After a Cesarean...What's a Birth Professional to Do?

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ABSTRACT

The discrepancy between the evidence supporting vaginal birth after cesarean and actual medical practice illuminates the larger issues of evidence-based care versus current obstetrical practice. Although the reasons for the disconnect between what we know to be healthy birth practices and what women actually experience are multiple and complex, a commitment to providing accurate education, truly client-centered support, and active patient advocacy will give women the ability to insist on best practice care for themselves and their babies. The International Cesarean Awareness Network believes that all childbirth professionals and advocates share a responsibility to promote change and must work together to be effective.

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Tackling the topics of cesarean surgery and vaginal birth after cesarean (VBAC) is an increasing challenge for the birth professional even though scientific evidence clearly supports reducing the skyrocketing cesarean rate and increasing the support for and availability of VBACs for childbearing women. We need to ask why this is so. For educators, nurses, and fellow care providers, the prevailing culture of medicalized, high-intervention maternity care (culminating in the rampant use of cesarean surgery) is the overwhelmingly acceptable norm, with VBAC nearing something akin to urban legend due to declining availability (see International Cesarean Awareness Network, n.d.) and the resulting lack of any real knowledge of or experience with VBAC. The International Ce-

sarean Awareness Network (ICAN) is focused on challenging this cultural and practice mindset. There are no easy answers, but narrowing the gap between the knowledge of safe birth practices held by the educated birth professional and the inherent expectations of both the birth professional and the consumer is one area where ICAN's mission of education and support plays an important role.

The conflict between routine repeat cesarean surgery (RCS) and VBAC is a microcosm of the bigger conflict between safe birth practices and current obstetrical practice, affecting the entire childbearing population in the United States. While the latest data on cesarean rates indicates a national rate of 31.8% (Hamilton, Martin, & Ventura, 2009), the

The International Cesarean Awareness Network (ICAN) is a nonprofit organization founded in 1982 and dedicated to improving maternal-child health by preventing unnecessary cesareans. To learn more about ICAN's mission, ongoing activities, and evidence-based resources, visit the organization's Web site (www.ican-online.org).

remaining two thirds of the childbearing population is not immune, given there is little indication that the rate will slow and the accepted indications for cesarean appear to be increasing. The interventions that lead to cesarean (such as elective or social induction) are also on the increase (Simpson, 2010). Our experience with women who seek out ICAN shows an increase in primary cesareans among multiparous mothers and an almost universal lack of any counsel on VBAC as an option for a subsequent pregnancy (see Norman, Kostovcik, & Lanning, 1993; Soliman & Burrows, 1993). Most of these women ended their pregnancies in the operating theater after a predictable course of interventions—interventions that, if not explicitly criticized in the medical literature, are certainly not supported as best practice (see Keirse et al., 2000). Women with a previous cesarean are rarely counseled as to the existence of VBAC, much less the advantages of planning one, nor are they counseled as to the risks of RCS, especially multiple surgeries. Instead we have, for all intents, returned to “once a cesarean, always a cesarean” as de facto practice. Most of these women received some sort of “child-birth education” and then labored within the hospital system and so have, in theory, been exposed to evidence-based information on pregnancy, labor, and the postpartum period. Where is the disconnect between what women should know and what actually happens?

Using RCS and VBAC as an example of the broader issues within the current maternity care system, we can identify some of the issues facing both the birth professional and the consumer. Looking at the published evidence about cesarean and VBAC is both heartening and disheartening: heartening because the evidence is that, although cesareans are safer than ever before, they should be used in a judicious manner (not prophylactically), and VBAC is a safe, viable option for most women who have had a previous cesarean; disheartening because, even with tens of thousands of research dollars having been spent in the past two decades to define the risks and benefits of VBAC and RCS, the evidence has not translated into education and medical practice.

We maintain that the failure to accurately communicate the risks and benefits of RCS versus VBAC is a stumbling block that needs to be addressed in order to apply the gathered evidence to good practice. We know that the statistics as stated in the Figure are not generally given to women. Uterine rupture rates are often misquoted

and highly inflated. It is not uncommon for us to hear from women that their provider stated the uterine rupture rate is anywhere from 2% to as much as 20% after one cesarean, with maternal death and fetal death almost guaranteed. The RCS is often scheduled at the first prenatal appointment of a subsequent pregnancy, and women report they are frequently told “VBAC is illegal” or “no one will ‘do’ VBAC anymore” or “we now know VBAC is a lot more dangerous than we first thought”—if the women know enough to ask about VBAC. The risks of RCS, especially for a woman planning more than two pregnancies, are almost universally ignored, or only appear in the fine print of the consent form presented to a woman on the day of her scheduled surgery. There can be no argument that the primary maternity care provider bears a large part of the burden to accurately present risks and benefits of both RCS and VBAC, and there is also little doubt that factors beyond academic knowledge play an important role—so called “medicolegal concerns,” corporate financial concerns, and lack of training in nonmedicalized birth all play into the current climate of reliance on surgery (see Rybak, 2009). However, given that the typical consumer spends less than 10 minutes with her caregiver at any given exam, there are other players in this arena who can and should be a force for accurately educating the consumer.

Educating the consumer about safe birth practices is ICAN’s mandate.* Supporting women after a cesarean (medically indicated or otherwise), educating women about VBAC, and then supporting women in choosing the safest path for their next pregnancy are at their core safe birth practices. Unfortunately, we are most often educating after the fact. Our consumers have learned the hard way that pregnancy and labor are treated as pathology, that even if they have enough knowledge to know there are interventions they should question, it is almost impossible to prevail against the overwhelming culture that is current obstetrical practice. This is magnified when a woman seeks a VBAC. More often than not, ICAN is the only source of evidence-based information on the risks and benefits of RCS and VBAC and the

* ICAN’s Mission Statement: “To improve maternal-child health by preventing unnecessary cesareans through education, providing support for cesarean recovery, and promoting Vaginal Birth After Cesarean (VBAC).”

Figure. Comparison of risks pertaining to repeat cesarean surgeries (c-sections) versus multiple vaginal births after cesarean (VBACs). Adapted from “After a Cesarean. . .What’s the Safest Path to Your Future Births?” (International Cesarean Awareness Network, 2008).

only source of support for a decision to choose VBAC. If we have any hope of derailing the juggernaut of worsening maternal and fetal outcomes in the United States, the wider worldwide childbirth community must begin to support and educate as ICAN does. (For international childbirth maternity care statistics, see The United Nations Children’s Fund, 2007, and World Health Organization, 2007).

WHAT BIRTH PROFESSIONALS CAN DO

Many couples attend a childbirth preparation course. Within the curriculum, there is usually some discussion of cesarean surgery. Research has shown that if a woman is told about the option of VBAC at the time of her cesarean, she is more likely to have a VBAC. A discussion of the realities of post-cesarean pregnancy and the validity of VBAC as a choice would also serve this purpose. Honest discussion of the difficulties facing a woman who does not want RCS for all her future

pregnancies, including candid discussion of VBAC bans and the restrictions placed on VBAC within the hospital system, should not be controversial. Childbirth educators have the opportunity and ethical requirement to give the most accurate and up-to-date information about birth practices, even when it does not reflect current practice on the labor and delivery floor. Avoiding the first cesarean is a significant step in the direction of best practice, one which the childbirth educator is better positioned to support than ICAN. There is a real risk that a hospital-based educator may “get into trouble” for not teaching a good patient course, but ultimately this becomes a question of

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priorities. Teaching factual information is protective. Accurately informed consumers have better experiences, better outcomes, and express greater consumer satisfaction. Ultimately, this benefits the hospital itself.

The rise of the doula as a participant in the childbearing process is a positive change. Research has shown that the presence of another woman during labor reduces the likelihood of cesarean surgery and improves outcomes. However, as the presence of a doula has become more normalized and as more women are hiring doulas, there is also an increased risk of institutionalization. Doulas find themselves in similar circumstances to the hospital-based childbirth educator—muzzled for fear of losing access to clients within the hospital system. They also have similar ethical responsibilities to their clients. Although a doula cannot speak for her client, she can be a force for best practice if she has adequately prepared her client for the realities of the labor and delivery floor and is not afraid to speak the truth when the client is buffeted by conflicting information. “Preserving the experience” is a false positive outcome when ultimately the experience has negative repercussions in the months and years to follow, no matter what the client may describe in the hours and days after giving birth. ICAN knows that women appreciate honesty, even honesty that is difficult to hear. This is truth that doulas are well equipped to speak.

The labor and delivery nurse may be the most important factor in how labor plays out. A supportive nurse can make the difference when a woman seeks a low-intervention labor or wavers in the face of the difficulties of labor. And there is no doubt that the nurse is also often caught in the middle of the conflict between the patient and the machinery of institutionalized maternity care. Staffing concerns, pressure from physicians to comply with a schedule, and burnout all play a role in the lack of support some women experience. Nevertheless, nurses are called to advocate for their patients, and this is no less true on the labor and delivery floor than in the cardiac wing. Part of ad-

vocating is assuring that the patient understands her choices and options, even those that are not part of routine protocol. A commitment to staying current with the evidence for best practice through continuing education and working as a profession to support best practice is required to effect any real change within the hospital system. To do anything less is to compromise the very principles of nursing.

The skills needed to adequately support women to avoid unnecessary cesareans, including RCS via VBAC support, are the same skills needed to provide best birth practice for all women. Supporting VBAC is supporting healthy birth. The task is a difficult one, and although it is tempting to focus on the individual birth as a measure of success, the problem is a systemic one and will not be fixed “one birth at a time.” All birth professionals—paid and volunteer—have a role to play, and unless we work together, there is no reason to believe that any of the current measures of success will improve. Providing expectant families all possible resources and support, from the moment of conception, through pregnancy, labor, and into the weeks and months after a birth is vital. Change will come when the consumer understands best birth practice. It is our job to teach them.

REFERENCES

- Hamilton, B. E., Martin, J. A., & Ventura, S. J. (2009, March 18). Births: Preliminary data for 2007. *National Vital Statistics Reports*, 57(12). Hyattsville, MD: National Center for Health Statistics.
- International Cesarean Awareness Network. (2008). *After a cesarean. . . What's the safest path to your future births?* Savage, MN: Author. [Brochure].
- International Cesarean Awareness Network. (n.d.). *VBAC policies in US hospitals: How to use the VBAC policy database*. Retrieved February 24, 2010, from <http://ican-online.org/vbac-ban-info>
- Keirse, M., Neilson, J., Crowther, C., Duley, L., Hodnett, E., & Hofmeyr, J. (2000). *A guide to effective care in pregnancy and childbirth* (3rd ed.). New York: Oxford University Press.
- Norman, P., Kostovcik, S., & Lanning, A. (1993). Elective repeat cesarean sections: How many could be vaginal births? *Canadian Medical Association Journal*, 149(4), 431–435.
- Rybak, E. A. (2009). Hippocratic ideal, Faustian bargain and Damocles' sword: Erosion of patient autonomy in obstetrics. *Journal of Perinatology*, 29(11), 721–725.
- Simpson, K. R. (2010). Reconsideration of the costs of convenience: Quality, operational, and fiscal strategies to minimize elective labor induction. *The Journal of Perinatal & Neonatal Nursing*, 24(1), 43–52.

Supporting VBAC is supporting healthy birth.

Soliman, S. R., & Burrows, R. F. (1993). Cesarean section: Analysis of the experience before and after the National Consensus Conference on Aspects of Cesarean Birth. *Canadian Medical Association Journal*, 148(8), 1315–1320.

The United Nations Children's Fund [UNICEF]. (2007). *Child poverty in perspective: An overview of child well-being in rich countries. Innocenti Report Card, 7*. Florence, Italy: UNICEF Innocenti Research Centre.

World Health Organization. (2007). *Maternal mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA, and The World Bank*. Geneva, Switzerland: Author.

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Reading Tracy Posner's birth story again gives me shivers ("The Most Amazing 24 Hours," *The Journal of Perinatal Education*, 19(1), 4–7). As her prenatal yoga teacher, I am so proud of her and her efforts. She had the benefit of a wonderfully supportive husband and an amazing doula. Tracy came to prenatal yoga class nearly every week throughout her pregnancy and also attended a "Comfort Measures for Birth" workshop that I offer for couples. In class, she had the opportunity to practice everything that we, as childbirth educators, preach. We preach relaxing, we talk about breathing, and we focus on positive language and empowerment and, of course, educating. Over the years, I have found that I can offer my yoga students the opportunity to try things out—to practice the techniques we use in childbirth while holding a challenging yoga pose. The similarities are strong and the learning opportunities are immeasurable. The marriage of the two disciplines, yoga and childbirth education, provides so much opportunity for women to practice and gain confidence in their abilities and their body. I feel that every childbirth educator would benefit from tossing a few yoga postures into their curriculum, and every prenatal yoga instructor would benefit from understanding more about the birth process and pregnancy.

Lamaze International's Prenatal Yoga Workshop was created to provide an opportunity for practitioners of both disciplines to blend their experiences together in order to provide more learning opportunities for the women we serve. It was created as an innovative and current way to implement the six Lamaze Healthy Birth Practices into the lives of the women of today. Participating in this workshop won't turn a childbirth educator into a prenatal yoga teacher, or a prenatal yoga teacher into a childbirth educator, but it will allow for some new ways to provide moms with practical applications that they can use in labor and beyond. For more information on Lamaze's Prenatal Yoga Workshop, visit the "Specialty Workshops" link under "Events" at the Lamaze Web site (www.lamaze.org).

Tracy's birth experience is a wonderful example of how she integrated her yoga practice into her labor. She felt empowered to request being upright when she wanted to be, and perhaps most importantly, she learned to listen to her body. For anyone who has practiced yoga, you know that you must listen to your body, and when you do that, you can also learn to soften around your discomfort and even settle into it, often accepting the discomfort and learning from it. Isn't that what we teach our pregnant women? Don't we want them to become aware of their body and all its capabilities?

Being a small part of Tracy's birth experience touched my life in a positive way, as it does with all of the women I work with, and as I am certain it does with all of us in this profession.

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