their cesareans generate a remarkable amount of debate and concern in both the practice of obstetrics and bioethics because of the complicated questions and issues they generate about autonomy and medical authority. In 2018, an international journal published a series of articles relative to the efficacy and safety of cesarean deliveries in response to the alarmingly high global rate of cesarean birth, which doubled in the last 15 years (Visser et al., 2018). Researchers who examined maternal and infant outcomes in 194 World Health Organization (WHO) member states found that national cesarean delivery rates greater than 19% offered no additional maternal or infant mortality rate improvement (Molina et al., 2015). Nevertheless, in the United States (U.S.), nearly one-third (31.9%) of women deliver by cesarean section, well over the 19% goal (Martin et al., 2019). Statistically, many women fall victim to the saying “once a cesarean, always a cesarean.” Increasing access to a trial of labor after cesarean (TOLAC), resulting in vaginal birth after cesarean (VBAC), is one method to reduce the overall U.S. cesarean rate (American College of Obstetricians and Gynecologists [ACOG], 2019). Despite national recommendations, fewer than 20% of women with one prior cesarean and 7% of women with two or more prior cesareans attempt a vaginal birth (Thorton, 2018). Research suggests that provider reluctance and systemic barriers create disparities in VBAC access, which depends on demographic, socioeconomic, and geographic factors (Ibrahim, Kennedy, & Holland, 2020).

The birth method decision is personal and should be made in concert with both mother and doctor, each respecting the other’s knowledge and experience. Several factors influence the patient’s decision-making process to try a vaginal delivery, including medical risk, personal experiences, the reason for the original cesarean section, recovery time, overall health, and

physician preference. However, for some physicians, while the patient's opinion and experiences may be recognized and considered, their recommendations emanate much more from an overly cautious, sometimes misconceived, view toward pregnancy risk or an attempt to avoid expensive malpractice suits as well as inherited obstetric practices. This paper explores the gendered and racial assumptions underlying medical use of cesarean sections and claims of patient autonomy, or lack thereof, regarding VBAC in order to redress the harm done by a long history of abuse and disregard for women in medical settings, especially women of color.

Access to VBAC is an important issue, affecting all birthing people. However, I refer to pregnant women and mothers to emphasize the gendered assumptions about childbirth and motherhood. The experience of giving birth, a process potentially open to those born with a uterus, is socially informed by the history of treating women generally as less powerful, less articulate, and less intelligent than men. These gendered assumptions also impact transgender and nonbinary people, creating even more significant barriers to achieving equitable healthcare. While this paper explicitly addresses gender norms that influence decision-making and autonomy, further research is required to credibly address the pregnancy experience of transgender and non-binary people.

## **1.1 VBAC Background**

A physician may recommend an unplanned cesarean for several reasons – it may be labor that is not progressing, fetal distress, breeched or transverse births, multiple births, or any other complications that require immediate intervention (Mayo Clinic, 2020). After a cesarean section, a woman may either attempt a VBAC delivery or schedule an elective repeat cesarean delivery for subsequent pregnancies. The greatest challenge in counseling a woman who has had a previous

cesarean is that both TOLAC and repeat cesarean carry serious risks, and the evidence may not clearly indicate which procedure is best for each expectant mother. A cesarean section, a major abdominal surgery, carries inherent risk, including major infection, postpartum hemorrhage, reactions to anesthesia, blood clots, wound infection, surgical injury, and increased risk for future pregnancies (Mayo Clinic, 2020). Further, neonatal risks for cesarean delivery without labor include respiratory morbidity, tachypnea, respiratory distress, and more significant complications if delivered before 39 weeks gestation (ACOG, 2019).

The National Institutes of Health (NIH, 2010) examined the safety and outcomes of TOLAC and VBAC, finding that TOLAC is a reasonable option for many women who have experienced a previous cesarean delivery. The benefits of a VBAC can include avoiding abdominal surgery, a shorter recovery period, a lower risk of infection, and less blood loss (ACOG, 2019). Additionally, multiple cesareans deliveries create the potential for future pregnancy complications avoided by vaginal delivery. VBAC, however, is not without its own risk, carrying the possibility of infection, blood loss, and the serious risk of uterine rupture when the scar on the uterus opens during labor (ACOG, 2019). The incidence of uterine rupture significantly increases the likelihood of maternal or neonatal morbidity (ACOG, 2019). The research, comparing the risks of repeat cesarean and attempted TOLAC, are primarily retrospective observational studies that examine clinical birth outcomes. While the absolute risk of maternal death for both options is low, the risk of maternal death during a planned repeat cesarean is remarkably greater, with 13 in 100,000 compared to 4 in 100,000 for a VBAC (Cheng et al., 2011). Between 60-80% of women who attempt a TOLAC deliver vaginally without complication; however, should a TOLAC result in an unplanned cesarean, the mother experiences the greatest risk for severe obstetric complication (Lehman et al., 2020). The likelihood of a TOLAC resulting in a vaginal delivery depends heavily

on individual factors, such as a history of prior vaginal delivery, the reason for index cesarean, and obstetric factors (Cheng et al., 2011).

Access to TOLAC is crucial as it allows women with a previous cesarean to choose either another cesarean or attempt a vaginal birth, with necessary medical interventions if needed. The history of VBAC practices, and changing recommendations, provide the context to understand why some women decide to take on the risks associated with VBAC, as the risk may be conflated and misunderstood. Within the past 40 years, the rate of VBAC has fluctuated significantly, influenced by changes in clinical recommendations, specific provider preferences, and insurance company regulations (Kukla & Wayne, 2018). In 1988, the NIH and WHO released a statement supporting VBAC in an effort to decrease the high rate of cesarean section (Cheng et al., 2011). Subsequently, as data continued to reflect VBAC's relative safety with few maternal and fetal deaths in VBAC trials, the rate of VBAC increased and peaked in 1996, rising from 5% to 28.3% within 10 years (Lyerly & Little, 2010).

In the late 1990s, however, VBAC deliveries swung downward, declining rapidly because of studies that identified the rise of the rare, but devastating, risk of uterine rupture and postpartum hemorrhaging, prompting the 1999 ACOG guidelines to require the immediate availability of physicians who could perform emergency cesarean sections at hospitals offering TOLAC (Lyerly & Little, 2010). Driven both by hospitals adopting no-TOLAC policies and physicians refusing to provide VBAC support, the VBAC rate dropped to 8.3% by 2007 and, despite slightly increasing over time, the rate continues to remain less than 15% (MacDorman et al., 2017). The downward trend of VBAC coincides with the upward trend of cesarean deliveries. While a discussion of the medical risk and benefits of VBAC is an essential part of the decision-making process, the ethics of VBAC is far more complex.

## 1.2 Ethics of VBAC

The decision to birth vaginally or via cesarean can be life-altering, with people in bioethics and obstetric practice still debating the ethical implications, despite that decision being personal. Lyerly (2006) persuasively argues that the culture of birth is expert-centered rather than patient-centered, forcing women to defer to medical authority. Mainstream bioethics refers to the ethical obligation of a physician as one that balances the principle of respecting patient autonomy, the ability of an adult with decision-making capacity to make medical decisions, with adhering to the principle of beneficence, the physician's duty to protect the welfare of the patient (Kukla et al., 2009). The presence of a "second" patient complicates identifying where the physician's duty to the mother lies, as some consider the fetus as an independent patient and others consider the mother and fetus as a two-patient ecosystem (Mattingly, 1992).

Ethical recommendations to promote patient autonomy by expanding options for vaginal or cesarean births available to women do not, unfortunately, directly translate into enhancing women's autonomy. Feminist bioethicists argue that ethical debates contemplating birth practices "cannot begin by trying to 'balance' autonomy and welfare protection, but must (among other things) first provide a more richly textured understanding of autonomy in the context of birth" (Kukla et al., 2009, p. 3). The availability of TOLAC is dependent on hospital policy, creating significant disparities in access to VBAC supportive care and disproportionately affecting rural women and women of color (ACOG, 2014). Many women with prior cesarean experience feel pressured by their physicians to accept the inevitability of a second cesarean, and they may be labeled as "bad mothers" if they defy medical advice and opt for a VBAC against the doctor's recommendation (Cohen, 2010). Rather than discussing whether doctors should respect a woman's autonomous decision, even against medical advice, this paper will explore the external and internal

conditions that influence women's decision-making, concluding that the traditional conception of autonomy is not sufficiently robust to promote women's full inclusion in the birth process. Women bring their external experiences into the delivery room; as a result, the doctor-patient relationship is reflective of her world in a microcosm. Additionally, women of color bring the added experience of systemic racism and the very real issue of implicit provider bias.

This paper explores and outlines pertinent factors impacting the decision-making process, concluding that health care providers bear the responsibility to understand these factors and better encourage women to make their own decisions about how, where, and with whom to give birth. Chapter Two presents one woman's birthing story as a way to recognize the impact of trauma and the importance of women's narratives of birth as a relevant outcome to providers. Chapter Three provides historical background relative to the medicalization of childbirth as influenced by social norms of race and gender, situating the current disparities in maternal health and VBAC barriers as a continuation of reproductive injustice. Chapter Four critiques the use of maternal-fetal conflict (MFC) in ethical dilemmas in pregnancy and birth as originating from blame and stereotypes of maternal sacrifice, justifying forced intervention and fetal consequentialism. Chapter Five compares traditional conceptions of autonomy to feminist bioethicists' criticism of individual autonomy, concluding that providers have a duty to go beyond respect for autonomy and actively promote and empower women to make informed choices through the lens of reproductive justice. Chapter Six presents conclusions and recommendations for providers to recognize the patient's birthing experiences as ethically relevant.

## 2.0 Importance of Storytelling

It is ethically crucial for health care providers to give serious consideration to the life factors that influence the decisions patients make relative to pregnancy and labor. Such practices ensure that women enjoy full reproductive justice. By definition, *reproductive justice* includes the right not to have children, to have children, and to parent children in safe and healthy environments (Ross & Solinger, 2017). It is a feminist political framework developed through critical race theory in response to the limitation of liberal feminism to represent the lived experience of intersectional identities. A provider should allow a pregnant woman to make informed decisions regarding labor after through the lens of reproductive justice. However, many women share stories online of their decision being ignored or feeling pressured to make a different decision.

Although patients have increased access to online medical information and support groups, few studies observe and consider the influence that online birth narratives and discussion boards hold in decision-making. A 2015 study found that VBAC-seeking women use online discussion boards to inspire others with their birth stories, to gain emotional support from other discussion board users, and to find supportive health providers and medical advice to successfully advocate for a VBAC (Konheim-Kalkstein et al., 2015). Fransisco and Sanchez (2017) specifically researched VBAC narratives from Black women, citing VBAC as an empowering experience and an opportunity to rebuild both their trust in medical providers as well as their self-trust after a negative birth experience. One woman described her experience this way: “I learned my lesson, no more just blindly trusting doctors without real research and proof. No more being compliant” (Fransisco & Sanchez 2017, p. 85). Online communities empower Black women through the process of gaining knowledge, finding supportive providers, and becoming informed about birth.

Women's birthing experiences are at the center of this ethical analysis because their birth narratives are often minimized when a healthy baby is born. Tasha published her VBAC birth story on her blog because she wanted to share her experiences publicly. For that reason, I am directly citing this person and sharing quotes of her story in order to frame my discussion of the decision-making process since they are such an important factor in developing individual patient perspectives. Traditionally, birth is a primarily private affair, and women who have negative experiences secretly process their emotions alone. However, the practice of sharing personal experiences online is successfully creating a shared public discourse, identifying commonality among pregnant women around a common experience in many women's lives. Because VBAC requires a prior birth experience, I include the mother's emotional feelings about her experience as relevant to the decision-making process.

## **2.1 Tasha's Story**

Tasha originally posted her story on her blog "VBAC Mom," in *Black Women Do VBAC*, an online forum that shares stories and resources for Black women who have experienced one or more cesareans. In 2012, Tasha was pregnant for the first time and wanted a "traditional birth" in a hospital. As a nurse, she was familiar with the hospital system and trusted the process. That perception changed at her 37-week appointment when Tasha began to feel as if she had "no plan, no preparation, and no guidance when making decisions in relation to birth," describing the experience to her friend: "I remember feeling like a number ... I recall vocalizing to her how much my prenatal care seemed like part of a business!" (Tasha, 2015b, para. 3).



On the morning of October 12th, Tasha arrived at the hospital in labor, and the nurse told her that the baby was “high.” Tasha (2015b) describes the process of receiving an epidural for her intense labor pains:

Once I was in a room I was asked if I wanted an epidural. With no hesitation, I firmly said “yes”! I did not know how else I would deal with the pain. I emptied my bladder, and the nurse placed a Foley catheter. I could tell by the phone conversation the anesthesiologist was not happy about placing my epidural so close to shift change. I however, was looking forward to what I thought would be pain relief. He arrived at shift change, and although a little grumpy he placed the epidural.

I anticipated the very minute my pain would go away, despite him clearly telling me there is a chance that the epidural could partially work or not work at all. After about an hour of no relief, my nurse volunteered to page anesthesia so that my epidural could be assessed. Approximately an hour later a new, fresh anesthesiologist came up to the floor. (paras. 9-10)

Despite two epidural attempts, Tasha’s intense pain did not subside. The nurse told her this was due to her high blood pressure, and she gave Tasha an IV of magnesium sulfate. The obstetrician on call wanted to start the conversation about having a cesarean. “I was emotional, I felt like a failure, I was tired, and had really already given up!” (Tasha, 2015b, para. 11). After Tasha reluctantly agreed to a cesarean, she remembered feeling alone and unaware in the operating room, waking up confused and experiencing little skin-to-skin with her baby in the recovery room.

Retroactively, looking back at her experience, Tasha (2015a) explained her feelings toward her first delivery:

This day would change my life forever! My first birth looked nothing like I imagined. There was oxygen, a blood pressure cuff, IV pitocin, IV magnesium Sulfate, an epidural, several cervical checks, a continuous fetal monitor and a Foley catheter. On October 25th 2012 after several hours of labor, my first born son entered the world via an unnecessary cesarean under general anesthesia due to a high spinal. I birthed alone and unaware of anything going on in the operating room. The next few days were a blur! The next few weeks when I was fully oriented I processed my birth experience. I was happy, sad, confused, and broken! (para. 2)

For months following the birth, Tasha had symptoms of postpartum depression, which she connects to her birthing experience: “I felt lonely, isolated, guilty, at fault, ashamed, embarrassed, incomplete, not whole, I ultimately felt like my body failed me” (Tasha, 2015b, para. 14).

Pregnant for a second time, Tasha wanted her second delivery to be different. She did her research and joined a local Positive Birth Group online. There she read stories about “natural” births and found support from women with similar experiences. Additionally, Tasha decided to hire a “hypno” doula, Katherine Stangling, who specializes in the *hypnobabies* method, using hypnosis techniques to relax the body and lessen pain during labor (Muir, 2018). Tasha (2015a) wanted to give birth at the Labor of Love Birth Center, and she described the reasoning behind her decision to have a VBAC:

There was no question surrounding how I would deliver this baby, I was NOT having another cesarean. It did not take long for my husband and I [*sic*] to decide that this baby would be born vaginally. I wanted this VBAC with every inch of my being. I educated myself, hired a hypno doula, hired a midwife, took a hypnobabies class, received chiropractic care, walked 1-2 miles a day, made nutrition/hydration/supplements a priority, and most importantly I believed in myself! My husband was on board and was a huge supporter, this was all I needed. (para. 3)

On the day before her labor, Tasha felt empowered by a home birth after cesarean story and support from her midwife. She woke up the morning of December 10th with waves of pressure. She listened to positive birth affirmation and hypnobabies deepening CDs while preparing for the upcoming labor. On the way to the birthing center, Tasha (2015a) felt the urge to push and described the rest of her labor:

My doula helped me out of the car and up the stairs. As soon as I got in the door of the birth center, I had the urge to push. I had been pushing the entire trip to the birth center in the car. I knew that I would not make it upstairs to a birthing room. I slowly squatted down to the lobby floor to push while my birth team gathered pillows, pads and other supplies. I remember being so excited! It happened so fast, my doula on one side and my husband letting me squeeze his hand on the other; I pushed a total of four more times and birthed my beautiful baby boy onto the lobby floor of the birth center at 11:19 AM. There were tears and smiles and not much talking during this time. My doula whispered in my ear, “you’re not broken, you’re whole.” (para. 9)

Tasha's first birthing experience had an enormous impact on her decision to have VBAC. She positively remembers having immediate skin-to-skin contact with her husband cutting the umbilical cord. In addition to being able to eat and rest after labor, Tasha (2015a) felt that her second birth experience was healing: "I made informed decisions during this experience that empowered me, my family, and many women I will meet along the way for a long time. I took charge of my own birth! This is my amazing, healing VBAC journey!" (para. 10).

After her first birth experience, Tasha (2015b) felt broken, "I felt I would never have children again," robbed, "I didn't feel like a woman," and angry, "I was angry at myself ... I was angry at the health care system ... I was angry that I was angry" (para. 18). Through online support groups, she connected with women who shared similar stories and understood her emotions. Once Tasha processed the pain and trauma of her first experience, she shared her story, which was an important part of her healing journey. Therefore, Tasha made the decision to have a VBAC for her second pregnancy after thoughtful consideration and reflection on her previous experience. She entered her second pregnancy educated about birth options, informed about local resources, and empowered to advocate for herself. Online birth forums connect women from around the country to resources and create a community of shared experiences. While Tasha found support enabling her to have VBAC, some women continue to face substantial barriers, coercion, and forced procedures, accumulate into what is termed obstetric violence (addressed further in 4.2.1). Considering the impact of personal experience on decision-making, providers should recognize the relevance of previous birthing experiences to the decision-making process.

### 3.0 A History of Medicalization and Medical Authority

In 2016, Natalie planned a home birth for her first pregnancy. Her physicians advised against a home birth because she has a blood clotting disorder, Factor V Leiden, requiring a blood-thinning injection twice a day during the pregnancy. Despite the physician's insistence that she be induced at 39-weeks to guarantee the necessary time between injection and an epidural, Natalie planned and hoped for a non-medicated labor and delivery. She hired a midwife, trained and experienced managing potential hemorrhaging, which is the principal concern for someone on blood-thinners. Following 36 hours of active labor, her team of midwives encouraged her to transfer to the hospital. While her son was not in distress, Natalie did not want to risk the negative impact of prolonged labor. At the hospital, her non-medicated birth turned into a cesarean delivery:

After two failed epidurals, pitocin not really working either, and four entire hours of pushing at 10 cm dilated...my midwife-now-doula pulled me out of my zone, "Natalie...you've done everything you can. You have tried every single position, you have fought harder than anyone I've ever seen...I think it is time to opt in for a cesarean before baby does go into distress. You have worked so hard."

Even typing those words out makes me cry. Every time. Because I was in the ZONE of pushing, bearing down, with all my might, SURE HE WOULD COME OUT. But his head was driving straight into my right hip, swelling and not turning.

I succumbed and signed the documents for a cesarean. (Brenner, 2020, paras. 11-13)

Due to the epidurals not working, physicians put Natalie under general anesthesia, which affected her baby's heart rate, resulting in an Apgar of one and resuscitation. As a former doula and birth photographer, she witnessed all types of birth and went into her first birth well-informed. Natalie felt she had done everything to facilitate a non-medicated home birth and still experienced an unplanned cesarean. Every time she remembers meeting her son for the first time, it brings tears to her eyes as she remembers the trauma of the experience: "The grief in how poorly our birth went... when I had done everything 'right'" (Brenner, 2020, para. 19).

While Natalie was excited to be pregnant again, she was terrified of reliving and repeating her traumatic birth experience:

As my belly grew rounder and due date came closer, I was having a lot of flash backs from Ira's birth.

Many appointments with the Maternal Fetal Medicine doctors, I was asked to be induced at 39 weeks. Why? I would ask. It was always about planning to get off my blood thinners in case I wanted an epidural...which I had stated over and over again, I didn't want one.

I had a call with an anesthesiologist to discuss the chance of a repeat failed spinal if I ended up needing a cesarean. He said it was very likely my body wouldn't take the meds, just as it didn't the first time.

I knew without a doubt that I wanted to go into labor on my own. Pitocin —or other medical inductions— forces your body into labor when you or baby are likely not ready. (Brenner, 2020, paras. 26-29)

At every appointment, physicians pressured Natalie to change her mind about induction and scheduling a cesarean. Her physicians told her that the baby would be too big for her body and that induction was necessary if she was overdue: “She wouldn’t ALLOW me to go past 41 weeks, which in & of itself is an unethical approach to medicine. This is my body” (Brenner, 2020, p. 126). Another physician told her that she was more concerned about having a vaginal birth than ensuring the safety of her baby. Natalie felt that her physicians were making an unfair moral judgment about her decision when her baby showed no signs of distress. She persisted, advocated for herself, and trusted her own body, resulting in the birth of her second child via VBAC:

With doctors at multiple MFM clinics, I sat & I listened to them tell me why I was making bad decisions for my body + my baby. When I asked why or for an explanation, I was met with generalized and false fear-based stats + suggestions to control this process.

Again: baby never in distress, which is important to note.

This body isn’t the medical field’s.

I am my son[’]s mother.

I knew all along what we needed for a *CHANCE* to conquer a successful VBAC.

I am grateful I listened to myself, instead of allllll the voices telling me I was crazy, inadequate in knowledge, and selfish. (Brenner, 2020, paras. 130-135)

Although Natalie’s first cesarean section may have been medically necessary, it still left an emotional scar. Her physicians seemingly ignored the impact of her first birth experience on her decision to advocate for a VBAC, and rather than empathizing, they made moral judgments about her decision. Natalie’s story suggests that exploration of women’s emotional experiences of

childbirth, typically overlooked in the medical model of pregnancy, is relevant and can help address potential gaps in pregnant women's care. There is no way to identify how many women have had similar experiences, but history indicates that many women have long resisted the medicalization of childbirth and medical authority.

The public principally views the medical field as objective, based in scientific reasoning. While evidence-based research is highly regarded as the standard for medical practice, the concept of medicine as solely a science-based field is relatively modern, and as noted by Munson (1981), medicine was once thought of as an art or a craft. It is dangerous to ignore the human-nature-driven subjectivity of medical training. Assuming that all medical standards are based in objective fact neglects the subjective and often intangible harm of implicit bias. Providers who counsel women about VBAC should be aware of the influence of the historical process of medicalization, medical authority, and reproductive injustice. Also, providers must be mindful of their attitudes and assumptions and not project their personal values they hold onto the mother. The public acceptance and rejection of the changing birth practices are relevant, but I focus on physicians' attitudes and perspectives to determine their ethical obligations. This chapter examines providers' changing notions about birth and the subsequent impact on the options available to pregnant women today. This chapter also analyzes physicians' medical authority and historical participation in the reproductive injustices that are morally relevant to the treatment of women seeking VBAC. Physician reliance on medicalized pregnancy and institutional authority makes it increasingly difficult for pregnant women to refuse medical intervention.



### **3.1 Medicalization of Childbirth**

Early American obstetricians started replacing midwives under the narrative that pregnancy was too risky and required “professional” supervision, shifting the location of birth from home to the hospital and the primary overseer of pregnancy and birth from midwife to physician. Pregnancy and birth are increasingly medicalized worldwide; however, historians regard the United States as especially medicalized, with 98.6% of all U.S. babies delivered in a hospital setting (MacDorman & Declercq, 2019). Countries with significantly high maternal/infant mortality rates prioritize access to medical intervention as an essential tool to improving women’s health. However, the United States, with an already high number of medicalized births, has a higher maternal mortality rate when compared to similarly wealthy countries (Tikkanen, 2020). Thus, physicians should scrutinize the prevailing view that pregnancy is inherently risky and requires high surveillance for its historical roots in the development of obstetrics.

#### **3.1.1 The History of Midwifery and Obstetrics**

Midwives are trained healthcare providers who assist women before, during, and after labor. A recent comparative study of 11 wealthy countries found that the number of U.S. practicing obstetricians and gynecologists far exceeds the number of practicing trained midwives, whereas, in other high-income countries, the opposite is true in that midwives outnumber obstetricians-gynecologist (Tikkanen et al., 2020). The lack of national policy, leading to differing state licensure requirements, restrictive scope-of-practice laws, and rules that require physician supervision all contribute to the absence of midwives in a majority of U.S. births. Seemingly, the U.S. does not recognize or prioritize the value of midwifery, contributing to a statistic that puts the

U.S. maternal mortality rate almost four times greater than the maternal mortality rate of Sweden, where midwives outnumber obstetrician-gynecologists five to one (Tikkanen et al., 2020).

The unique history of obstetrics and gynecology in the United States may explain the how and why of U.S. maternal medicine evolution. Historically, midwives primarily attended all deliveries, and physicians deferred to women as experts in childbirth. Midwives shared their skills and traditions informally, and women labored and delivered in their homes. Enslaved West African women brought their traditions of midwifery to the American colonies and were in charge of delivery, not only in their own communities but also for the enslaver's immediate family (Owens, 2017). In the 1800s, the public viewed hospitals as places of death, and before the introduction of antiseptics and anesthesia, women were more likely to die in the hospital than at home (Wolf, 2018). Midwives called physicians to assist them only with a complicated birth and if the death of the mother or child was imminent. In fact, early medical schools bypassed training for physicians to assist in childbirth. Early 19<sup>th</sup> century obstetricians practiced "conservative" medicine, recognizing that most births were low risk; they cautioned against "meddlesome midwifery" such as cesarean sections and the use of forceps.

During the 19<sup>th</sup> century, those overseeing a birth performed cesarean sections only in emergency cases, generally with adverse outcomes. In 1827, Dr. John L. Richmond performed the first recorded cesarean section in the United States, resulting in the infant's death (Wolf, 2018). Since cesarean section often also resulted in maternal death, physicians attempted them only in a desperate attempt to save the life of the infant when, otherwise, the death of both the mother and infant was likely. Typically, doctors prioritized the life of the mother because, before the development of pasteurized milk and refrigeration, "motherless babies were doomed to short, miserable lives for want of mothers' milk if a wet nurse could not be found" (Wolf, 2018, location

no. 798). In order to avoid the intervention of surgery, doctors often used forceps during a difficult birth, sometimes intentionally ending the life of the fetus to save the mother.

As medicine grew increasingly professionalized, physicians intentionally excluded midwives to gain control over birthing practices, with the exception of the segregated South, where Black “granny midwives” still provided the majority of care to poor and rural pregnant women. The obstetrician struggled to gain respect within the professional field and with women who traditionally trusted the care of midwives. In the early 20<sup>th</sup> century, Dr. Joseph DeLee, head of obstetrics at Northwestern University, described childbirth as a pathological process that damages both mother and babies and therefore promoted the routine use of sedatives, ether, episiotomies, and forceps (Rooks, 2014). Physicians falsely asserted that midwives were incompetent and unable to handle pregnancy dangers, promoting racist and sexist assumptions about granny midwives. Bonaparte (as cited in Pérez, 2015) noted that “some physicians even labeled grannies as ‘a cross between a superstitious hag and meddling old biddy’” (para. 8). The rhetoric that midwives were incompetent and the professed inherent dangers of pregnancy helped reduce the use of midwives. As a result, midwives’ clients – mainly poor and Black women – were ushered away from well-respected Black midwives and alternatively turned toward teaching hospitals, providing obstetric experience to physicians in training. Between 1900 and 1935, the percentage of birth attended by midwives decreased from nearly 50% of all births to 15%, resulting in a 41% increase in infant mortality due to birth injury (Rooks, 2014).

The term *obstetrics* derives from the Latin word meaning to “stand before,” and until World War I, physicians regarded birth as typically straightforward and requiring little medical expertise (Wolf, 2018). Obstetrics, not yet combined with gynecology, was not well regarded as a medical profession and, as mentioned previously, medical schools neglected obstetrical training.

Obstetricians prided themselves in the often-self-taught skill necessary to successfully deliver a child without resorting to surgical interventions. As new surgical techniques began to make surgery slightly safer for the mother, physicians started to emphasize the life of the fetus, which resulted in the rise of the cesarean section rate in the early 20<sup>th</sup> century. In 1916, Dr. Edward B. Cragin, a practicing obstetrician and lecturer at the Columbia University College of Physicians and Surgeons, made famous the dictum, “once a cesarean, always a cesarean,” which became the medical mantra governing obstetrical practice for most of the twentieth century. At this time, American obstetricians used the “classic” cesarean cut, which is a long vertical incision from the umbilicus to the pubic bone (Wolf, 2018). Despite the development of a transverse cut in Europe which proved to be less prone to uterine rupture in subsequent labors, the United States did not adopt that technique until the 1970s.

### **3.1.2 Pregnancy and Risk**

Barker (1998), a sociologist and anthropologist, claims that biomedical rhetoric introduced by the *Prenatal Care* pamphlets and published in 1913 was critical to the medicalization of pregnancy. Following the Progressive Era (1890-1920), the early 20<sup>th</sup> century saw a rise in *pronatalism*, the government’s effort to encourage white women with American citizenship to have more children and to increase social programs that introduced ways of improving infant health (Wolf, 2018). One example of pronatalism is the U.S. Children’s Bureau’s publication of the *Prenatal Care* pamphlets to improve maternal and infant outcomes. The pamphlets served as handbooks for pregnant women, with the text describing pregnancy within a disease model, giving physicians the cultural authority to diagnose and treat pregnant women (Barker, 1998). Subsequent publications of the pamphlet (1924, 1935) shifted the language from preventative actions to the

necessity of medical technology to monitor all pregnancies. Concurrently, obstetricians, with growing concern for risk to the fetus, grew inclined to perform cesarean sections on “older” women with more than one child as “the patient has already done her duty to the State, and the possibility of further childbearing may be regarded as a matter of indifference” (Wolf, 2018, location no. 1283).

The reconceptualization of pregnancy as biomedical led to the image of “pregnancy and birth as inherently high-risk, a pathological process that is irresponsible to undertake without large amounts of expert help and surveillance” (Kukla and Wayne, 2018, para. 6). By the 1950s, physicians principally attended births and were responsible for common interventions such as general anesthesia, use of forceps, and episiotomy. Later, the development of several diagnostic tools contributed to the heightened sense of risk with the already common interventions. Based on the observations of Dr. Emanuel Friedman, an obstetric resident in the 1950s, the Friedman curve created a standard for the length of “normal” labor (4-8 hours) that obstetricians used to calculate the medical necessity of a cesarean section (Wolf, 2018). Despite the differences in labor time for first-time mothers and medicated vs. unmedicated labor, doctors rapidly adopted the Friedman curve at every birth, resulting in the “failure to progress” as the principal reason for performing a primary cesarean.

Additionally, the development of the Apgar score, a method to measure the health of a newborn, prompted immediate attention on the infant after labor (Owens, 2018). In the 1960s, prevention of genetic defects became a public health crisis, initiating societal and political programs aimed at pregnant women’s behaviors. Dr. Virginia Apgar, who developed the Apgar score in 1952, spread public awareness of birth defects as a public health issue while simultaneously placing the primary responsibility to prevent birth defects on mothers (Owens,

2018). These anxieties heightened the need for surveillance during pregnancy, fostering the necessity of medical technology during labor and delivery. In general, physicians' attitudes toward routine labor shifted from careful observation to immediate intervention because some physicians viewed birth as inherently dangerous to the fetus (Owens, 2018).

Further, the advancement of technologies allowed physicians to monitor the previously obscured fetus more closely. Before the development of ultrasound imaging, physicians did not typically regard the fetus as a separate patient, but technical advances allowed physicians to view the fetus as a patient in its own right (Owens, 2018). In 1969, a group of physicians from Yale University were the first to publish data that represented patients with continuous electric fetal monitoring (EFM) to identify fetal distress and prevent asphyxia at birth (Stout & Cahill, 2011). Physicians quickly advocated for and adopted EFM into clinical practice before establishing randomized EFM clinical trials and national standards for use (Freeman, 2002). This was despite little evidence of improved neonatal outcomes and widespread misinterpretation of the EFM readings. The ability to observe the fetal heart rate continuously altered obstetrics practice by allowing physicians to monitor multiple patients simultaneously. The first randomized controlled trial of EFM found no difference in infant outcomes, rather, finding that EFM use leads to a significantly higher number of cesarean deliveries (Wolf, 2018). As a tool, EFM contributed to the medical environment in which a physician could rely solely on technology to indicate when something was wrong rather than trusting the symptoms described by the pregnant woman, undermining a woman's authority to interpret what was happening to her body.

### 3.2 “Reproductive Injustice”: The Role of Medical Racism

Black women in the United States are three to four times more likely to experience a pregnancy-related death than white women. As a Black woman pregnant for the first time, Imani feared being ignored and dismissed by medical professionals:

From almost the moment I found out I was pregnant, I worried. Every mom-to-be worries—Will I have pregnancy complications? Will my child be healthy? Will I poop during labor?—but with my being a black woman in America, the realization quickly set in: Being pregnant meant putting my well-being, even my life, on the line in a way that white moms, statistically, don’t have to. (Bashir, 2019, para.3)

Stories of Black women being ignored and dying in the hospital influenced Imani’s decision to have a home birth. At 35 years old, her grandmother died while pregnant in the hospital. Initially, Imani planned to have the assistance of a midwife, but after discovering a community of unassisted-birth moms online, she educated herself on how to have an unassisted birth:

I know what you’re thinking: What if something goes wrong? Isn’t a hospital the safest place to be? I understand that. In many ways, that’s true. But ultimately I didn’t want to be in an environment that would exacerbate my birthing fears (stress during pregnancy is linked to poor birth outcomes), and I didn’t want to place my pregnancy into the hands of a system that doesn’t seem to value the lives of women and children who look like me. (Bashir, 2019, para. 9)

With the help of her husband, Imani gave birth at home to a healthy son without complication: “Rather than feeling uncomfortable and scared with my feet in stirrups, I felt totally safe at home. . . . My baby and my body knew what to do” (Bashir, 2019, para. 14). While Imani’s experience was empowering, she believes that “we should live in a world where black women don’t have to feel afraid of giving birth in a hospital—every woman should be able to have a safe birth on her terms” (Bashir, 2019, para. 19). Many patients experience fear and a lack of trust in the medical system, especially those impacted by medical racism. Providers who counsel VBAC decision-making for Black mothers should be aware of how medical institutions profited from and perpetuated race science, actively participating in the medical abuse of people of color. As Imani’s story indicates, distrust toward medical institutions results from the frequent experience of racism in medicine.

Reproductive justice advocates recognize the importance of a woman’s right not to have children, to have children, and to be able to parent children in a safe and healthy environment. The reproductive justice framework certainly extends to all women, but it is especially important for Black women who have had life experiences impacted by social, political, and cultural assumptions of race and gender (Ross & Solinger, 2017). *Reproductive injustice*, introduced by Davis (2019), connects the practice of medical racism, the legacy of race science, and the medical abuse experienced by enslaved people to the high prevalence of premature birth and low birth rates for Black women. Obstetrics practice, relying less on patient narratives, views Black women’s bodies differently since “both racism and slavery in the United States have facilitated a reproductive dystopia in which almost all aspects of reproduction idealize whiteness” (Davis, 2019, p. 13).



### 3.2.1 The History of Race and Medicine

In the early 19th century, medical researchers closely examined the alleged differences between Black and white bodies in an effort to justify the practice of slavery (Owens, 2017). Such scientific racism emboldened doctors that practiced early gynecology to use enslaved women's bodies to practice gynecological surgeries that would, ostensibly, benefit white women. Dr. James Marion Sims, considered to be the "father of modern gynecology," perfected the surgery to repair a vesicovaginal fistula, an opening between the vagina and bladder caused by childbirth, on Black enslaved women without anesthesia and, to repair the damage caused by those surgeries, Black women required multiple subsequent surgical interventions, often for the remainder of their lives (Washington, 2006). The practice of abusive medical experimentations on Black bodies reveals the paradox in scientific racist thinking: "Given this supposedly vast biological chasm between blacks and whites, how could scientists logically infer results of medical experiments from blacks to whites?" (Washington, 2006, p. 74). Whereas physicians identified white women as too delicate for unnecessary surgery, Black women falsely "were seen as willing and strong servants for white medical men, impervious to physical pain and unafraid of surgeries" (Owens, 2017, p. 20).

Doctors who performed gynecological surgeries on enslaved Black women recognized that physiologically there was no difference between the races but continued to exploit Black bodies to improve their medical knowledge and surgical techniques. During the 19th century, when cesarean sections were likely to be fatal, physicians performed the majority of recorded cesarean deliveries on Black and poor women of the South (Wolf, 2018). Considering the enslaver, rather than the Black woman, as their patient, physicians continued to perform experimental cesarean sections on Black women, continuing their efforts to perfect the surgery. The exploitation of Black women, especially pregnant Black women, is a foundational part of American racism and the

establishment of early medical institutions. The history of racism is far more complicated than described here, but maternal and infant health disparities combined with social, cultural, and political assumptions of childbirth are evidence that medical racism is deeply embedded.

### **3.2.2 Racial Differences in VBAC**

National organizations recognize that the reduction of the rate of low-risk cesarean births is a way to lower the overall U.S. cesarean delivery rate. A higher percentage of Black women (30.3%) compared to white (24.9%) and Hispanic (25.4%) women had an initial low-risk cesarean, which establishes a pattern of repeat cesareans for the majority of these women who went on to experience additional births (Martin et al., 2019). The philosophical thought process of “once a cesarean, always a cesarean” still holds true. Studies show that Black women are more likely to attempt a VBAC, which is also more likely to result in cesarean delivery. Researchers found that Black women, compared to other racial groups, were 40% less likely to experience uterine rupture, one of the most significant associated risks, concluding that “it is unclear whether this discrepancy in magnitudes of risks and benefits across race associated with VBAC trials is attributable to selection bias or inherent racial differences” (Cahill et al., 2008, p. 1). Considering the effects of racism, it is possible that physicians are predisposed to believe Black women need an eventual cesarean section, therefore, intervening more often for their Black patients.

Although the national data for VBAC delivery rates do not vary by racial group, there is a valid concern that the inclusion of a race factor in the popular VBAC calculator may result in more Black women being denied the possibility of VBAC as a valid option or pressured into a cesarean delivery at the hospital. The VBAC calculator systemically assigned a lower chance of successful VBAC to women who identify as African American and Hispanic when compared to their white

counterparts. Recently, Vyas et al. (2019) criticized the utilization of race as a factor in prediction models as exacerbating racial disparities, concluding that observational data problematically identify existing racial disparity and creates a predictive model that ensures that these trends will continue.

Recently, a joint statement by multiple obstetrics and gynecology professional organizations recognized racism, not biological race, as a public health issue that requires examining the historical roots of the medical specialties involved in racism and oppression (ACOG, 2020). The use of race in algorithms calculating risk not only obscures the underlying structural reasons for health disparities but also reinforces the assumptions of a biological difference between race. For instance, a 2016 study found that nearly 50% of white medical students and residents participating in the medical survey believed, erroneously, that the skin of Black people is thicker than those of white people (Hoffman et al., 2016). This concerning statistic confirms that assumptions of biological race differences are persistent and dangerously continue to hold onto a place within the modern practice of medicine. Further, racism in medicine is indicated by the fact that Black women continue to be more likely to have their medical concerns dismissed.

### **3.3 Medical Authority**

The medicalization of pregnancy and birth is intertwined with the history of obstetricians successfully achieving cultural authority over pregnant bodies. Through experimentation on Black women's bodies, physicians established their birthing expertise. Disparities affecting Black women today represent the persistence of the racial overtone in scientific thinking, which has

informed so many historical movements such as the practice of medical experimentation on Black bodies, Progressive Era eugenics, and criminalization of Black motherhood. Societal expectations of maternal sacrifice and blame directed at women for any adverse outcome pressure all pregnant women to accept and rely on technology and medical authority, even when they would choose otherwise. In an era when American society expected white women to increase the population of “socially good” genes, birth was a moral achievement and best handled by obstetricians. Today, women who resist medical technologies are labeled as “non-compliant” or “difficult” and made to feel as if they are “bad” mothers.

The legal and institutional pressure on physicians to rely on medical technology, rather than “hands-on” techniques, partially explains the mindset of physicians who resist the unknown of unmedicated and unmonitored labor. During the 1980s, obstetricians saw a rise in birth injury claims as lawyers used EFM documentation to argue that the physician failed to intervene during fetal distress. In response, most physicians attempted to eliminate all potential risks during birth, commonly defaulting to more interventions (Wolf, 2018). Additionally, high insurance premiums for obstetricians and fear of expensive malpractice litigation contributed to the physicians’ perceived need to employ any and all technology to minimize the risk of severe birth injury (Yang et al., 2009). Therefore, the pervasiveness of a medical culture that preferred unnecessary intervention over potential fetal harm became the standard of obstetric practice in the United States, explaining physician reluctance toward VBAC.

In the physician-patient relationship, physicians enjoy privileged social status and superior medical knowledge, the combination of which creates a power dynamic, principally benefiting the physician as the patient relies on the physician to provide available treatment options and medical

advice (Lipworth et al., 2013). Freeman (2014) describes how the current medical structure has given physicians epistemic power over pregnant women's bodies:

To maintain that someone has epistemic privilege over her body is to maintain that the way her body feels to her is a legitimate source of evidence for making claims about it. On the other hand, the epistemic authority of physicians is based on third-personal, disembodied, indirect, yet practiced and experienced expert knowledge. Even though a pregnant woman has epistemic privilege over her body insofar as she alone has access to how her body feels; a physician can still have epistemic authority over her body insofar as he or she has expert knowledge to interpret, explain, and if necessary, diagnose, and treat what a pregnant woman is feeling. (p. 48)

The *medical gaze*, a term initially used by Foucault, becomes natural and necessary as the pregnant woman starts to conceptualize her identity as the subjective patient (Barker, 1998). The deference to medical authority may limit the options presented to pregnant women and create an adversarial physician-patient relationship when providers invoke judicial authority or threats of criminalization.

Medicalization of the birthing process and medical racism directly impact modern obstetric traditions; therefore, health providers counseling for VBAC should be aware of this context as it affects prior experiences that factor into the medical decisions of many women. This is the first step to genuinely promoting reproductive justice for all women and respecting a more nuanced conception of autonomy in birth. Traditionally, bioethicists and providers have neglected the negative impact of medical racism and personal experiences, both important issues, as significant

to their patients. This oversight cultivates an atmosphere in which autonomy and informed, respected decision-making by the mother, cannot truly occur. As a result, women privately have endured painful and emotionally harmful experiences at the hands of well-intentioned providers. Ethical guidelines that presume a just society provide little guidance or reassurance to women who have experienced past harm. Existing gaps in care are further exacerbated by women's mistrust of the medical system. Historical injustices are not forgotten and are more often known by the communities that experience injustice than the providers who care for them.

#### 4.0 Maternal-Fetal Conflict

The case of Rinat Dray, a 32-year-old Brooklyn woman, made national headlines after she filed a lawsuit against the private institution, Staten Island University Hospital (SIUH), for violating her physical autonomy by performing a cesarean section without consent (Hatocollis, 2014). During Rinat's first and second pregnancies, physicians pressured her into cesarean deliveries, leaving her with physical and emotional pain. In 2011, Rinat, determined not to repeat those experiences for her third pregnancy, hired a doula for support and researched VBAC-friendly hospitals. As soon as she arrived at SIUH, the physician insisted that she needed a cesarean. Although she asked for more time, "I was begging, give me another hour, give me another two hours," the doctor replied that "I'm not bargaining here" (Hatocollis, 2014, para. 20). In another report, Rinat remembers the doctor saying, "It doesn't matter if you're making good progress. I don't think it's going to be natural. I don't have all day for you" (CBS News, 2014, para. 4). When she objected to that recommendation, the doctor told her the baby would be in peril, and her uterus would rupture and "that she would be committing the equivalent of child abuse and that her baby would be taken away from her" (Hatocollis, 2014, para. 3).

When Rinat repeatedly refused to consent, her physician used a secret internal hospital policy to override her consent. The 2008 SIUH policy, "Managing Maternal Refusals," states that if a physician judges that "there is an emergent need to treat the fetus," then the attending physician, in emergent situations, can "choose to take the measures necessary to override the refusal and protect the medical welfare of the fetus without further delay" (Redden, 2017, para. 24). This policy offers step-by-step instructions for the physician to override a pregnant woman's objection without obtaining a bioethics consultation or court order. Rinat's hospital records show

that two physicians and the hospital lawyer “determined that there was insufficient time to seek a court order, and that he would override the plaintiff’s refusal to consent and proceed with a c-section” (*Dray v Staten Is. Univ. Hosp.*, 2018, para. 4). “They pushed me into the operation. I was begging all the way, ‘Don’t do it, my baby is fine! Don’t do it!’” Rinat recalled her physician’s response, “Don’t speak” (CBS News, 2014, para. 6). Not only did she experience the trauma of a forced procedure, but also the physician mistakenly cut her bladder during the procedure, causing permanent damage. Rinat, an Orthodox Jewish woman, described her experience this way: “I was psychologically distraught and physically injured. In our community, there are many large families and we hoped to have the same joy ... I wish to have more children, but I fear getting pregnant again” (Redden, 2017, para. 28).

In 2014, Rinat Dray filed a lawsuit against the hospital for “improperly substituting their judgment for that of the mother” (Hatocollis, 2014, para. 6). Additionally, her lawyers argued that the hospital and physician violated New York’s Public Health Law, which protects a patient’s right to refuse treatment. National Advocates for Pregnant Women (NAPW) helped Rinat bring public attention to her case and provided legal support. Her lawyers presented evidence that a physician wrote in Rinat’s medical records, “the woman has decisional capacity. I have decided to override her refusal to have a c-section” (NAPW, 2018). However, the hospital successfully got most of the claims dismissed at the trial court level, citing legal technicalities. Rather than address the legality of the hospital’s policy, that court ruled that the actions in the lawsuit exceeded the one-year statute of limitations and did not meet the standard for battery, as a private institution was not subject to the referred Public Health Law (*Dray v Staten Is. Univ. Hosp.*, 2018).

In 2018, a New York appeals court affirmed the lower court’s ruling: “the court thus finds that the state interest in the well-being of a viable fetus is sufficient to override a mother’s objection



to medical treatment, at least where there is a viable full-term fetus, and the intervention presents no serious risk to the mother's well-being" (NAPW, 2018, para. 2). Further, the court's ruling dismissed claims that the hospital policy was a violation of civil and human rights because it singles out pregnant women as an exception to bodily autonomy. As this is an ongoing legal action, reproductive justice lawyers have filed an amicus brief in support of Rinat's case, arguing that "subordinating women's fundamental rights on the basis for concern for a fetus is the very heart of sex-discrimination these laws are intended to eradicate" (Diaz-Tello, 2020, p. 2).

The policy at Staten Island University Hospital, part of Northwell Health, became public during the court proceedings. Currently, Northwell Health refuses to confirm if its other 23 hospitals implemented the same policy, despite the New York State Department finding that it violates New York's Patient Bill of Rights (NAPW, 2020). This policy is contrary to ACOG's (2016) recommendations, condemning the use of coerced medical intervention and asserting that physicians should respect a pregnant woman's refusal of medical interventions. Explicitly, they "strongly discourage medical institutions from pursuing court-ordered interventions or taking action against obstetricians-gynecologists who refuse to perform them" (ACOG, 2016, p. 2). While policies like this violate ethical norms, their existence speaks to the tendency for health providers to position fetal interests against the mother to justify violations of maternal autonomy and rely on medical authority.

As discussed in Chapter Three, physicians established medical, obstetrical authority through the medicalization of childbirth and amplified maternal responsibility to prevent adverse outcomes. Once it was possible for physicians to view the fetus as a separate patient, it was also possible to view the mother's interest as separate from the interest of the fetus, resulting in the adoption of the maternal-fetal conflict language. The *maternal-fetal conflict* (MFC) refers to the

physician's obligation to balance the interests of the mother against the interests of the fetus (Harris, 2000). Most physicians would not condone a forced procedure; however, they also may not recognize the more subtle ways women are coerced into medical procedures, with or without a court order. The premise of the MFC creates a false dichotomy between the interests of the mother and her fetus, ignoring the gendered and racial assumptions of the framework. Creating an adversarial situation allows providers to determine if a pregnant woman's medical decision is legally open to being overridden, ostensibly to protect the health of the fetus. It reduces the ethical discussion to a single instance in time, negating the degree of trauma that may affect the patient for the rest of her life. The imposition of medical authority over a pregnant woman is not an ahistorical trend; rather, it is a consequence of the deeply embedded and accepted assumptions of the MFC.

Chapter Three argues that the MFC mistakenly identifies the conflict as between mother and child, perpetuating normative expectations of maternal sacrifice. In obstetrics, the consequence of creating the MFC has been the acceptance of obstetric violence and fetal consequentialism, considering the birth of a healthy baby as more important than any harm to the mother. Furthermore, physicians who blatantly weaponize concerns for fetal health against the mother contribute to harm against the mother's bodily autonomy, create patient distrust in medical systems, and generally target women in a way that reveals implicit bias based on gender, race, and class.

## 4.1 The Maternal-Fetal Conflict Debate

The maternal-fetal conflict exists because medicalization has encouraged the medical community to view pregnancy and birth as inherently risky, requiring high levels of surveillance. Through this lens, it is easy to imagine how physicians may view the mother's interests as in conflict with those of the fetus. Even in a desired pregnancy, when a pregnant woman and fetal interest should theoretically align, every decision a pregnant woman makes is subject to scrutiny. Pregnant women can find an exhaustive list of things to avoid online, including but not limited to deli meat, soft cheeses, unpasteurized dairy, caffeine, alcohol, smoking, and certain medications (Timmons, 2016). The intense scrutiny of a pregnant woman's behavior and medical decisions stems from the supposed "maternal-fetal conflict," positioning the interest of the mother in opposition to her fetus.

A classic example of the MFC is that of a woman diagnosed with cancer, whose medical treatment is potentially harmful to the fetus's life. In this case, utilizing bioethics principles, the physician must balance the obligation of respect for the mother's autonomy, beneficence and nonmaleficence for the mother and the fetus, and justice, distributing benefits and harms equally when possible (Oduncu et al., 2003). This balancing act and subsequent distribution of medical risk and benefit is the calculus the physician must make both before and during treatment. For both doctor and patient, the real conflict arises when the pregnant woman makes a decision that is contrary to medical advice, whether that is a "risky" VBAC or the refusal of medical interventions during labor that would benefit the fetus. Legal scholar Oberman (1999) appropriately renames the "maternal-fetal conflict" as the "maternal-doctor conflict" because it reflects the "doctors' seemingly well-motivated efforts to promote the maternal or fetal well-being by imposing their perception of appropriate medical care on their pregnant patients" (p. 454). For example, the

conflict between Rinat Dray and her physicians was about how she should give birth. While Rinat believed that a vaginal delivery would benefit both her and the baby, her choice was disregarded, without hesitation, by both doctor and the hospital, specifically on the grounds that her decision would harm the fetus.

Bioethicists and physicians treat pregnancy-related medical decisions differently due to the presence of a “second patient.” Philosophers and feminists often debate the status of personhood for a fetus and the implication for women’s reproductive decision-making. Even without defining personhood, most ethicists agree that physicians have a relevant moral obligation toward the fetus (Lyerly et al., 2008). Avoiding the personhood debate, McCullough and Chervenak (2008) conceptualize a fetus as a patient with dependent, rather than independent, moral status. A person has certain protected rights due to their independent moral status, such as the right to refuse treatment. Before viability, the fetus becomes a “patient” when the pregnant woman presents the fetus as such, allowing women the choice to continue with the pregnancy. Therefore, the fetus has dependent moral status since it relies solely on the woman’s decision to see the pregnancy through viability. Once the fetus is presented as a patient or reaches the point of viability, physicians have beneficence-based obligations toward the fetus (McCullough & Chervenak, 2008). While the framing of beneficence, rather than rights-based obligation, avoids categorizing the fetus as an independent patient, it still promotes the MFC.

Several scholars agree that using the MFC in pregnancy-related ethical dilemmas creates a false narrative, mistakenly insinuating that there is a conflict between the pregnant woman’s interest and those of her fetus. Lyerly, Little, and Faden (2008) warn that conceptualizing the fetus as a patient is misleading. The designation of a fetal patient may encourage physicians to think of the fetus and the pregnant woman as two separate entities, which creates a normative status for the

fetus, establishing equal professional obligations and duties toward both “patients.” Additionally, the MFC framing positions the doctor and court as having a greater interest in fetal well-being, implying that the fetus needs rescuing from a callous mother (Kukla & Wyane, 2018). Therefore, the “maternal-doctor conflict” is a more accurate depiction of the conflict arising for women who choose not to comply with medical recommendations because it reveals the provider’s explicit choice to ignore the desires of the mother for the sake of the fetus.

In VBAC decision-making, physicians may invoke the MFC when a woman goes against their medical advice not to have a vaginal birth. They assume that the pro-VBAC decision is based on the mother’s selfish decision to prioritize her preferences, subordinating the health of her child. Therefore, the balance of this chapter explores the use of the MFC by health providers to justify coerced medical intervention, justify blame against the pregnant woman, and fetal consequentialism during labor and delivery. The MFC framing in obstetrics literature and practice harms patient autonomy and undermines trust, which should be an essential part of the physician-patient relationship. Additionally, the MFC provides a vehicle to allow providers to justify violating a woman’s bodily autonomy, often mistakenly identified as “for the sake of the fetus,” thus eroding patient trust in the health care system, especially women of color.

## **4.2 Forced Intervention**

In extreme cases of the MFC, when the mother and physician can seemingly come to no agreed-upon resolution, health providers may look to the law to determine the appropriateness of overriding patient autonomy to, in the health provider’s opinion, save the life of the fetus. While the United States Supreme Court ruled overwhelmingly that it is impermissible to infringe upon a

pregnant woman's right of autonomy upon appeal, lower courts often make irreversible swift decisions, ruling in favor of court-ordered medical intervention. Historically, medical providers use both judicial law and coercive tactics to force women to adhere to medical recommendations and deliver children by an unwanted cesarean section. The act of choosing to disregard medical authority poses a risk in its own right as it may be sufficient to legally determine the mother of being "*incapable* of making decisions about her birth," resulting in the conclusion that "her 'choice' never really existed" (Morris & Robinson, 2017, p. 25). While court-ordered medical interventions are the most apparent form of violation against pregnant women, the practice of threatening to involve child protective services is a horrific, commonly used coercive tactic to force women to choose between an unwanted procedure and the risk of losing their existing children.

Morris and Robinson (2017) found that physicians have threatened to contact Child Protective Services (CPS) if a woman does not consent to a cesarean. They interviewed Jennifer Goodall, who described her experience attempting to have a vaginal delivery for her fourth pregnancy after three prior cesareans. One of her physicians told her that she was "basically murdering my baby and that it was dangerous and that she wouldn't support it" (Morris & Robinson, 2017, p. 26). Soon after, Jennifer received a letter from the hospital, threatening to involve CPS because she refused to agree to a cesarean. When she decided to go to the hospital, after attempting a home birth, the nurse told her that the physicians would deny her care unless she agreed to a cesarean section. Physicians also threatened Rinat Dray when she declined a cesarean telling her that "if you're not going to sign the form for the C-section, ... the state is going to take your children" (Morris & Robinson, 2017, p. 26).

The threat of CPS is not the only coercive tactic commonly utilized by physicians to pressure women when there is a conflict. Morris and Robinson (2017) identify four additional tactics: 1) abandoning the patient, 2) refusing patient hospital admission, 3) labeling a woman as “non-compliant,” and 4) using the power of multiple physicians to bully a patient into submission. Consequently, the active or implied threat of any of these actions can be as stressful to the women as the actual act of obtaining a court-ordered medical intervention, which creates patient fear and undermines trust in the provider.

Studies have shown that some physicians are more likely to use threats of forced intervention and criminal charges against poor women, women of color, and immigrants (Samuels et al., 2017). According to documented legal cases, from 1973 to 2005, women of color (59%), specifically African American women (52%), were statistically overrepresented by legal cases in which the women's pregnancy was a necessary factor for deprivation of women's physical liberty (Paltrow & Flavin, 2013). The reasons for legal action against pregnant women vary but generally include suspected patient drug use, patient refusal of treatment orders, patient failure to obtain prenatal care, and potential abortion. Vedam et al. (2019) found that one in six women, regardless of race, experience one or more types of mistreatment. These include a health care provider shouting or scolding them, ignoring their request for health, threatening to withhold care, or forcing the acceptance of unwanted treatment. The same study found that Indigenous, Hispanic, and Black women, compared to white women, were more likely to report having experienced at least one form of mistreatment by health care providers. Lower socioeconomic status, hospital birth, unexpected obstetric complications, and conflict with health care providers are factors most associated with reported experience of mistreatment (Vedam et al., 2019). These studies show that

women of color disproportionately experience abuse by their health provider and are more likely to be taken to court as a reported threat to their children.

#### **4.2.1 Obstetric Violence**

In Latin America, maternal health advocates have coined the term *obstetric violence* to describe harmful hospital-based obstetric practices as overt violence and bring attention to structural and gendered inequality (Zacher Dixon, 2015). Kukura (2018) argues that the term has “rhetorical power to help identify, condemn, and organize around the mistreatment of women in childbirth” (p. 764). There are three specific obstetric violence categories experienced by pregnant women before and during childbirth: abuse, coercion, and disrespect. Obstetric violence appropriately describes Rinat Dray's experiences, including the doctor saying “don’t speak” as she was lying on the operating table before her court-ordered cesarean section, a surgery that resulted in a bladder injury that required subsequent corrective surgery (Hartocollis, 2014). Unless the patient attempts to deliver at home, coercive action, such as institutional policies against supporting VBAC, severely limits the options available to pregnant women when seeking care, eventually compelling them to undergo unwanted surgery if relying on VBAC-restrictive hospitals.

The purpose of using obstetric violence terminology is not to criminalize physicians nor prevent them from fulfilling their ethical patient obligations. Critically, the concept of obstetric violence brings awareness to patient mistreatment that is both difficult to confirm and rarely researched but is anecdotally documented by pregnant women as leaving lasting trauma in those who experience it. Medical providers may assume that the birth of a healthy baby outweighs any and all emotional harm to the mother, making it difficult for women to pursue a legal remedy



against medical providers, resulting in the silent suffering of countless women (Kukura, 2018). As in the legal case of Rinat Dray, personal injury suits are challenging to prove unless there is harm to the fetus or maternal death. Obstetric violence terminology emphasizes the harm done to Rinat and Jennifer, exposing the frequent use of coercive tactics and legal interventions that undermine pregnant women's autonomy. Like the maternal-doctor conflict, obstetric violence makes explicit the harmful actions of a physician who chooses to disregard the choice of the patient.

### **4.3 Judgment and Blame**

As mentioned in Section 3.1.2, maternal responsibility to prevent congenital disabilities began in the Progressive Era, contributing to the requirement of expert surveillance during pregnancy. While selflessness and sacrifice of motherhood was a long-established tradition, early 20<sup>th</sup>-century public health campaigns defining "proper" behaviors related to pregnancy and motherhood redefined maternal expectations (Waggoner, 2014). Thus, contemporary maternal sacrifice morally requires pregnant women to accept medical management of pregnancy without question. Through this view, pregnant women experience surveillance and judgment based on societal expectations of maternal self-sacrifice by a physician who expects mothers to spend their entire lives devoting themselves to reducing risk to their children.

Mykitiuk and Scott (2011) identify the assignment of responsibility to and blame on pregnant women as tied directly to increased medical surveillance and risk management of pregnancy. The assumption that the mother and fetus have a conflicting interest perpetuates an expectation for the mother to sacrifice her well-being for the birth of a healthy baby. Therefore, if a pregnant woman engages in risky behavior or makes a decision against medical advice, she is

deemed a “bad” and “selfish” mother. The assignment of VBAC as unnecessarily risky is an example of when “harm is conceptualized as calculable and preventable, the mother becomes blameworthy if she does not engage in approved risk-reduction strategies” (Mykitiuk & Scott, 2011, p. 327). The accusation of child abuse is more likely to be used against vulnerable women, who may already face stereotypes of being an unfit mother (Kukla & Wayne, 2018). Historically, women of color have had their motherhood systematically devalued and been the targets of criminalization and forced procedures (Roberts, 2017). Focusing on personal failures and individual choices reflects a larger trend toward private responsibility for health, ignoring the role of social determinants of health and the responsibility of society to mitigate the barriers to health care access.

Furthermore, women are subject to the good vs. bad mother dichotomy, informed by religious connotations of the self-sacrificing Virgin Mary. Expectant mothers may internalize the view of delivering a baby as a moral achievement, whereas infertility is “often attributed to a moral failing on the part of the woman” (Layne, 2003, p. 148). The depiction of the good mother as one who unflinchingly subordinates her needs to deliver a healthy infant makes it nearly impossible for women who feel pain, anger, or frustration over their birthing experience to be taken seriously. Layne (2003) describes the blame and responsibility put on mothers who experience loss in the following manner: because women are held responsible for any adverse outcome that may happen to the fetus, “her virtue as both a woman and mother may be questioned” (p. 145).

Regardless of any moral responsibility acknowledged by the mother toward her fetus, it is problematic for physicians to assume that the MFC exists to place sole responsibility for adverse outcomes on the mother and ignore the importance of the social context in which women make medical decisions. Expectations of maternal sacrifice inform physicians calculating who is at

greater risk during delivery, creating the tendency to prioritize fetal well-being. Providers may regard a pregnant woman attempting a VBAC against medical advice as selfish and responsible for any harm that may happen, to either mother or child, because of her choice. Likewise, Rinat Dray's physician said that her own "culpable conduct and want of care" contributed to any injuries she may have sustained (Hatocollis, 2014, para. 13). Judgment and blame are irrespective of potential trauma that may have happened during her prior pregnancy and mitigates the health care provider's role in creating the conflict. The unfortunate consequence of negative experiences during childbirth is the real risk that the mother will cease interacting with her health care provider, thus discontinuing health care for herself and her child.

#### **4.4 Fetal Consequentialism**

The societal consequence of assuming a conflict exists, in which one's interest can be prioritized over another, creates the tendency to lean toward *fetal consequentialism* or the premise that a healthy child's birth outweighs any harm to the mother (Abrams, 2013). In legal cases, fetal consequentialism describes the judicial reasoning for denying claims brought against providers and hospitals when a healthy baby is born. Despite the apparent violation of Rinat Dray's bodily autonomy, the appellate court's decision to dismiss all of her charges against the hospital was based on the court view that the state had an interest in the fetus and there was no significant risk to the mother (NAPW, 2018), proving that forced interventions are legally acceptable and not a thing of the past.

Sawicki (2017) uses the term fetal consequentialism to describe situations in which health care providers "dismiss birthing mothers' informed requests for minimal invention during labor

and delivery in an effort to reduce the risk of fetal harm even when risk is minimal” (para. 2), violating what should be the mother’s autonomous decision. However, some physicians’ attitudes toward perceived risk are inconsistent as they tend to avoid medical intervention risks during pregnancy but medically intervene, despite the risks, during labor and delivery (Lyerly et al., 2009). Fetal consequentialism explains the underrepresentation of pregnant women in clinical research, leading to uncertainty in prescribing certain medications to pregnant women. Instances of the maternal-doctor conflict generally exist because of the prioritization of the fetus.

Unwarranted suspicion by the health care provider of a pregnant woman’s motive behind the decision to have a VBAC is harmful and problematic. Unless presented by evidence otherwise, the physician should view that mother as one who is making her decision with the baby’s well-being in mind, knowing that she will be most directly affected by any adverse outcome. However, should that not be the case and she does not adhere to expected maternal obligation, it should not be the health provider’s role to strip away her civil liberties by forcing a procedure upon her without her consent. When the medical community simplifies the conversation surrounding VBAC decision-making to only the balancing of objective risks and benefits, they discount the ethical relevance of negative consequences stemming from obstetrical coercion and mistreatment. The provider’s potential bias for the fetus, instances of obstetric violence shared in online forums, personal experience of trauma and mistreatment, and individual values and preferences all influence the mother’s decision-making process. Physicians tend to work on the assumption of the MFC, but it is a false construct that reflects professional prejudices and may do more harm than good, particularly within disproportionately impacted and under-resourced communities. Consequently, the MFC obscures the social and cultural contexts that physicians should consider ethically relevant to VBAC decision-making.

## 5.0 Decision-Making Process

In 2015, Jaimie scheduled a cesarean section for the breeched presentation of her firstborn. Although she wanted an unmedicated, low intervention birth experience, she hoped for gentle, family-centered cesarean delivery:

Unfortunately, much to my surprise, there was nothing gentle or family-centered about it. Without going into much detail, we did not get skin to skin in the OR, my baby was unnecessarily whisked to the nursery, and kept there hours past the time he stabilized simply because the doctor who needed to discharge him to me was unreachable. To top it off, all of my family got to meet my baby before I did. I was not the first to hold him. I was not the first to gaze into his eyes. It was, for lack of a better word, my worst nightmare. (Zaki, 2019, para. 4)

Jaimie's recovery was difficult, and she had to heal mentally, physically, and emotionally. When she was pregnant for the second time, she knew she wanted a VBAC. Communication with care providers and education about the birthing process helped Jaimie feel empowered and advocate for the VBAC she received. However, reflecting on the experience, Jaimie realized, as in her first birthing experience, many things bothered her about the birth of her second child:

But reflecting, I can't help but feel that if other things were in place that wouldn't have happened. For instance, I was not allowed to eat for the 22ish hours I was in the hospital in labor. I had no energy left after being awake for approximately 40 hours (36 of those

hours in labor). I was yelled at by one nurse for using the labor ball in the shower, even though it helped relieve my discomfort better than any other method we tried. (Zaki, 2019, para. 11)

Although her physician ultimately respected her decision to have a VBAC in the hospital, Jaimie felt that her physician imposed nonessential medications and contested every decision. During this pregnancy, Jaimie felt that she had to fight every step of the way, canceling appointments, ignoring phone calls, and having her husband advocate for her when the pressure was too great: “It hurt that I had to fight so hard. I had great support, but I never should have felt like I was in the fight of my life” (Zaki, 2019, para. 10).

After delivering her second child via VBAC at the hospital, Jaimie decided to have a home birth for her third pregnancy. Jaimie’s decision to deliver her third child via VBAC at home resulted from her two prior negative experiences and was both healing and empowering:

They were each so unique. But this home birth man... let me tell you, it healed things I didn’t know needed healing. It added a new depth of love for my husband that I didn’t know could exist. It added a new level of self worth I didn’t know I needed to achieve. I thought I was there. I though[t] I was healed. I knew I could birth vaginally.... But I finally had “it”... I had complete autonomy, felt 100% respected and unhindered. I never felt doubted. When I doubted myself, my support team believed in me even more. (Zaki, 2019, para. 16)

Jaimie's sentiment embodies the experiences of more than a thousand women who participated in an online questionnaire. Researchers summarized participant remarks concerning their birthing experience as "I had to fight for my VBAC," referring to the difficulty women had in finding the dual combination of a supportive physician and a hospital willing to provide care (Ibrahim, Knobf, Shorten et al., 2020, p. 3). Although studies suggest that nearly 50% of all pregnant women who have had a prior cesarean are interested in a VBAC option, only approximately 13% of them complete a subsequent VBAC (Osterman, 2020). One study found that 46% of the women who wanted to consider delivery via VBAC seriously were denied that option, primarily because of health reasons unrelated to cesarean, the unwillingness of their caregiver, and the unwillingness or inability of the hospital to approve the procedure (Declercq et al., 2013).

Jaimie's experience, and these studies, bring into question what it means for the mother to possess the autonomy to make, and then actually enact, her birthing choice. Some providers will not present VBAC as an option and pressure women into choosing a repeat cesarean because of perceived risk. Providers and hospitals that prevent women from attempting a vaginal birth convey delivery via a VBAC as a medical intervention rather than the likely physiological result of no assistance. For example, some women purposely labored at home as long as they possibly could, until they crowned, before going to the hospital, arriving too late for providers to perform a cesarean delivery (Ibrahim, Kennedy, & Whittemore, 2020). Autonomy, ensuring that there are options and respecting patient choice regarding intervention, means very little to women who have either been or feel forced to accept an unwanted procedure. Laboring at home to avoid an unwanted surgery is undoubtedly indicative of the mother's lack of trust in her medical providers.

National statistics do not record the number of women who undergo an elective repeat cesarean simply because they felt they had no other choice. Physicians may view the decision to have a VBAC or an “elective repeat cesarean delivery” as a purely autonomous decision, but physicians also often see this choice as one that has been made in a vacuum, and therefore, ignore the obstacles that pregnant women must navigate. When women choose to have a VBAC, regardless of medical advice, focusing on individualistic autonomy coupled with a lack of understanding of personal prior birthing experience’s impact on the mother allows some providers to make unnecessary moral judgments rather than consider the context in which that mother’s decision was reached.

This chapter explores how autonomy is used and misused in bioethics, concluding that relational theories more adequately capture the complexity of VBAC decision-making than individualistic conceptions of autonomy. Additionally, this chapter analyzes the impact of dismissive language in counseling, which acts as a barrier to VBAC and the individual, social, and systemic factors that promote access to VBAC. Finally, this chapter claims that the responsibility of the provider goes well beyond merely respecting patient autonomy and includes the requirement to understand the factors that impact the decision-making process to allow true provider advocacy for the best promotion and protection of women’s full inclusion in the birth process.

## **5.1 Autonomy in Decision-Making**

An *autonomous agent* has the ability to self-govern themselves; they possess the capacity to make decisions and the moral right to do so without interference from others. *Respect for autonomy*, one of four principles in bioethics, refers to the obligation of the provider to respect



medical decisions made by a patient who exhibits decision-making capacity. Traditionally, autonomy refers to a negative right that prevents providers from interfering in a patient's informed decision but does not consider external factors that may limit patient autonomy. As an alternative to paternalistic medicine, physicians have adopted the *informed consent process*, in which providers communicate the risks and benefits of a medical procedure to ensure patient autonomy. The narrow focus of consent as an expression of autonomy "ignores the ways in which health-care practices influence the development and demise of the capacity for personal autonomy" (Dodds, 2000, p. 214).

Childbirth is a complex process that can become emergent within minutes, making it difficult for women who have not discussed their options previously to give informed consent authentically. During her hospital VBAC, Jaimie pushed back against some of her physician recommendations. However, after 36 hours of labor, she was exhausted and not in the right state of mind to consider all of the risks. "Although it was my completely autonomous decision because of a long labor, I was administered medication I didn't want" (Zaki, 2019, para. 12). In this case, Jaimie's "informed consent" was not informed at all, but one obtained while Jaimie was in extreme pain and unable to make the most informed decision.

The concept of autonomy confirms the legal right of patients to accept or refuse treatment through the legal standard of informed consent, but it fails to acknowledge the patient's reliance on the physician to provide available treatment options and medical advice. If providers refuse to discuss VBAC as a viable option, pregnant women may feel that providers are making their decision for them. Further, the law historically has permitted bodily autonomy violations when rendering decisions for cases of maternal-fetal conflict, making pregnancy the exception to the rule. Rooted in Christian and Western ideals of individualism, autonomy places moral worth on

the individual who has “self-determination, self-awareness, self-interest, and self-reliance” (Gómez-Vírseda et al., 2019, p. 6). The creation of these normative standards leads to the presumption of an independent male patient and fails to account for the social pressure of maternal sacrifice and the distinct context of pregnancy, as discussed in Chapter Four.

### **5.1.1 Relational Autonomy**

Recently, bioethicists have begun to acknowledge the relational dimension of healthcare, and some, informed by feminist criticism, argue against an individualistic interpretation of autonomy in medical ethics. In genetic counseling, “treating a person’s consent as a decision of only one person, where medical professionals only provide non-directive guidance, does not begin to accommodate the complex and iterative ways in which such decisions are made in practice” (Dove et al., 2017, p. 160). Not only do most people not fit the ideal of living a self-sufficient, isolated, and utterly independent life, but also theories of autonomy devalue women’s experiences and ignore the fact that people live in a socially constructed world. Alternatively, the concept of *relational autonomy* is based on the premise that “persons are socially embedded and that agents’ identities are formed within the context of social relationships and shaped by a complex of intersecting social determinants, such as race, class, gender, and ethnicity” (Mackenzie & Stoljar, 2000, p. 4). Relational autonomy is an umbrella term for theories that challenge the original definition of autonomy and what is necessary and sufficient for autonomous decision-making.

Pregnant women are affected by individual, social, and systemic factors that influence medical decision-making relative to subsequent births following a cesarean. Each woman has her own individual experiences, values, and medical history, influencing her preference for a VBAC or repeat cesarean. The presence of supportive friends and family and the cultural importance of

vaginal birth impact these preferences. Systemic factors include hospital policy, provider preferences, and insurance coverage. At the center of decision-making is the physician-patient relationship and trust that patients place in their physicians to provide sound medical advice. As discussed in earlier chapters, physicians function within a historically paternalistic medical system, and some physicians treat Black and brown pregnant patients differently from all others, based on a long history of racist societal policies and viewpoints. Therefore, conceptualizing autonomy as relational recognizes the multiple and complex factors that influence a patient's preference regarding their delivery approach and the need to give serious consideration to the historical, social, and racial influences that impact medical decision-making.

Recognizing that the principles of individual autonomy and informed consent were generally designed for a patriarchal society, as one in which women are inherently groomed to be subordinate to men, feminists are critical of informed consent as able to ensure genuine autonomy for all patients (Stoljar, 2011). Thus, in addition to securing informed consent, healthcare providers are responsible for promoting patient autonomy and supporting informed decisions. Reducing structural barriers to VBAC is necessary at an institutional level, but every physician can promote patient autonomy through conscientious consideration of the relational and life factors that influence decision-making. It can be argued, based on birthing experience accounts, that many pregnant women view themselves as unable to exercise their autonomy and experience disrespectful language. My intention is not to imply that these women actually have less autonomy or outline the necessary conditions for authentic autonomy, instead I consider what providers can do to promote, to the mother, a concept of her autonomy that incorporates her personal values and preferences. Undoubtedly, many women resist medical authority, educating themselves and finding support online. Taking personal responsibility to be informed and engaged in medical

decision-making is essential for all patients; however, women should not feel that they have to fight to have their autonomy respected. Providers need to be honest about the risks and benefits of VBAC, and if there is no indication of severe complications for either mother or child, they should, without moral judgment, support pregnant women's decisions.

### **5.1.2 Maternalism**

Despite the usefulness of relational autonomy as an alternative to individual autonomy, some feminists have cautioned that relational autonomy, as a character ideal and paternalism-limiting concept, potentially implies that oppressed agents have less autonomy and that oppressed groups have to either choose well-being through self-subordination or choose opposition to oppression through self-sacrifice (Khader, 2020). Adopting a relational concept of patient autonomy need not imply that decisions influenced by external pressure are not autonomous and should be overridden. Instead, before entering the delivery room, a thorough discussion of what a “good” birth experience looks like, based on the woman's values and preferences and what options exist in emergent situations, will create a feeling of patient inclusion and mitigate paternalism. If women change their minds in the midst of labor or an unpredictable event occurs, providers who are aware of their patient's values can act in ways that would promote the preferences of their patients.

*Maternalism*, as an alternative to paternalism, addresses the conceptual implications of relational autonomy by considering how intervening in a person's decision can preserve or support a patient's autonomy. By definition, maternalism is “acting for the benefit of another person in a way that takes a person's autonomous agency into account” (Sullivan and Niker, 2018, p. 7). It differs from paternalistic intervention by requiring that the intervention must occur within the

important relationship of mutual trust and knowledge of the subject's attitudes and preferences. For instance, doulas work with women over time, making birth plans and advocating for the women's priorities during labor and delivery. Acting as support, doulas practice a form of maternalism that protects women's autonomy during birth. Unfortunately, not all women have access to a doula; therefore, it falls to the physicians who endorse maternalism to advocate for women's autonomy and improve birthing experiences.

## **5.2 Factors that Impact Decision-Making**

After having one cesarean, a hospital VBAC, and home birth, Jaimie became a doula to help women achieve “beautiful, empowering births, whether that is cesarean or vaginal, medicated or unmedicated” (Zaki, 2019, para. 8). Following her cesarean delivery, Jaimie struggled with postpartum depression, mental and emotional healing, and the physical effects of surgery. She fought hard to have a VBAC for her second delivery because she wanted a birth where she felt autonomous, both heard and respected. Finding a supportive provider and educating herself on birthing practices empowered her to push back on some medical recommendations. However, Jaimie was exhausted by how hard she had to fight. Pregnant for the third time, Jaimie decided she did not want to give birth in the hospital. She sought a midwife provider, but New Jersey law prevents midwives from overseeing a home birth after cesarean, resulting in her decision to birth at home without assistance:

I'm sharing this story to tell you that it is okay to be unhappy with your birth experience.

It is okay to work toward something “better”. It is okay to stand up and take risks. I'm not

saying you should birth unassisted. That's not right for everyone or every situation. What I am saying is that it is 100% possible to have a birth experience where you walk away feeling great. Where you walk away feeling autonomous and respected. Because ultimately, that's what we all want. A healthy baby and a healthy mama that were provided with the opportunity to exercise informed consent and make the decisions that are best for them without coercion or pressure. (Zaki, 2019, para 18)

The obstacles and support that Jaimie experienced correspond to an analysis of women's perceived barriers and facilitators to achieving VBAC, including individual, social, and systemic factors (Ibrahim, Kennedy, & Wittemore, 2020). The researchers considered women's lack of knowledge about their medical eligibility, perception of their body as broken or inadequate for childbirth, or concern about the loss of control, risk, and painful labor as individual barriers. On the other hand, personal factors that were perceived as facilitators were knowledge of physiological birth, a prior vaginal delivery, self-trust in the ability to have a vaginal birth, and expectation that vaginal birth has an easier recovery. As quoted by the researchers, a participant described her self-advocacy and determination as "unlike with my first pregnancy, I was educated about the different interventions and medications and was able to advocate for myself. I was confident and bold enough to say no when the doctor on call attempted to rush and intimidate me into breaking my water too early" (Ibrahim, Kennedy, & Whittemore, 2020, p. 357).

As with Jaimie, the social factors of a supportive family, a culture that supports and values vaginal birth, and the support of other women online helped facilitate VBAC access. Conversely, unsupportive health providers, institutional policies, and lack of financial resources act as systemic barriers to women interested in labor after cesarean. The threat of child protective services or a

court-ordered intervention, a de facto VBAC ban (no restrictive policy but no provider able to attend a VBAC), and the lack of VBAC friendly hospitals in their location intensify the perception of an unsupportive system. Alternatively, in countries with high VBAC rates, receiving information from a supportive clinician and receiving professional support from a calm and confident provider during birth are crucial for promoting vaginal birth after cesarean (Nilsson et al., 2017).

### **5.2.1 Restrictive Policy, Language, and Algorithms**

Language is important. The language utilized in documenting VBAC institutional and state policy can significantly impact access to a pregnant woman's preferred approach to birth. Some women may choose, like Jaimie, to deliver at home because of state midwife provider regulations, but others may feel uncomfortable birthing without assistance. Many women may not know what their options are at any given time or place as policies have changed through the years, varying by state and hospital, making it difficult for women to be aware of their options without outside information. Online support groups facilitate sharing experiences and knowledge, but access to such support depends on financial ability to have access to equipment and a network, online proficiency, and the ability to articulate traumatic events and share with others. Thus, women who do not have this technical capacity have little to no access to current outside information, and the documentation of restrictive national VBAC policy guidelines is problematic, potentially reducing their choices to the single option of cesarean. Historically, the VBAC rate has been married to policy and practice changes, with high VBAC rates occurring in the late 1980s and, as policy became more driven by risk avoidance, significantly declining in the late 1990s.

In 1999, the ACOG Bulletin documented the requirement of the “immediate availability” of physicians and emergency delivery capability changing from prior statements of “readily available.” While the language is not restrictive, the immediate availability standard has been adopted by some providers and institutions as restrictive even when hospitals meet the recommended criteria (Lyerly & Little, 2010). The consequence of the “immediate availability” language is that hospitals, professional providers, and insurance companies have chosen to utilize this language to justify opposing women seeking VBAC.

Lyerly and Little (2010) maintain that hospital policies conflate the restrictive, presumptively recommended, and non-directive guidelines because of over-reaching policies that quickly shifted from demanding all women attempt a trial of labor to complete VBAC bans. *Restrictive* guidelines indicate a treatment that would be unreasonable for providers to offer ethically, while *presumptively recommended* refers to evidence that favors one option over the other, but there are exceptions based on medical factors and personal values. *Non-directive* guidelines refer to options that are both equally reasonable and should be left to patient preference. In 2010, ACOG guidelines reflected a change from past policy and recommended, based on consistent scientific evidence, that most women are good candidates for TOLAC (Kamel, 2010). It is not just that the ACOG bulletin language is problematic. The way medical teaching, medical students, and medical professionals interpret recommendations should be examined.

While the 2010 ACOG guidelines lifted the “immediate availability” language to be less restrictive, women’s birthing experiences indicate that provider practices and institutional policy continue to be barriers. Restrictions surrounding VBAC undermine a pregnant woman’s ability to refuse treatment, creating the lived reality that an unwanted cesarean delivery is a requirement upon admission to the hospital. Even without restrictive policies, the language that care providers



use to counsel women for VBAC may imply that patient preferences will be ignored. De facto VBAC bans refer to hospitals that have no explicit policy but have no professional provider with the ability to provide VBAC support. Unfortunately, many women have had to be strategic and change providers when they learn that a “provider claimed to be supportive of VBAC, but then through their actions or policies revealed to be unsupportive,” otherwise known as a “bait and switch” behavior (Ibrahim, Knobf, Shorten et al., 2020, p. 8). Further, judgmental and dismissive language is alienating and may act as a deterrent against having a hospital birth.

The language by which providers discuss the success or failure of vaginal delivery is value-laden and reveals cultural and social norms of birth. Proponents of “natural” birth believe that birth is a physiological process, but there exist many different definitions of what counts as a low intervention birth. The impact of what birth should look like may support feelings of failure when experiences fail to meet expectations. Also, some feminists expressed concern about “cesarean deliveries on maternal request” as further medicalizing the birthing practice and normalizing cesarean delivery (Lyerly & Little, 2010). Regardless of whether a woman’s preference for a vaginal birth reflects normative beliefs, providers should avoid prescribing their assumptions as the “right” way to give birth and, preferably, focus on the patient’s expressed values.

Recommended by ACOG, the VBAC calculator is commonly used to aid providers in determining who is a “good” VBAC candidate by considering individual factors such as age, body mass index, race and ethnicity, previous vaginal delivery, and history of decent or dilation arrest. A recent study found that the Grobman 2007 model and Metz 2013 model were accurate only when the VBAC predicted “success” probability was greater than 60% (Harris et al., 2019). This means that women with calculated VBAC odds below 60% were likely to have been unnecessarily encouraged to have a cesarean delivery. Additionally, based on the Grobman 2007 VBAC

calculator, racial disparity is perpetuated, as a 30-year-old Black woman with one previous cesarean delivery due to arrest of dilation or descent and a BMI of 25 has a determined 44% probability of completing a VBAC without complication, whereas a white woman with the same individual factors is assigned a 61% probability (Vyas et al., 2019). As discussed in previous chapters, the inclusion of race in the VBAC calculator may lead physicians to disproportionately deny their Black patients the option of vaginal birth, regardless of other circumstances.

### **5.3 Promoting Autonomy**

Forced or coercive practices during birth are morally impermissible, and “even when restrictive guidelines are warranted, the rights of pregnant women to bodily integrity must be maintained” (Lyerly & Little, 2010, p. 10). While ensuring accurate, informed consent and respecting treatment refusal is necessary, reflecting on relational autonomy requires a greater commitment to promoting personal patient autonomy. Many women describe feelings of empowerment through their VBAC experiences, especially after a previous traumatic birthing experience (Francisco & Sanchez, 2017). As shown, ethical recommendations to promote autonomy by expanding options for vaginal or cesarean births available to women do not directly translate into enhancing women’s autonomy. Additionally, when confronted with a multitude of medically uncertain options without guidance, patients may experience a sense of abandonment (Lyerly & Little, 2010). The presumptive rhetoric of choice may disadvantage the women who face more social and systemic barriers; consequently, they are the most profoundly affected by coercive methods and restrictive policies.

Alternatively, thorough and supportive counseling is an essential tool in aiding pregnant women to recognize and articulate to their provider the birthing path they wish to follow. Pregnant women need to feel secure in making decisions and be assured that providers would not dismiss or disrespect them during birth. As the gatekeeper to information and expert knowledge, the physician has a duty to establish a mutually trusting physician-patient relationship. While online storytelling and support promote empowerment and self-advocacy, there exists individual patient information and support that only medical providers can provide. The narrative of profound distrust of the medical system due to a negative childbirth experience can prevent other pregnant women from seeking medical care when complications arise, leading to potentially adverse outcomes. Therefore, VBAC counseling should promote autonomy by supportively providing unbiased and adequate information relative to TOLAC and repeat cesarean since both are reasonable options for most women. Encouraging autonomy in VBAC decision-making requires a more nuanced understanding of the relational dimensions of autonomy. The first step to achieving that understanding is to realize that autonomy in general, but especially in maternal health, is embedded in a social context and influenced by gender and racial expectations. Respecting women's refusal of medical interventions, which continues despite the consensus against forced interventions, should be practiced by all providers.

#### **5.4 Tasha's Decision-Making Process**

This paper emphasizes the importance of storytelling by introducing several women's birthing narratives. Davis (2017) interviewed Black women for her ethnographic research because "women's own words are a legitimate source for knowledge production" (Davis, 2019, p. 23). As

presented in Chapter Two, Tasha's first highly medicalized birth experience directly impacted her decision to select VBAC for her second pregnancy. Tasha thoughtfully and painstakingly details her birth experiences to share her story with others. Her narrative echoes several women's emotional, mental, and physical experiences documented in this paper. However, the stories included represent a small fraction of the multitude that exist and are never told. While each is unique and personal, together, they call attention to the interactions of pregnant women with their providers. A seemingly brief and routine interaction with a physician may forever impact a patient and their attitude toward the health care system.

In 2012, Tasha arrived at the hospital, excited for the birth of her first child. Nothing happened as expected, and she was subject to several medical interventions, many of which she questioned:

During this time I was also being told by my nurse that due to my "high blood pressure" I would be started on an IV drip of magnesium sulfate. I was able to check into my nurse brain long enough to argue that my blood pressure could be high for many reasons (i.e. pain, two epidurals, and anxiety). I refused the IV and demanded them to test my urine for protein. I agreed to the IV Magnesium only if my urine was positive for protein. I quickly gave up the fight after my OB told my nurse over the phone that I needed to start the IV magnesium STAT! I remember feeling so tired, and worn out. (Tasha, 2015b, para. 10)

Under the weight of medical authority, Tasha was unable to refuse medical treatment. As a nurse, Tasha had some medical knowledge, but the physician's insistence limited her ability to advocate for herself.

Because fetal monitoring straps require women to stay confined to their beds, Tasha requested the removal of the fetal monitoring to sit up. She vocalized the need to stand up, but the nurse refused because she had an epidural. Although both epidurals failed to provide pain relief and Tasha could still feel sensation in her legs, the nurse was reluctant. Tasha (2015b) described her attempt to sit up: “I wanted to at least take the fetal monitor off and sit up. I felt like my body needed gravity to help me get my son down and out. Fetal heart tones were good, so I decided to sit up on my own, which made my nurse very uneasy” (para. 10). Likely Tasha’s physician and nurses would have respected an insistent refusal, but the fact Tasha had to fight so hard is indicative of the pressure put on pregnant women to accept any medical risks to protect the fetus.

Tasha (2015b) woke up with many questions that her physician never answered, including why certain medications were given and why her husband was unable to join her in the OR:

My OB left shortly after the surgery, and I was handed over to the care of the nurses and the OB on call. My recovery was difficult in the early days, I was in pain, sore, sedated, and showed mild signs of magnesium sulfate toxicity. My son spent the next five days in the hospital due to jaundice and labored breathing, but at discharge from the hospital was pretty healthy. (para. 12)

Months after the experience, Tasha still felt profound sadness and anger at the role her physician played. Assumptions of fetal consequentialism played into her emotional turmoil. She was supposed to feel happy over the birth of a healthy baby. New mothers are not allowed to express their frustration and grief. She had to process her emotional trauma alone and put on a brave face in public:

This was one of the most happiest times of my life! However, it was not! I grieved for what could have been, and what should have been. I was desperate to find answers to what was. I clearly remember being not only sad, but angry, and in denial about my emotions. I put on the perfect façade telling everyone who asked how I was doing that I was ok. I was really crumbling, and did not know where to turn without feeling judged or even more of a failure. I decided I should just suck it up. I had a healthy baby, and well meaning family and friends told me that is all that mattered. But, if that was the case why did I feel this way. I thought about my birth experience every single day. (Tasha, 2015b, para. 14)

Tasha (2015b) rescheduled several postpartum visits with her obstetrician, not wanting to see the person who “cut me open, stitched me up, and left me in the care of her colleague” (para. 15). She burst into tears when the physician asked how she was doing. All of her emotions about her experience came out, and instead of validating her feelings, her physician dismissed her concerns:

I opened up to her about my feelings regarding my birth experience and the role she played. She offered me a box of tissue, a referral to a counselor of her choice, and downplayed my PPD to “baby blues”. She assured me that this was “normal”, and to be “expected”. She assured me “it would get better”. I left that appointment feeling worse than I did going in. (Tasha, 2015b, para. 14)

Although Tasha does not focus on her experiences as a Black woman, it is a part of her story. Black women are more likely to have their pain and concerns dismissed by physicians. A negative experience like this erodes patient trust in the medical system, which may be difficult, perhaps impossible, to overcome.

Tasha's decision to have a VBAC was not a superficial preference for a vaginal birth. She feared repeating the trauma and pain, and her journey to VBAC was empowering and healing. Educating herself about birth options, finding support groups online, and building a team of people empowered Tasha (2015a) to advocate for the birth experience she wanted:

This entire experience was much different from my first birth experience. I was awake and immediately held my baby; my husband was able to cut his umbilical cord. Once I was upstairs in the bed, I had skin to skin and was able to breastfeed. I immediately drank fluids, I was able to have a few bites of soup, and I took an herbal bath with my baby. I spent the next 4-5 hours at the birth center for observation. My oldest son and mom later joined us, this was one of the best days of my life! (para. 10)

## 6.0 Conclusion

In conclusion, this paper shows that the decision-making process to deliver a child by the process of VBAC is an ethically complex and nuanced issue. The chosen narratives within the paper demonstrate the interconnection of systems and individual care, and I argue that maternal health providers have an opportunity to empower women to make informed medical decisions that reflect the mother's values and acknowledge her prior experiences. After the birth of a healthy child, women may feel compelled to keep silent about the pain and trauma of their experience. This paper intentionally focuses on women's experiences and the reasoning for their decision because their stories often go unheard. Bringing women's narrative experiences to the forefront of an ethical approach to labor after cesarean identifies pregnant women as experts on themselves and their experience.

Beginning with the history of medicalizing childbirth and reproductive injustices, this paper acknowledges the impact of the past on current obstetric practices. The implied and referenced MFC preserves historical expectations of maternal sacrifice and individual responsibility on the mother to prevent harm, supporting the view that pregnancy is inherently risky and requires surveillance. As demonstrated through the narratives, the ethical principle of respect for patient autonomy does not sufficiently promote pregnant women's autonomy. Additionally, medical algorithms and restrictive policies reduce lived experiences to statistical data points, perpetuating existing health disparities. Therefore, I argue that physicians must listen to the mother's lived experience of birth, good or bad, as an ethical practice and because it is critical to the mother's health.



The stories included in this paper do not represent all women's experiences with the medical system, including those who prefer repeat cesareans and those who had a negative experience with labor after cesarean. As mentioned in the paper, women report individual, social and systemic barriers to labor after cesarean. For society to reach full reproductive justice for all women, the commitment of institutions to the dismantling of harmful systems will be required. It is recognized that a genuinely well-meaning physician may work within an institution and medical system that participated in reproductive injustices or unethical policies, and as such, that physician's ability to address the mother's birthing needs may be limited. However, at the individual level, that physician has the ability to create a mutually trusting physician-patient relationship by simply asking and listening to the pregnant woman describe her prior birthing experiences. Listening to the lived experiences of women may reveal past trauma and inform the decision-making process. The ethical recommendation that providers should support informed decisions of labor after cesarean aligns with the reproductive justice framework.

In closing, this thesis has provided an ethical recommendation for physicians, given that some women identify as ignored and disrespected by providers. These physician-patient conversations may be difficult, and achieving a comfort level requires exposure and practice. Initiatives that expose medical students to ethical scenarios in obstetrics have the potential to prepare students, not only as future physicians in general but specifically as future physicians who consistently strive to create a solid physician-patient bond. For example, the University of Pittsburgh Medical School is piloting the OBGYN Ethics Telemedicine Simulation for medical students to practice delivering highly sensitive news via telemedicine. An ethics simulation, where the student has to counsel a woman with a prior cesarean on her birth options for a second pregnancy, could teach students how to navigate labor after cesarean counseling and the social,

cultural, and systemic factors involved. Creating a trusting relationship in which the patient feels comfortable sharing their story is critical in these scenarios. Providers who recognize the importance of the birthing narrative have the opportunity to restore mutual trust and respect in the physician-patient relationship.

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