The ACOG Standard on Vaginal Delivery After Cesarean: A Market Restraint Without Remedy?

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ACOG'S VAGINAL BIRTH AFTER CESAREAN STANDARD:

A MARKET RESTRAINT WITHOUT REMEDY?

[COMMENTARY]

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One of my patients who always planned to have a large family recently gave birth to her ninth child, and interestingly, this birth was her eighth consecutive uncomplicated VBAC. I shudder to think of what might have happened to her over the past 15 years had VBAC not been an option.1

I. INTRODUCTION

The two most prevalent surgical procedures in the United States today are abortion, at an estimated 1.3 million in 2001, and cesarean delivery, at just over one million in 2002.2 And while the focus here is on cesareans, their similarities should not go unnoticed. Abortions and cesareans share clinical, political and commercial convergence. Both are directed at women and birthing; one interrupts a natural process, the other completes a natural process in an unnatural way. They evoke controversy and spawn alliances of advocates and critics. Both are profitable. But while abortion is uninterruptedly conspicuous in American politics, the country’s record-high cesarean rate receives little attention in the lay press. The U.S. cesarean rate has risen from 5.5 percent in 1970 to 26.1 percent in 2002, the highest rate ever reported.3 The World Health Organization says there is no justification for any region in the world to have a cesarean rate more than 10-to-15 percent. At the same time the U.S. ranks twenty-eighth in infant mortality among industrialized nations.4 It ranks twenty-first in the world for maternal mortality, a death rate that has not decreased since 1982, and increased in 1999.5 The U.S. Center for Disease Control estimates that maternal deaths may be under-reported by one half to two thirds and that

4. Id. noting the U.S. ranks behind Cuba and the Czech Republic.
half of U.S. maternal deaths are preventable. This means the United States is one of the most dangerous places in the industrialized world to give birth.

A force behind the aggressive cesarean rate is the American College of Obstetrics and Gynecology (ACOG), described as "the largest trade union for obstetricians and gynecologists in the United States," and whose conduct is the subject of this paper. In late 2003 the ACOG Committee on Ethics issued a statement declaring elective cesareans to be "ethical," thereby providing its members with "an ethical pass to perform a procedure that is proven more dangerous to women and babies." ACOG acknowledged cesarean risk in a release summarizing the results of a study that found "a cesarean delivery significantly increased a woman's risk of experiencing a pregnancy-related death (35.9 deaths per 100,000 deliveries with a live-birth outcome) compared to a woman who delivered vaginally (9.2 deaths per 100,000)." The effort here is to reflect upon the commercial dimension of cesarean delivery, the impact of ACOG's behavior on the market, and whether anti-trust litigation might be a means to protect women and babies from harm.

Medical markets in the United States are conspicuous in their restraint. They have no parallel in the scale of official and unofficial interdiction into the affairs of private citizens interested in exchanging money for the promise of good health, restoration of function, or the cure of disease. The use of professional, corporate and political power to suppress and manipulate American medicine has been the subject of a number of books, usually written by physicians who have entered the Aesculapian temple, observed its inner workings, and emerged to inform the laity of what health economists have long known: profit maximization has approximately the same presence in health care as it does banking, auto sales, lawyering, and other market endeavors. A purpose here is to expose to legal scrutiny a restraint that currently deprives tens of thousands of women from giving birth vaginally after having undergone a cesarean section. The restraint has its genesis in a 1999 standard adopted by

6. Id.
8. Id. ICAN described the ethics statement as "frightening." Id.
9. Id. (quoting ACOG Committee on Ethics' July 2003 press release).
10. NATIONAL RIGHT TO LIFE, OVER 40 MILLION ABORTIONS IN U.S. SINCE 1973 http://www.hrlc.org/abortions/aboramt.html (last visited March 20, 2004). Estimates show that in each of the years of 1997 through 2001, some 1,328,000 abortions were performed in the United States. Id. (noting that "[e]xcept when noted, the following statistics are based on research by the Alan Guttmann research affiliate of Planned Parenthood Federation of America.").
ACOG in which the college emphasized the “need for those institutions offering VBAC [Vaginal Birth After Previous Cesarean] to have the facilities and personnel, including obstetric, anesthesia, and nursing personnel immediately available to perform emergency cesarean delivery when conducting a trial of labor for women with a prior uterine scar.”12 The standard was defined by ACOG as full attendance during the entire labor of a VBAC trial of labor by a physician capable of performing a cesarean.13 Predictably, independent practitioners shut down their VBAC practice because they could not treat patients in their clinic setting and simultaneously attend a VBAC patient at a community hospital.14 Reflect for a moment on how compliance with the standard serves the financial interests of both hospitals and OB/GYN specialists. Cesareans produce hospital revenues of $14,000 to $17,000 each, while vaginal deliveries produce $6,000 to $8,000 each. Additionally, the hospital stands to receive additional revenues because of the increased re-hospitalization rates related to cesarean delivery. As for the OB/GYN practice? Vaginal deliveries produce no surgical fees. The record-high cesarean rate is likely to become an abstraction for executives and physicians who observe its contribution to their bottom lines.

The practical effect of the standard has been to confer exclusive legitimacy for the performance of VBACs upon university and tertiary-level medical centers staffed by surgeons, anesthesiologists, and surgical teams. These islands of concentrated medical technology are not conveniently accessible to the overwhelming majority of women who desire a VBAC and wish not to return to the clinically-discredited era of “once-a-cesarean, always-a-cesarean.” The profit-and-loss practicalities of medical practice prevent specialists and family practice physicians from leaving their private clinics to attend at a community hospital the labor of women awaiting a VBAC. Women are thereby routinely dissuaded from the VBAC option. Only the determined are likely to undergo the travel, cost, and inconvenience of undergoing pre-natal care from her local physician, then giving birth at a distant medical center.

The VBAC controversy is a sub-part of the greater and long-standing cesarean rate controversy. Cesarean rates in the U.S. have been hovering in the 22-to-24% range over the past three decades, despite World Health Organization condemnation. Public health officials, women’s advocacy groups, insurers, and others have long criticized the high rate of surgical birthing in the United States. The literature is replete with assaults upon the integrity of physicians and hospitals responsible for what is viewed as self-serving financial and clinical

12. I CAN, CRITIQUE OF ACOG PRACTICE BULLETIN #5, JULY 9, 1999, “VAGINAL BIRTH AFTER PREVIOUS CESAREAN” [hereinafter VBAC]. It appears the college fully recognized the implications of the “immediate availability” language on markets with limited OB/GYN access areas, and that standard would serve as a barrier to VBACs by women and physicians who had mutuality regarding its performance. Id.
13. Id.
incentives for fueling indefensibly high cesarean rates.

This analysis suggests the following: (1) Critics of the U.S. cesarean section rate have the moral and scientific high ground in this debate; (2) Whereas market restraints are acknowledged for their infliction of economic harm, medical markets have the unique ability to inflict clinical harm, injury, and even death upon consumers; (3) The ACOG standard is illustrative of the capacity of a private organization, exercising peer authority, to impose upon the broader community mandates generally reserved to government; (4) The ACOG standard is instructive regarding how a group of sellers can exercise market power in the name of "safety," in this instance a disputed "patient safety"; (5) An anti-trust challenge of a hospital bylaw incorporating the standard would be measured against the judicial "rule of reason" test; (6) A consumer advocacy group, co-joined with one or more woman plaintiffs denied a VBAC in a community with otherwise comprehensive birthing services, would likely have legal standing to prosecute a civil antitrust lawsuit; (7) One or more family practice physicians may have standing to seek injunctive relief against a community hospital denying the performance of a VBAC, particularly in a location remote from a tertiary care medical center, and, finally, (8) It is improbable that a court would intervene in the private rule-making of ACOG, but it may enjoin a hospital from enforcing the standard over the protestation of a demanding patient, particularly she is a Medicaid patient. This commentary is limited to an anti-trust objection to the standard. The issue, however, deserves to be again considered within the context of a Medicaid challenge and the standard’s cost to the federal-state program, as well as its risks to Medicaid beneficiaries.

This paper was inspired by a professional report submitted by a graduate student, Julie Barto, the nurse-manager of an obstetrical and gynecological practice in an upper plains community of 110,000, with one competing OB/GYN practice, and two nonprofit community hospitals. She estimates the 2004 cesarean rate in her community to be thirty-six percent. Her research confirmed at a local level what the clinical literature has been reporting at the national level: a renewed controversy about the relative safety of vaginal birth after cesarean section and a corresponding rapid decline in the number of women currently experiencing VBACs. This trend reverses a pattern established in 1980 when the U.S. National Institute of Child Health and Human Development concluded that VBAC was "an appropriate option by which to decrease the increasing cesarean section rates," a finding subsequently supported by clinical research demonstrating its relative safety. This authoritative pronouncement was


enthusiastically embraced by practitioners, patients and third-party payers, resulting in the number of women who had successful VBAC in the United States increasing from 3.4 per 100 women in 1980 to a peak rate of 28.3 per 100 women in 1996.\textsuperscript{18} However, the VBAC rate has since fallen to 16.4 per 100 in 2001, a forty-two percent decrease.\textsuperscript{19}

Barto attributes the decrease in her community to the 1999 standard\textsuperscript{20} and its adoption by the community’s two hospitals.\textsuperscript{21} The community’s two OB/GYN practices, which serve approximately 185,000 women residing in an eighteen-county area, responded with policies that exclude the attendance of an elective VBAC.\textsuperscript{22} As a result, this population of women has been effectively deprived of the VBAC option, available to them from both OB/GYN and family physicians prior to adoption of the 1999 standard. They, like similarly-situated women across the nation, have been unwittingly returned to the “once-a-cesarean-always-a-cesarean” era.\textsuperscript{23}

The VBAC controversy has been exhaustively debated in medical and nursing journals. Its treatment, however, has been largely confined to clinical arguments and the discussion of research methodology. Consumer advocates for VBAC choice have been trumped by this relatively small, but clinically powerful, group of medical specialists. The ACOG “immediately available” standard is a stark illustration of how a practice guideline adopted by a private organization can profoundly restrict market access to a product or service. This restraint, embedded in the politics of the medical malpractice insurance crises, is of a magnitude normally reserved to governmental agencies in the exercise of legitimate police power. This paper hypothesizes that the standard has produced market restraints in violation of federal and state antitrust law. Further, it contemplates whether a woman, or a group of women, would have legal standing to successfully challenge a hospital that has incorporated the standard in its bylaws, thereby precluding reasonable access to a VBAC. It also considers whether an antitrust remedy might be available to family practice physicians who deliver babies but can no longer attend women with a prior cesarean

\textsuperscript{18} Id. (noting that “[b]oth obstetric care providers and women desiring an alternative to cesarean birth, as well as government and private insurance company payers, enthusiastically embraced VBAC-TOL;” “TOL” meaning “trial of labor”).

\textsuperscript{19} A literature search failed to locate published rates for 2002 and 2003. However, the Barto Report and the action taken in 2003 by the Sioux City hospitals suggests the rate may in 2004 be lower than the 16.4 per 100 rate reported in 2001.

\textsuperscript{20} AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, Practice Bulletin No. 5, VAGINAL BIRTH AFTER PREVIOUS CESAREAN DELIVERY (1999).

\textsuperscript{21} The hospitals are Mercy Medical Center and St. Luke’s Regional Medical Center, Sioux City, Iowa, both Level II trauma classified hospitals. Barto reports the standard was adopted by the governing boards of both hospitals on September 17, 2001, despite opposition by family practice physicians in the community.

\textsuperscript{22} Barto, Impact of Revised Policy on VBAC, supra note 14, at 8. “Before the 1999 revised VBAC guidelines were released by ACOG, family physicians throughout the service area successfully performed VBAC deliveries unattended by an OB/GYN. Under the new standards . . . attendance of the family physician responsible for monitoring the course of labor, but also an OB/GYN trained to perform cesarean sections.” Id. at 16.

\textsuperscript{23} Christoph Rageth et al., Delivery After Previous Cesarean: A Risk Evaluation, 93 OBSTETRICS & GYNECOLOGY 332 (1999). “Nonetheless, a trial of labor after previous cesarean is safe.” Id.
because a local hospital has adopted the standard. Collaterally, it speculates about the role of a professional liability insurance carrier that conditions coverage on a hospital's compliance with the standard.

It hypothesizes that the standard, when implemented by a community hospital, may constitute an impermissible restraint of trade when arising out of professional and economic self-interest, and may be subject to legal challenge by one or more women deprived of a clinically safer and less costly birthing alternative. Also, it is contended that affected family practice physicians may be capable of waging a successful legal challenge on anti-competitive grounds, bolstered by their academy's position that trial of labor after cesarean should be encouraged.24 The restraint is aggravated by incompatible financial incentives implicit in the ACOG standard, forcing community-based OB/GYN practitioners to deny the clinically safer and more convenient VBAC to their patients.25

Objections to the standard have been largely restricted to exchanges within clinical research circles. The literature is tempered with professional politeness. Women's advocacy groups, while more direct in their criticism of ACOG and its promotion of cesareans, appear to have been ineffective in stemming the overall cesarean rate. They might be better positioned to direct their resources toward litigation, to call into question the legality of a market behavior that subjects women and babies to unnecessary risk and death. Their arguments, however sound, articulate and persuasive in journals and newsletters, may be more effective in the pleadings and briefs of a lawsuit alleging unlawful market restraint, attempts to monopolize, conspiracy with medical centers, and abuse of power. A starting point: unmask cesarean's clinical layer, take Illich's suggestion regarding the de-mystification of medicine, and provide the court with a financial report.

II. THE CESAREAN MARKET AND PROFIT

"In the U.S. the hospital delivery charge for a cesarean section is 130% higher than a normal vaginal delivery . . . .26 In 1998 mean charges for a cesarean section were $7,201 for the mother, and $4,819 for the baby, compared to normal vaginal delivery charges of $3,277 for mother, and $1,949, for the baby.27 Assuming the same charge spread in 2004, the commercial value of the

24. AMERICAN ACADEMY OF FAMILY PHYSICIANS, TRIAL OF LABOR VERSUS ELECTIVE REPEAT CESAREAN SECTION FOR THE WOMAN WITH A PREVIOUS CESAREAN SECTION (2001) (proposing the following standard: "The woman should be offered the opportunity throughout the pregnancy to discuss the various management options and their expected outcomes, including costs.").

25. Id. BARTO, supra note 14, at 16-17 ("A family physician is unwilling to fully attend a patient's labor with the possibility that the obstetrician will deliver the patient by cesarean . . . . The obstetrician is unwilling to fully attend a patient's labor only to have the family physician deliver her vaginally. Physicians are compensated for the delivery, not for the time attending the labor.").


27. Id. (citing HEALTH CARE INVESTMENT ANALYSTS, 1998 DATA (1998)). Note: A five-year annualized market basket inflation adjustment of 4.5 percent produces a mean combined charge of $14,585 for a cesarean section in a U.S. hospital in 2004. It is assumed vaginal delivery has experienced the same inflation; hence the 130 percent charge differential between cesarean and vaginal delivery is
record-high cesarean rate, when compared to World Health Organization guidelines, can be demonstrated to serve the financial interests of hospitals that choose to adopt the ACOG standard. The birthing market is overwhelmingly fee-for-service; hence, the increased length of stay required by cesarean produces additional revenues. Additional profits are gleaned from the higher rate of re-hospitalization related to surgical delivery. In one study “researchers used data from 256,795 delivery records of mothers who delivered a single live infant, and found that a total of 3,149 women, [or 1.2 percent] were re-hospitalized within 60 days” of cesarean delivery. They observed that women with cesareans were nearly twice as likely to be re-hospitalized than women who had spontaneous delivery.

The cost consequences of routine elective cesarean delivery for a second birth are significant. Chicago researchers estimated that over the reproductive life of 100,000 women there will be 117,748 cesarean deliveries and 5,500 maternal morbid events, at a cost of $179 million dollars. It is worth remembering that a costly healthcare transaction is disappointing only to the buyer; it is hardly disappointing to the physician-hospital that sells the service and records the sale.

Continued growth in the cesarean market affirms the influence exercised by physicians over their pregnant patients vis-à-vis the influence exercised by non-physicians. For example, The Coalition for Improving Maternity Services (CIMS) warns of the hazards of cesarean, reciting that “(a) [w]omen run five to seven times the risk of death with cesarean section compared to vaginal birth;” complications during and after the surgery include surgical injury to the bladder, uterus and blood vessels; “(c) [o]ne in ten women report difficulties with normal activities two months after birth;” “(d) “[t]wice as many women require re-hospitalization as women having normal vaginal birth;” and (e) “[r]eproductive consequences compared with vaginal birth include increased infertility, miscarriage, [and] placenta previa.”

used for current comparison purposes. Id.

28. Id. (citing M. Lyndon-Rochelle et al., Association Between Method of Delivery and Maternal Re-Hospitalization 283, J. AM. MED. ASS’N. 2411-416 (2000)).
29. Id. (citing M. Lyndon-Rochelle et al., Association Between Method of Delivery and Maternal Re-Hospitalization 283, J. AM. MED. ASS’N. 2411-416 (2000)).
32. COALITION FOR IMPROVING MATERNITY SERVICES, The Risks of Cesarean Delivery to Mother and Baby: ACIMS Fact Sheet, (n.d.) (citing E.L. Shearer, Cesarean Section: Medical Benefits and Costs, 37(10) SOC’Y SCI. MED. 1223-31(1993)).
33. COALITION FOR IMPROVING MATERNITY SERVICES, The Risks of Cesarean Delivery to Mother and Baby: ACIMS Fact Sheet, (n.d.) (citing S.M. Miovich et al., Major Concerns of Women after Cesarean Delivery, 23(1) J. OBSTETRICS, GYNECOLOGY & NEONATAL NURSING, 53-9 (1994)).
35. COALITION FOR IMPROVING MATERNITY SERVICES, The Risks of Cesarean Delivery to Mother
CIMS states that "[e]specially with planned cesarean," some babies will inadvertently be delivered prematurely,"36 "that one to two babies per 100 will be cut during the surgery;"37 that compared to vaginal birth, babies delivered by elective cesarean "are 50% more likely to have low Apgar scores, [five] times more likely to require assistance with breathing, and [five] times more likely to be admitted to an intermediate or intensive care."38

Most relevant to this commentary are the hazards of elective repeat cesareans. CIMS asserts that "[e]lective cesarean section carries twice the risk of maternal death compared with vaginal birth";39 "old scar tissue increases the likelihood of surgical injury"; "one or more out of 100 women with a history of more than one cesarean will have an ectopic pregnancy . . ."40 which is associated with hemorrhage, "one of the leading causes of maternal death in the [United States]." The odds of placenta accreta, when the placenta grows into the uterus, increases from one in 1,000 to one in 100,41 noting that nearly all women with this complication will require a hysterectomy, nearly half will have a massive hemorrhage, and as many as one in 11 babies and one in 14 mothers will die."42

III. MOTHERS AS CONFUSED CONSUMERS

The VBAC controversy has created uncertainty among American women. The following question presented to women’s health website is illustrative:

I keep hearing different information on whether it is safe for a woman to have a vaginal delivery after cesarean section. For some time, [sic] I thought that this was the recommendation of most physicians. Yet new reports suggest that it may not be such a good idea after all. What’s the safest alternative?43


40. Id. (citing E. Hemminki & J. Merilainen, Long-Term Effects of Cesarean Sections: Ectopic Pregnancies and Placental Problems, AM. J. OBSTETRICS AND GYNECOLOGY 1569-74 (1996)).

41. Id. (citing H. Asakura & S.A. Myers, More Than One Previous Cesarean Delivery: A Five-year Experience with 435 Patients, 85(b) OBSTETRICS & GYNECOLOGY 924-29 (1995)).


The answer was found in the numbers, stating that the risk of uterine rupture during a VBAC ranges from 1.6 per 1,000 deliveries to 24.5 per 1,000 deliveries, noting, however, that "[t]hose at the highest risk were women for whom labor was induced with prostaglandins . . . ." Risk levels for women with a spontaneous onset of labor or induced without prostaglandins were reported at 5.2 to 7.7 ruptures per 1,000 deliveries. Noting that VBAC seemed to be a potentially healthy and more economical alternative than returning to the “adage of once a c-section, always a c-section,” the writer pointed out that while the United States has one of the highest c-section rates in the world, it ranks fifteenth in perinatal child mortality.

The relative safety of VBAC when contrasted with repeat cesareans is prevalent in the literature. The following excerpt is typical:

There are many benefits of vaginal delivery, for both mother and baby. During a vaginal delivery the amniotic fluid is squeezed from the baby’s lungs, making it easier for him or her to breathe. This does not happen as much during c/section. Furthermore, it is a misconception that c/section is always safer for babies than vaginal delivery. Scalpel injuries and trauma to babies during c/section, although rare, can certainly occur. In most cases vaginal deliveries are safer for mothers than c/sections, with some medical studies indicating that the chance of death for a mother is [seven] times higher when delivered by c/section versus vaginally. Contrary to popular belief, a c/section is a ‘major’ operation, not unlike a hysterectomy in [its] complexity and potential complications! These complications may include infection, hemorrhage, scar tissue formation (which may produce lifelong abdominal or pelvic pain), anesthesia complications, opening of the skin incision leading to a very large scar, damage to the bladder or intestines, and the formation of blood clots within blood vessels or the lungs.

Robertson, citing research establishing the association between uterine rupture and induction of labor with prostaglandins, held out the hope that its conclusions would likely cause “some physicians to reconsider their actions.” His optimism is not supported by history. A 1984 study by two Chicago obstetricians estimated that the number of cesareans in the U.S. could be halved, pointing out that “[in] 1984, 21.1% of the nation’s 3.7 million deliveries were by Cesarean section”, more than a 400% increase since 1965. One of its authors, after dismissing the fear of lawsuits as being a convenient excuse for the high cesarean section rate, observed, “[t]he bottom line . . . is that a Cesarean is often much easier for an obstetrician. They don’t have to stay up all night waiting.”

44. Id.
45. Id.
46. Id.
49. CLARK C. HAVINGHURST, HEALTH CARE LAW & POLICY 48 (The Foundation Press, Inc. 1988).
50. Id. at 49 (quoting Dr. Stephen A. Myers of Mt. Sinai Hospital, Chicago, who said “the biggest
Now, twenty years later it is rare for obstetricians to stay up all night. Conveyor belt birthing protocols, with induction, is the rule. Mother Nature is replaced by a “pit-drip” pump as the initiator of the birthing process. The International Cesarean Awareness Network, Inc., (ICAN) a women’s advocacy group, is one voice of protest. In a white paper, it “advises women and health care practitioners to avoid induction of labor unless a true medical indication exists,” stating further, “[i]nduction of labor frequently leads to further intervention in birth including the need for fetal monitoring, epidural anesthesia, instrumental delivery and cesarean section.” ICAN informs women that: (1) “[f]irst time mothers are especially vulnerable,” noting that “[i]nduction itself doubles a first-time mother’s risk of having a cesarean section,” and “[a] cesarean puts a woman’s entire reproductive life, including subsequent pregnancies, at higher risk;” (2) “[f]or all women, induction of labor increases the use of forces and vacuum extraction as well as rates of shoulder dystocia;” (3) “[w]omen with a prior cesarean who are induced have a 33 to 75 percent risk of having another cesarean;” (4) “[i]nduction of labor has been shown to increase the risk of uterine rupture for women with a prior cesarean scar,” and (5)”[b]abies whose births are induced” are more likely to “experience resuscitation, admission to the intensive care unit, and phototherapy to treat jaundice, which generally requires separation from the mother.”

A prospective multi-center comparison of outcomes of 7,229 study patients who attempted trial of labor and those who underwent elective repeat cesarean concluded that “[l]abor after previous cesarean delivery has a 75 percent success rate, with a risk of uterine rupture of less than one percent.”

The study, issued in 1994, reported that cesarean delivery had been the most frequently performed major operation in the United States each year for the previous nine years, citing data from the National Center for Health Statistics indicating that there were almost one million cesarean deliveries performed in 1990. “It estimated that 48% of the rise in the cesarean rate between 1980 and 1985 was due to repeat cesarean births.”

IV. THE MORAL, CLINICAL HIGH GROUND

The surgical removal of a baby from the womb of its mother is an act that exudes deep philosophical and cultural conflict. It is emblematic of a belief
chasm between those who embrace allopathic-dominated western medicine and those who view its technology as financially and clinically exploitive. Such intervention into birthing is met with hostility by the likes of Ivan Illich and health advocates for women. Intervention begets intervention. Cesareans beget cesareans. They object to the locus of decision-making, seeing wall-to-wall conflicts of interest on the part of specialists and medical center executives who promulgate standards for the express purpose of collusive profit enhancement. In a fee-for-service market they are its fiscal beneficiaries. Arguably, it is illustrative of Illich`s contention that:

A professional and physician-based healthcare system that has grown beyond critical bounds is sickening for three reasons: it must produce clinical damage that outweighs its potential benefits; it cannot but enhance even as it obscures the political conditions that render society healthy; and it tends to mystify and to expropriate the power of the individual to heal himself and to shape his or her environment.

The one-out-of-four-or-greater rate of surgical delivery buttresses his assertion that `Contemporary medical systems have outgrown these tolerable bounds... [and that] [t]he medical and paramedical monopoly over hygienic methodology and technology is a glaring example of the political misuse of scientific achievement to strengthen industrial rather than personal growth.`

Illich`s non-technical use of the term `monopoly` may find legal substance in an analysis of ACOG`s behavior; standard-setting by a group of medical elitists, independent of other legitimate stakeholders. Arguably, its contribution to the proliferation of surgical delivery is the quintessential misuse of scientific achievement. But is the resulting market restraint, when tested against the rule of reason and balancing its pro-competitive and anti-competitive effects, unlawful? Can ACOG be held legally accountable for the ramifications of its purely internal promulgations? Or, should its restraints be attacked at the situs of their enforcement, within hospital and medical staff bylaws? Or, should they be confronted at a collateral source, within the risk-management criteria of insurance carriers that underwrite professional liability risk for hospitals and physicians?

Attack strategies presuppose a substantive target. A court is unlikely to entertain litigation directed at restraints that are not extractable from the stream of constraints common to organized healthcare delivery. It must first be oriented

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55. IVAN ILLICH, MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH 13-14 (Random House 1976) (contending that improvement in the health status of western societies and the mutation of sickness `are dependent variables of political and technological transformations, which in turn are reflected in what doctors do and say; they are not significantly related to the activities that require the preparation, status, and costly equipment in which the health professions take pride`).

56. Bruce L. Flamm et al., Vaginal Birth After Cesarean Delivery: Results of a 5-Year Multicenter Collaborative Study, 76 OBSTETRICS & GYNECOLOGY 750 (1990). `Analysis of national statistics revealed that 48% of the rise in the cesarean rate between 1980-1985 was due to repeat cesarean births. More than one-third of all cesarean operations are performed because of a history of previous cesarean delivery.` Id.

57. ILLICH, supra note 55, at 9.

58. Id.
to the subtleties of private rule-making and its potential for the suppression of competition and consumer choice. Also, a court must be persuaded it has the capacity to referee a medical controversy and reach conclusions that courts routinely reach in adjudicating disputes over the sale of timber, or pre-owned automobiles, insurance or accounting services. Courts, like the lay citizenry, are inclined to succumb to the "mystification" of medicine, in what has been referred to as "The Medicalization of Judicial Decision-Making."\textsuperscript{59} At the risk of extraneousness, claimants may wish to reiterate some observations made by the 18th century philosophers about human self-interest and power,\textsuperscript{60} and more recently by a pair of Harvard Business School professors contending that humans have four brain-based drives: (1) to acquire, (2) to defend, (3) to bond, and (4) to learn.\textsuperscript{61} The suggestion is that physicians, and in this instance members of the American College of Obstetricians and Gynecology, possess the same brain-based drives as all humans in their effort to carve out a livelihood on this earth.\textsuperscript{62}

V. HARM TO MOTHERS, BABIES

Anti-trust law is primarily concerned with economic harm. It seeks to moderate the financial exploitation that accompanies market power. Its enforcement has two objectives: (1) to strip sellers of unreasonable profits realized through the unlawful exercise of market power, and (2) to protect buyers from being assessed costs disproportionate to the value of a good or service in a competitive market. Here the sellers are physicians who are board-certified in the practice of obstetrics and gynecology. The affected buyers are women eligible for and desiring a VBAC. The best-positioned plaintiff—for legal standing purposes—would be a woman who desired a VBAC in a community whose hospital or hospitals had adopted the ACOG standard, effectively denying her a VBAC, and whose cesarean birth resulted in harm to herself or her baby. Demonstrable evidence of actual injury would bolster allegations that the standard, when enforced by hospitals, is inimical to society's interest in

\textsuperscript{59} Paul S. Appelbaum, \textit{The Medicalization of Judicial Decision-Making}, \textit{in} Elder Law Readings, Cases and Materials 89 (2d ed., 2003). Appelbaum argues that questions of moral competence is a legal matter, not a medical matter. \textit{Id.} at 90. Similarly, it is argued here that courts should be as wary of self-interest in the sale of cesarean sections as they would be of the sale of securities or pre-owned BMWs. \textit{Id.}

\textsuperscript{60} Donald W. Light, \textit{Is Competition Bad?}, 309 New Eng. J. Med. 1315 (1983). The author suggested that certain 18th century philosophers provided insight into the conduct of modern-day professionals, specifically physicians, stating: Montesquieu agreed with Hobbes that "every man who has power tends to about that power; he will go up to the point where he meets with barriers." Precisely for that reason, Montesquieu argued vigorously for the competition that commerce brings; for as each man pursues his interest he will be a countervailing force to others. \textit{Id.} at 1316.


\textsuperscript{62} Robert L. Heilbroner, \textit{The Worldly Philosophers: The Lives, Times, and Ideas of the Great Economic Thinkers} 18 (7th Ed., 1999) "Since he came down from the trees, man has faced the problem of survival. . . . It is hard to wring a livelihood from the surface of this planet." \textit{Id.}
promoting natal-related health of mothers and babies.

A tandem legal assault—coupling a cause of action for personal harm to mother and child with a conventional anti-trust claim—would depict the multi-dimensional harm caused by the standard. The notion of exposing mothers and infants to needless personal injury, lifelong debilitation, and death for professional and economic gain is likely to incite a court to apply “the spirit and habit of fairness, justness, and right dealing which would regulate the intercourse of men with men.”63 The standard offers policymakers a “perfect-storm” illustration of the contagiousness of private medical rule-making within a risk-management environment preoccupied with protecting the industry from liability for its mistakes.

VI. NEW ENGLAND JOURNAL OF MEDICINE

The July 5, 2001, issue of the New England Journal of Medicine contained a study and an accompanying editorial that focused international media attention on the VBAC issue and “set off a flurry of activity on internet sites and in doctor’s offices all over the world.”64

The headlines suggested that new research supported repeat cesareans over VBAC, causing a number of physicians to opine that repeat cesareans were as safe or safer than vaginal birth. Less attention was paid to subsequent attacks on both the study and the Journal editorial, written by Michael E. Greene, M.D. The study contained “little new or groundbreaking-information and relied on questionable data collection.”65 “But take a closer look,” wrote Jill MacCorkle, contending that overuse of medical intervention in childbirth has transformed ordinary vaginal birth into major surgery and arguing that “A careful critique exposes the limitations of the current medical model of childbirth and questions whether the model holds any credibility for women.”66

Dr. Flamm observed, “The amazing thing about the uproar surrounding this study’s publication is that it was ignited, not by the study itself, but by a strongly-worded editorial that accompanied it.” He concluded, “Strangely, the profound conclusions espoused in the editorial had little if anything to do with the results of the study.”67 He emphasized that, “Even the charts of the 91

66. Id.
67. Id. Flamm notes:
There was obviously no way for the authors to know if they were dealing with uterine ruptures, inadvertent dehiscences, or even coding errors. All they did know for certain was that someone, most likely a secretary or clerk in a medical records department, had include a code 665.0 or 665.1 on the list of discharge costs,” adding, “It is absolutely essential to stress that no hospital charts or medical records were actually reviewed in this study.”
women believed to have experienced uterine rupture, the very focus of this study, were apparently not available for review.""

MacCorkle, the mother of two, one delivered by cesarean and the second vaginally at home, and the editor of The Clarion, the newsletter of the International Cesarean Awareness Network, was more forceful in her criticism of the Lydon-Rochelle study and the New England Journal's editorial: "It is certainly not newsworthy to find that elective repeat cesarean does not completely protect a woman from the risk of rupture. It is the prior cesarean, not the VBAC, that exposes mother and baby to the risk of uterine rupture. Physicians know well that cesareans cast a long shadow over the rest of a woman's reproductive life."

VII. THE LAWYERS MADE US DO IT!

An ACOG bulletin cites lawsuits as a major factor in approaching VBAC with more caution. The "lawyers-made-us-do-it" rationale for performing medically unneeded services is embedded in the physician psyche, even though it is by its very essence a breach of medical ethics. The physician-patient fiduciary relationship requires that the physician-as-fiduciary act in the best interest of the patient, even if it contrary to the physician's best interest. By definition, care given for the primary purpose of protecting oneself against legal liability is a breach of the duty of trust owed by a physician to a patient. The ACOG standard thereby constitutes a collective breach of fiduciary duty because it subordinates the welfare of patients seeking VBACS to the welfare of ACOG's membership. MacCorkle states it another way:

ACOG exists to protect and advance the interests of its surgeon members, with the health of women and infants an important, but secondary, goal. With the current president of ACOG an admitted advocate of primary elective cesarean surgery without medical indication, it's little wonder that the pendulum of obstetric opinion in the US is swinging back toward more medicalization of birth and more unnecessary surgical delivery of babies.

Section 1 of the Sherman Act prohibits "every contract, combination... or conspiracy, in the restraint of trade or commerce among the several states." An antitrust challenge of the ACOG standard must be accommodated by this language and its judicial interpretation. Accordingly, is ACOG engaged in trade or commerce? Or, if the action was brought against a community hospital, is it engaged in trade or commerce? The antitrust challenge to professionalism has been well established. The U.S. Supreme Court has during the past three


68. MacCorkle, supra note 63 (reinforcing the numbers when stating: "yet the cesarean rate reached 22.9 percent in 2000, an 11 percent increase over the previous four years and the highest rate reported since 1989").

69. Id.


decades extended Sherman’s reach to the learned professions, despite their contention that “competition is inconsistent with the practice of a profession because enhancing profit is not the goal of professional activities.” A 26.1 percent cesarean rate does produce profit, but profitability, even at extreme levels, is not evidence of a Sherman Act violation. The plaintiff will have the burden of establishing causation between the standard, its adoption by hospitals, and the reduced number of VBACs performed within a selected geographic market.

Markets across the country are recording high rates, with the highest clustered in the south and along the east coast. Mississippi’s rate is 31.1 percent; Louisiana’s, 30.4 percent; Arkansas’, 29.1 percent, and Alabama’s, 28.7 percent. New Jersey reports a cesarean rate of 30.9 percent. Puerto Rico’s rate in 2002 was an astounding 44.7 percent.

VIII. CONCLUSION

Somewhere in the recesses of a first year law school there emerged a tenet of Leibnitz optimism: “For every wrong there is a remedy.” The implication was that within the U.S. judicial system there exists a remedy for substantive wrongs, like the one here, where the abuse of power by medical elitists who in their pursuit of economic gain and convenience inflict unnecessary harm and death upon trusting patient-wards and their babies. A good lawyer and good research, it was thought, would produce a litigious attack capable of enjoining such a wrong. The law practice, however, soon delivers the tenet of reality: judicial remedies are available for a relatively narrow band of wrongs that people daily inflict upon each other.

This commentary, then, examines the law in search of a remedy for the women activists who rail against what they see as an assault upon the integrity and well-being of motherhood. Its working hypothesis is centered on demonstrated market restraint resulting from the 1999 ACOG standard requiring unprecedented and often impractical caution in attending a vaginal delivery by a woman who had previously undergone a cesarean. The college seizes upon and exploits the risk of uterine rupture associated with vaginal delivery, while understating the greater risk of surgical delivery. A legal attack on the standard should begin with an unmasking of the distorted “safety” rationale used by ACOG. The clinical evidence, if properly presented, should be sufficient to persuade a court to overcome its judicial aversion to disturbing conclusions reached by physician-priests within the Aesculapian temple. It can be argued that in this case the ACOG temple has functioned more like a union hall or corporate board room, and has used the pretext of safety to impose economic insults upon the market.

72. Id. at 563.
74. See supra notes 29-36 and accompanying text.