Increasing Cesarean Birth Rates: A Clash of Cultures?

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ABSTRACT

Cesarean birth rates in the United States reached a high of 27.6% in 2003, a 6% increase over 2002. A cultural conflict appears to exist between the views of those who believe that birth is normal and many cesareans are unnecessary and the views of those who feel that higher rates are justifiable. Childbirth educators can share cultural concepts of normal birth in their classroom.

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As most of us who read this journal know, a major increase in cesarean births has occurred in the United States in recent years. In 1976, the *American Journal of Obstetrics and Gynecology* published two papers documenting what was then considered a rapid increase of cesarean births. One paper came from a California hospital and reported an increase from 6.0% in 1969 to 9.1% in 1974 (Hibbard, 1976). The second paper, from a North Carolina hospital, reported a rise from 6.3% in 1970 to 10.3% in 1975 (Jones, 1976). By 2003, the national rate was 27.6, an increase of 6% from the 2002 rate of 26.1 (Hamilton, Martin, & Sutton, 2004). Rates varied in 2002 from 19.1% in New Mexico and Utah to 30.9% in New Jersey (Martin et al., 2003). Rates also vary within communities: In a 2002–2003 comparison of New York City hospitals, cesarean rates varied from 9.7% to 37.4% (Choices in Childbirth, 2005). Studies have also shown significant cesarean-rate variations between physicians practicing in the same institution. The Healthy People 2010 report included achieving an overall rate of cesarean birth of 15% (U.S. Depart-

ment of Health and Human Services, 1990). However, within a specific population, no one can absolutely know the ideal rate.

OBSTETRICIAN SEEMINGLY PENALIZED FOR LOW CESAREAN RATE

Recently, an obstetrician who practiced in a hospital located in the nation's Southern region maintained a cesarean rate below 10% for more than a decade. Yet, instead of receiving accolades for achieving Healthy People 2010's recommended rates, she faced difficult demands from the hospital's staff and administration.*

During her employment at the hospital, this physician not only maintained cesarean birth rates lower than the rates suggested by state and national recommendations, but also attained a high percentage of mothers with gestational ages of 39 weeks. Under her care, infants had higher birth weights than infants from other obstetrical practices in

* Identifying information has been withheld in order to protect the privacy of all parties involved in this situation.

Obstetrical colleagues and hospital administration told the physician that, in a 6-month period, she must raise her cesarean rate to a level within two standard deviations of the mean for that hospital—a mean that is higher than both the national rate and the rate for the state in which the hospital is located.

the same community. Additionally, her practice exhibited no indication of higher mortality or morbidity rates among her patients when compared with other local practices.

With improvement of the preterm birth rate and low birth weight being a national priority, one would think this physician would receive awards from her community and state, along with invitations to speak at national conferences to share her ideas with others. Instead, her obstetrical colleagues and the administration of the hospital where she practiced told her that, in a 6-month period, she must raise her cesarean rate to a level within two standard deviations of the mean for that hospital—a mean that is higher than both the national rate and the rate for the state in which the hospital is located. For this physician, the increase would have resulted in a cesarean rate of at least 20%.

One might assume that an implied “or else” mandate was included in the hospital’s directive. Instead of complying with the hospital’s demands, the physician subsequently chose to resign her position and establish her practice in another Southern state. In her resignation letter, she stated, “I leave [the hospital] with my morals and backbone absolutely uncorrupted. I am going to practice...in a place where unnecessary surgery is not encouraged.”

CESAREAN BIRTH: A CLASH OF CULTURES

How could such a state of affairs come to be? As a nurse-anthropologist, I view the above episode as a clear case of culture conflict. The great disparity in cesarean rates from one state to another and, in some cases, from one hospital to another in the same community, suggests that, while differences are apparent in patient populations, differences also occur in cultural values surrounding cesarean birth.

From one cultural perspective—a view shared by the above-described, targeted obstetrician (who was

trained in Canada) and the women who choose her for their care—birth is perceived as normal, and cesareans, while necessary and even lifesaving in some instances, are unneeded interventions for other women. From this perspective, not every infant in the breech position needs to experience a cesarean birth, and many women with previous cesarean births can be candidates for a trial of labor. In the community where this physician practiced, many women appear to be a part of the culture that does not welcome unnecessary birth interventions. Undoubtedly, many of this physician’s patients chose her as their obstetrician because they perceived that, under her care, they would have their best chance of a vaginal birth without unnecessary interventions. Thus, this particular obstetrician and the expectant mothers who continue to seek her care share in the cultural belief of normal birth.

An opposing cultural perspective—a view that appears to be shared by other obstetricians in the institution described above, as well as by the administration of the hospital—sees no problem in a cesarean rate that is higher than both the national rate and the rate for the state in which the hospital is located. This group’s two major concerns are the potential benefits of a cesarean birth and concomitant dangers of vaginal birth in a far greater number of women. Another concern involves the danger of an increased number of lawsuits should an adverse birth outcome occur.

MEDICAL, LEGAL, AND FINANCIAL CONCERNS OF CESAREAN BIRTH

How many cesarean births are medically necessary? No clear answer to this question is evident; additionally, the rate will vary somewhat with a specific population. Most would agree that placental abruption, placenta previa, transverse lie, and footling breech presentation are examples of medically necessary reasons for cesarean birth. In some labors, clear indications appear in which the baby cannot tolerate labor and, in a small number of instances, the mother may not tolerate labor. I have not seen data on the number of unnecessary cesarean births; because this is frequently a judgment call, it is unlikely that such data exist or will exist. What does seem clear in this instance is that the cesarean rate of < 10% in the practice of this particular obstetrician did not lead to a plethora of complications. In a Web-based, online medical forum that followed her story, this physician wrote:

The American Academy of Family Physicians (AAFP) recommends that maternity professionals offer vaginal birth after cesarean to women with a previous cesarean (see www.aafp.org/x1597.xml). AAFP found no evidence to support a policy of restricting planned vaginal birth after cesarean to facilities with surgical readiness throughout labor.

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Just for clarification—my babies were most likely to be born at 39 weeks. . . [and] there was no increase in macrosomia or diabetes. I have had NO permanent brachial plexus injuries—a couple of transient ones that healed completely—over 17 years. I get one or 2 more clavicle fractures a year but they are not deemed significant unless there is a brachial plexus injury and there wasn't in these. I was well within published norms for clavicle fractures but the reason I feel I had one or [two] more a year than [the] other OBs is that I [am] doing 3 times the average percentage vaginal births.

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I was very proud of my low prematurity rate—never thinking for a nanosecond that I would be cited because my babies were more likely to be TERM (not postterm) and heavier (NOT MACROSOMIC).

Concerns about legal liability are ever-present in the culture of medicine. Many obstetricians sincerely believe that, if there is any possibility of a problem or an adverse outcome, it is safer (legally) to have a cesarean birth than to risk a bad outcome and a subsequent lawsuit. Hospital administrators usually concur, because legal actions nearly always include the institution as well as the physician. I have not, however, seen data that suggest an increase in the number of cesareans decreases the number of lawsuits. Indeed, so many potential variables exist that clear data would be difficult to obtain. Thus, it is difficult to see how doubling an obstetrician's cesarean rate would decrease the likelihood of lawsuits.

An additional issue that some feel may contribute to the “push” for cesarean births involves financial concerns. In many institutions—including the hospital described here—the difference in hospital charges for a cesarean birth versus an uncomplicated vaginal birth is close to \$1,000. Of course, the hospital must deal with additional costs for personnel and equipment; therefore, it is difficult to determine if the hospital does indeed receive an additional profit for cesarean births. Moreover, many cesareans can be scheduled at a time when staffing is increased. For example, if a baby is in a breech position and one is committed to surgical birth interventions for all infants in the breech position, the procedure can be scheduled before labor begins. From the perspective of an assembly-line model of efficiency, this course of action may make sense. From the perspective of birth as a peak human experience for the parents, a surgical approach is

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questionable. In addition, unnecessary cesarean births increase the cost of care, due to increased hospital days and an increased risk of infection. Whether it is our tax dollars or private insurance fees, we all share in the cost of a cesarean birth.

CHILDBIRTH EDUCATORS CAN HELP CHANGE THE CULTURE

What does this mean for those of us who are childbirth educators? Clearly, most of us may not directly change the culture of obstetrical medicine. However, by creating cultural concepts of normal birth in our classrooms and encouraging class participants to question the current culture of obstetrics, change will come.

When I was a young nurse, and when my own children were born, fathers were not allowed in the labor areas (which were separate from the birth areas)—a cultural practice that seems as strange to many young couples today as those of indigenous peoples in the 19th century. Today, young couples ask me why we, the pregnant couples of that day, allowed such care; in turn, I ask them why they allow current practices that they find inappropriate. A survey conducted by the Maternity Center Association (Declercq, Sakala, Corry, Applebaum, & Risher, 2002) indicated that 70% of first-time mothers attend some type of childbirth education class; therefore, childbirth educators have the opportunity to provide a message in support of the culture of normal birth.

I believe an additional message for childbirth educators (CBEs) is apparent in the above-mentioned physician who challenged her employer's directives. In recent years, I have talked with several CBEs who have been pressured by the institutions where they teach to conform to institutional norms that may conflict with the message of the normality of birth and with the strategies they employ to help women address their own needs. Like the obstetrician in this story, some CBEs choose to resign and move on and, perhaps, conduct classes in their homes or in a community where there is freedom to teach according to their principles. Others, because they need their jobs or have additional positions in the institution coupled with that of childbirth educator, have elected to stay and persevere.

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In the booklet “What Every Pregnant Woman Needs to Know about Cesarean Section,” the Maternity Center Association reports sorting through hundreds of studies to help women understand the full range of concerns that are at stake with decisions about how to give birth. The booklet is available on the Maternity Center Association's Web site at www.maternitywise.org/mw/topics/cesarean/booklet.html

We need to support our colleagues, whatever their profession, who share our cultural values about normal birth.

Cultural conflict is likely to continue between those who believe birth is a normal part of life in most instances and those who take a more mechanistic, technological approach toward birth. Cultural conflict can lead to cultural change when issues are discussed openly and respectfully. We need to support our colleagues, whatever their profession, who share our cultural values about normal birth. We also need to educate parents about these values and raise discussions in our communities about both the meaning and process of birth.

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(Continued from p. 2.)

in line behind him and won't allow them either. The woman who spoke with me was using a new doctor at the hospital who actually likes doulas, but the unwritten "no-doula policy" is so entrenched that the doctor didn't even know that there's not an official no-doula policy in place—it's just a "firm understanding."

This same hospital also does not allow women to take a bath at any time during labor (although they have beautiful, large tubs in each room). They also do not allow labor balls to be used at all.

The chief of obstetrics also requires that all of his patients receive an epidural by the time they are dilated to 2 cm, and he encourages the rest of the OBs to do the same. The c-section rate in that hospital is above 35%, and some months it's above 50%. There's a celebration among the doctors when they go over the 50% mark. The induction rate is above 90%. The moms are also highly encouraged to put their newborns in the nursery during the night, "for the safety of the baby."

I talked with a couple of the LCCE educators who work there, and they said they are extremely restricted as to what they teach, and they absolutely are not allowed to refer students to the Lamaze International Web site or to hand out the six care practice papers. I'm afraid none of the LCCE edu-

cators wanted to contact Lamaze about this because they know it will be the swift and immediate termination of their employment. Another educator has already been fired because she taught "informed consent" as meaning that women have the right to ask questions and refuse treatment.

When LCCE educators aren't allowed to teach what is really best for a laboring woman, and they can't even teach about labor balls or warm baths or supportive doulas because then the moms would actually want to use them, something is wrong. And of course the LCCE educators at this hospital are afraid to say anything because of fear of losing their jobs.

[Editor's Note: This letter has been shortened. The author further expresses concern about hospitals that hire LCCE educators to use the name "Lamaze" and then implement restrictive policies that do not fit the Lamaze Philosophy of Birth or six care practices. She questions the role of normal birth advocates in such situations that occur across the country.]

Thank you for your time and consideration.

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