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CESAREAN NATION

A movement to discourage mothers who have had C-sections from going back to vaginal birth alarms many women and childbirth experts

By Kathryn Mora

When Jennifer Leidig, at eight months pregnant, was told her doctor's practice no longer supported allowing women to have vaginal births after cesarean sections because they "question the safety of Saratoga Hospital for VBAC," she felt betrayed: "How could they take such an important decision away from me and how could they not act in my best interest?" she wondered.

While awaiting the birth of her second child, due late in June or early July, Leidig felt a sense of elation until she received the telephone call, informing her of the news, two weeks ago. Now, she is faced with either scheduling another cesarean to give birth to her child or with trying to find a new medical provider and hospital that offers the VBAC option.

"Had I known then that opting for a C-section might prohibit me from ever having a vaginal birth in the future, I am not quite sure I would have made the same decision," says Leidig. "I believe that doctors who previously advised their patients that a vaginal birth after C-section was possible have a moral and medical responsibility to carry through with their promises."

While working on her doctoral dissertation at the University of Albany in humanities, with specialties in philosophy and women's studies, Leidig took classes in the history of women's medicine, an enlightening experience for her.

In her women's studies class, Leidig learned that men have made medical decisions for women through the years, not always in women's best interests. Although women have fought hard to gain control over their bodies and to do what is best for them and their families, for the most part, women have been without a voice when it comes to their reproductive organs.

"It's all too easy to allow insurance companies, doctors and hospitals to make women's health decisions," says Leidig. "The unwavering bottom line is they do not have the right to make these decisions for us."

Numerous community hospitals no longer provide VBAC services, although eight months ago, most still did.

There has been significant media frenzy in response to recent VBAC studies that claim the procedure threatens women's reproductive health. However, critics question both the methodology of the studies and the interpretation of the results by the media. Most controversial is an article about a nine-year-long University of Washington study, completed by Dr. Mona Lydon-Rochelle, a senior research fellow in the Department of Family and Child Nursing at the university, and her colleagues. The article appeared in the prestigious *New England Journal of Medicine* on July 5, 2001, under the title "Risk of the Uterine Rupture During Labor Among Women With a Prior Cesarean Delivery." The article was accompanied by a scathing anti-VBAC editorial by Dr. Michael F. Greene, an obstetrician and director of maternal/fetal medicine at Massachusetts General Hospital in Boston.

Leidig, who has been a resident of Saratoga Springs for 14 years, gave birth to her daughter, Katya, at Saratoga Hospital by cesarean section four years ago because the baby was in a breech position. Had she realized then that she might be giving up the choice to have a vaginal birth with her next baby, she would have at least considered an alternate procedure that might have turned her baby around. However, she was advised by her doctors that having a cesarean would not have any bearing on her future births.

"I can't promise for sure I would have made the same decision about not having the procedure to turn my baby around four years ago, but I do feel that because I made the decision on the advice of my doctors, they owe me a VBAC," says Liedig. "They have a certain responsibility to patients they formerly advise."

According to Henci Goer, an award-winning medical writer and a former childbirth educator from San Jose, Calif., "The main fear with labor during a VBAC is that the C-section scar will open enough to cause bleeding, or that the umbilical cord or the baby will pass through the opening. In 30 studies, totaling 56,300 VBACs, the rate of this kind of scar separation was 4 per 1,000 VBAC births. The few instances when this did occur and resulted in harm to a baby is the real issue. However, the perinatal mortality rate [stillbirths and newborn deaths combined] was 3 per 10,000—not much different than the perinatal mortality rate of 2 per 10,000 in 29,900 planned cesareans."

Within a handful of months after the Lydon-Rochelle article and editorial was published in the *New England Journal of Medicine*, many doctors and community hospitals across the United States, including Glens Falls Hospital in Glens Falls, stopped supporting any vaginal births after cesareans. Saratoga Hospital in Saratoga Springs is in the process of evaluating its fiscal and medical capability to continue to provide VBAC services, according to Tisha Graham, the hospital's childbirth educator. Meanwhile, both local obstetric practices affiliated with the hospital are no longer offering VBACs.

"A few hospitals which have banned VBACs view labor after a prior cesarean as a risky 'elective procedure,'" says Nicette Jukelevics, childbirth educator and presenter at the International Childbirth Education Association and at Lamaze International conferences. "They have determined that it's in their patients' best interest to schedule a repeat [cesarean] operation. Some hospitals say they are not equipped to provide an emergency cesarean quickly enough to comply with the current VBAC safety guidelines recommended by the American College and Obstetricians and Gynecologists [ACOG]."

It is interesting to note that the ACOG recommendations were issued in July 1999; almost three years passed before community hospitals and doctors stopped supporting women who wanted a vaginal birth after cesarean. However, within months after the article and editorial regarding the Lydon-Rochelle study was published in July 2001, many community hospitals and doctors began discontinuing VBAC support. And more continue to follow.

Mother Knows Best

An Interview of Carolyn Keefe
Photo by Andrea Sally Fischman

Carolyn Keefe, a cofounder of BirthNet, a Capital Region organization that informs the community about maternity care in order to improve it, is concerned that ACOG is not getting input from other maternity specialists in the medical community. "ACOG recommendations came out regarding VBACs without any apparent consultations with the family practitioners, osteopaths, anesthesiologists, nurses, hospital administrators and medical insurance companies," says Keefe. "It seems that in many cases, obstetricians are making all the decisions for consumers about VBACs and leaving consumers with few choices. Nor are they consulting other participants in the maternity system, most notable, midwives, who are the specialists in normal births."

In the book *Guide to Effective Care in Pregnancy and Childbirth*, by Murray Enkin and others, the authors question the notion that a C-section scar bursting during a VBAC is any more difficult to deal with than other, more common childbirth emergencies: "Treatment of rupture of a lower segment scar does not require extraordinary facilities. Hospitals whose capabilities are so limited that they cannot deal promptly with problems associated with a planned vaginal birth after cesarean are also incapable of dealing appropriately with other obstetrical emergencies. Any obstetrical department that is prepared to look after women with much more frequently encountered conditions, such as placenta praevia, abruptio placentae, prolapsed cord, and acute fetal distress, should be able to manage a planned vaginal birth safely after a previous lower segment cesarean section."

Keefe says, "One wonders if hospitals are able to handle any childbirth emergency, and if not, why are we using them for childbirth? The whole point of going to a hospital is in case of an emergency. If the capabilities of hospitals aren't there, why are we going to hospitals?"

Goer, author of *The Thinking Woman's Guide to a Better Birth* and *Obstetric Myths Versus Research Realities,* has a similar concern: "The general hospital population has about the same potential for a labor emergency as the potential for the scar giving way," she says. "If the hospital isn't safe for a VBAC labor, then it isn't safe for any woman in labor."

Specialists in the maternity field have also responded strongly to the *New England Journal of Medicine* article and the editorial about the Lydon-Rochelle study.

Dr. Bruce L. Flamm, research chairman for the Department of Obstetrics and Gynecology at Kaiser Permanente Medical Center in Riverside, Calif., in a December 2001 editorial in the medical journal *Birth*, titled "Vaginal Birth After Cesarean and the *New England Journal of Medicine*: A Strange Controversy," wrote that "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. Strangely, the profound conclusions espoused in the editorial had little if anything to do with the results of the study." Flamm is also a clinical professor in the Department of Obstetrics and Gynecology at the University of California, Irvine Medical School, Orange, Calif.

"Considering this study's serious methodological flaws and almost total lack of any new findings, it is indeed paradoxical that the *NEJM*, a journal that rarely accepts even the most outstanding papers in the field of obstetrics and gynecology, found this particular study suitable for publication," writes Flamm. Moreover, he says, the study by Lydon-Rochelle was not only accepted but was given the additional honor of appearing as the journal's "lead" article and the "fact that Dr. Michael Greene, author of the scathing editorial commentary that accompanied the study, is also an associate editor of the *NEJM* may be related to this paradox or may be completely coincidental."

The Midwives Alliance of North America wrote in a press release, titled "Questionable Medical Study Could Undo Two Decades Worth of Reform in Childbirth," that "The Lydon-Rochelle et al. study published in the *NEJM* does not confirm many former studies on the subject which suggests that a woman delivering vaginally after cesarean carries a decreased risk."

Betty Anne Daviss, chairwoman of the Midwives Alliance of North America's statistics and research committee, says, "The unqualified way in which the study [Lydon-Rochelle] is being interpreted is an unjustified threat to one of the major reforms in childbirth that women have accomplished since the early 1980s: vaginal birth after cesarean."

"[The] accompanying editorial misinterpreted the conclusions of the study," states Jukelevics, "and strongly recommended elective, repeat cesareans as a preferred alternative to the risks associated with VBACs."

According to Goer, a cesarean is anything but a "preferred alternative to the risks associated with VBACs." Cesarean section results in more pain, debility, and a longer recovery period. It substantially increases the risk of infection, injury to other organs, hemorrhage, and blood clots. "These complications, in turn, increase the likelihood of prolonged hospitalization, hysterectomy, readmission to the hospital, and maternal death," says Goer. "Babies who were healthy before delivery are more likely to be born in poor conditions or have breathing difficulties. In the long term, cesareans can lead to chronic pain or bowel problems, and they increase the risk of infertility, miscarriage, placental abruption, [placenta detaching before the birth], and placental previa [placenta overlaying the cervix]."

When Leidig gave birth to her daughter Katya at Saratoga Hospital, she felt that attending physician, Dr. Martha Dexter, and the nursing staff were exceptional. However, she said that the C-section itself was "horrible."

"I was overmedicated by the attending anesthesiologist because he was unprepared for a particular procedure I was also scheduled for [stem-cell preservation]," she says. "The meds knocked me nearly unconscious, only allowing me to briefly hallucinate and vomit. At first I did not believe the baby they were showing me was mine, and it took a while before I could really grasp the fact that she was mine. Emotionally, there was something missing. Physically, I could not even lift my baby to breastfeed for the first two days. The nurses had to come in and help with every little thing. It took a good two weeks before I was able to get the last of the drugs out of my system."

Leidig is not the only woman to complain that cesarean birth is a difficult—often hellish—experience. Women who have been through it say it is difficult, painful, emotionally draining, depressing and debilitating. And not all women who have had cesareans feel that it was the right choice for them—that in fact, they may have been pushed into it by a health-care provider. Take Victoria Greenwood of Delmar, for example.

Never Again
Interview With Victoria Greenwood
Photo by Andrea Sally Fischman

Greenwood and her husband arrived at St. Clare's Hospital in Schenectady, eager to give birth to their first child, almost 13 years ago. Upon arriving at the hospital, Victoria was given pitocin to stimulate her contractions. She remembers a doctor yelling at her husband because she refused pain medication, and the doctor on the next shift, although kinder and gentler, suggested that the baby was too big and that she might want a cesarean. "Not yet," Victoria kept saying, but finally, exhausted from not eating for two days, she agreed. Despite what the doctor had told her about her baby's size, her daughter Kate weighed only 5 pounds, 12 ounces.

It wasn't until a few years later that she and her husband found out that there were other options that would have had less of a horrific impact on her delivery.

Greenwood remembers that she was given medicine to make her stop shaking (a common symptom after giving birth). The anesthesiologist neglected to mention one particular side effect of the drug: amnesia. "I saw my daughter shortly after she came out, when my husband held her next to me, but I don't remember anything else until I woke up in the recovery room," says Greenwood. "Later, I learned I was actually conscious the whole time. By then, the baby had gone to the nursery, and I had to wait to be brought upstairs to see her—I remember my husband and I in the elevator on the way up, and he said, 'We're never going to do this again in a hospital!' I was shocked—he's a physician! But that's the way I felt, too."

Diana and Fred Conroy of Albany had a similar experience. They planned to have their first baby, now 5 years old, in the birthing center connected to their hospital. That didn't happen. Because Diana's membranes ruptured before her labor started, she was immediately hooked to IVs for induction, a continuous blood-pressure cuff, and tethered to a 4-foot wire. She ended up with a cesarean and a baby weighing 9 pounds, 12 ounces.

Months passed before Conroy was fully recovered from the cesarean, before she could even carry or push her son in a stroller. Emotionally it took longer. "I cried often," she says. "In simplest terms, I felt at that time, by having a surgical birth, I was no longer an active participant in a situation where my participation is supposed to be crucial. I had lost all power, control and identity . . . I felt guilty about the medications I intentionally exposed my baby to during my labor."

A Kinder, Gentler Cesarean
An Interview With Mary Ellsworth
Photo by Andrea Sally Fischman

Of course, there are women who have experienced cesareans who do not have a nightmarish tale to tell. Mary Ellsworth of Greenfield Center said she had a positive experience during the birth of her son, born July 4, 1996, even though it was a cesarean birth.

"It was OK because no one was pressuring my husband and me," says Ellsworth. "The midwife and the anesthesiologist were instrumental in allowing me to make decisions about my birth and making it positive. The nurse was going to take Clarence away from me right after the birth, before I had a chance to breastfeed him. The midwife told her to leave the baby with his mother and that she would take responsibility for him."

Some maternity advocates feel that the rise in cesarean births in the United States (according to the National Center for Health Statistics, C-sections now comprise 22.9 percent of all births in the United States—one of the highest rates in the world—and New York state's rate is even higher, at 24.7 percent) and conversely, the lowering of the VBAC rate has much to do with liability insurance and the threat of malpractice and little to do with what's best for mother and baby.

"I think liability is the root for doctors not supporting VBAC," declares Goer. "I think it is a chain of things. The root of it is that they are trained to think about surgery, the surgical aspects. Obstetricians have openly admitted that one reason for the turnaround is reducing liability stemming from the scar giving way during labor, a concern that arose from some successful malpractice suits involving VBACs. This self-confessed incentive provides a powerful motive for bias, conscious or unconscious, against VBAC and a cause for skepticism of statements and policies favoring elective cesareans."

Jukelevics adds, "Hospitals say they are not equipped to provide emergency cesareans quickly enough to comply with the current VBAC safety guidelines recommended by ACOG. Their major concern is a fear of malpractice suits in the event of complications following a uterine rupture. . . . Some facilities have decided that the number of VBACs they have per year does not justify the cost of complying with the new guidelines."

In a May 6 ACOG news release, doctors were warned about liability threats in obstetrics and gynecology: "You have to love what you do with a passion, because the liability threat will always be there, no matter how outstanding the care you provide," said ACOG President-Elect Dr. Charles B. Hammond.

According to the release, obstetrics-gynecology is considered a "high risk" specialty by insurers. It is always one of the hardest-hit professions in times of liability-insurance problems. The number of lawsuits against all physicians has been rising over the past 30 years in an increasingly litigious climate, and OB-GYNs remain at the top of the list of doctors affected by this trend.

"Although I have no proof, my suspicion is that the policy to ban VBACs is motivated by the insurance companies," Leidig states. "Even though the chances of anything going wrong during a VBAC are considerably low, I believe the payments of the corresponding lawsuits with the few patients concerned have been exceptionally high. I believe the insurance companies are pressuring the medical communities across America to change their policies and stop performing VBACs."

Further exacerbating the situation, wrote Dr. Flamm in his article "Vaginal Birth after Cesarean and the *New England Journal of Medicine*: a Strange Controversy," is that newspaper reporters somehow believe that studies published in the *NEJM* are of special significance and media coverage of the journal's articles is typical—no matter whether the studies were good or bad. In the case of the Lydon-Rochelle study,

Flamm says, the results were not accurate because of the method used to measure the uterine ruptures. No hospital charts or medical records were actually reviewed in this study.

Still, a *New York Times* story titled "A Risk Is Found in Natural Birth After Cesarean" declared that the Lydon-Rochelle study found that "VBAC was riskier to both mother and baby than a second cesarean," although not a single maternal death was reported in the study. Before offering alternative viewpoints, reporters quoted Dr. Greene's response to a woman asking about the safest method of birth for her next baby. He responded, "My unequivocal answer is elective, repeated caesarean section."

Today, more and more groups are forming to educate and support the public about choices and options available during pregnancy and birth.

Keefe of BirthNet says that her organization is always willing to engage in a battle worth fighting, educating people that maternity care should be supportive and respectful, and that each woman's fears and concerns should be addressed. BirthNet offers educational programs for the public throughout the Capital Region, including an upcoming VBAC program scheduled for June 17 at Saratoga Springs Public Library, which will examine issues around the controversy and the inconsistencies it has exposed in maternity care, along with ways to ensure that all women have access to their full range of birth options.

Another local organization, the Cesarean Group, offers a place for women to discuss their cesarean experiences with people who have had similar problems. Greenwood, who leads the group, says that no one can better relate to the stories of the women who were unable to see and hold their babies after the surgery, had difficulty nursing with the painful incisions and dealt with insensitive remarks about the cesarean procedure, than other women who have been through the experience. The group discusses ways to avoid some of the "traps" of the medical establishment and ways women can empower themselves in the face of limited childbirth options. Greenwood is a licensed registered nurse who moved away from traditional medicine some years ago.

"Only another woman who has been restrained during a cesarean can fully appreciate the horror and humor of the crucifixion position," Greenwood says. "You are on your back with your arms secured straight out from your sides, your ankles secured together to the stretcher. . . . And we don't need to be reminded again and again that the health of our baby needs to come first. We know that. We want that, of course—but it's particularly helpful to remind people that the baby's and the mom's health should come before the doctors', nurses', hospitals' needs, preferences, rules, regulations. . . . The main focus should be what's best for mom and baby."

After her first cesearean, Greenwood was pregnant again. She and her husband kept their word to each other: They never had a birth in the hospital again. "The idea for a home birth started right on that elevator, when I was 20 minutes post-cesarean," Greenwood says. "Both my husband and I felt betrayed by the doctors at St. Clare's, particularly my husband, who had to deal with an irate obstetrician who berated him because I refused the pain medication. I wasn't being a martyr—the pain was not that bad."

They hired a midwife, and instead of using pitocin to get her labor into full swing, she walked, took a shower, and got into various "funny" positions to stimulate the process. "It worked a lot better than lying in bed!" Greenwood says. Caroline came out a healthy baby girl, two pounds bigger than Kate. "The midwife made room for my husband so he could catch the baby as she came out. It was wonderful!"

"It was hard work and painful, but it was also wonderful—right there in my bedroom, no nurses to argue with just to see my baby, no nasty remarks from doctors, no janitors buffing the floors at 2 AM, no one telling me I was 'not competent' to take care of my baby," she says. "The icing on the cake was when my 2-year-old daughter came into the room to see her new baby sister, who was only minutes old, followed by my mom and my sister."

Like Greenwood, Conroy was determined to avoid a second cesarean when she became pregnant again. "While pregnant with our second child, I did a ton of research," she says. "I read everything I could get my eyes on about the benefits and risks of having a vaginal birth after a cesarean. One of my greatest concerns was that my uterus would not be able to grow and support a baby because it had been cut open."

She had another long labor, but this time with the encouragement and physical support of her birth team in her own surroundings. When Conroy reached 8 centimeters, she took off for St. Peter's Hospital with her husband and her birth assistants to meet her midwife. Some hours later, with no episiotomy (a surgical incision made to enlarge the vaginal opening) and no tearing, Conroy gave birth to her daughter, 9 pounds, 9 ounces.

Two years after her first cesarean, Ellsworth gave birth to Madeline at home. She said it was a long labor, but throughout the 48 hours, the midwives and she discussed a lot of things, like eating.

"One of the biggest things was being able to eat. I was happy to have the option, and I did eat cream of wheat and scrambled eggs—I was never denied food," Ellsworth says. "I think if I was at a hospital, I would have been forced into another C-section because I was in labor for 48 hours.

"I feel extremely happy that I had a lot of choices. That played a major role in the decisions involved in each birth, but that was because I talked to lots and lots of people before each one and wouldn't let myself be intimidated by the nurses in the hospital for my first birth."

Many women have taken what they have learned through support organizations, childbirth classes and the maternity and birth Web sites, and through their own birth experiences, to fight back. Leidig wrote a two-page letter to David Anderson, the president and CEO of Saratoga Hospital, to ask him to reinstate the VBAC services at the hospital as soon as possible, since she has only a few weeks left before she gives birth.

She told Anderson in her letter that her obstetrical practice has been forced to refuse her and other women the VBAC option until the hospital meets specific necessary conditions for the safety of VBAC patients. Unfortunately, she wrote, she is at the end of her pregnancy and finds herself in a position where she may have to leave her doctor of 10 years to find a new one—not something she is looking forward to—and leaving the warmth and support of her community behind. Leidig says she does not want to have another major abdominal surgery that isn't in her best interest, but she still wants to have her baby with her doctor, at her hospital.

"I have only a .8-percent chance of a rupture occurring during a VBAC," she says. "My odds of having something go wrong during a C-section are higher, and the odds of me having long-term medical problems due to multiple C-sections are much higher."

Leidig has already done the hard work: She has opened the CEO's door, and now she is waiting for his response.

Conroy completed her hard work too: educating herself about her options. The result is one she will not forget.

"At the end, I felt I could have moved the very earth itself with the pure elation, power and emotional strength I was riding on," Conroy says. "What a difference a vaginal birth made for me. I didn't have the stress and pain of an abdominal incision. . . . I believe it was because this time I played a very educated and active role. I remember telling everyone that if I could do this, then I can do anything."

Metroland was an alternative Newsweekly in the Capital Region in Albany, New York. Distributed free of charge, the paper offered local arts and music scene coverage, news and feature articles, and political columns with a mostly liberal bent.