the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, MD

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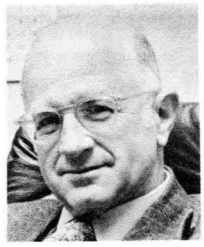
Caesarean Sections Continue to Increase



Dr. Robert Mendelsohn

As doctors race toward the 100 percent Caesarean section mark, apparently in the belief that God made a mistake when He didn't create zippers in women's bellies, this Newsletter is designed to sound an alarm for you, your relatives and your friends.

Even obstetricians now voice concern in their medical journals over the outrageous rate of sections. But their crocodile tears on behalf of damaged mothers and babies are matched by their total inability to take meaningful action to halt the Caesarean epidemic.

Hence, this Newsletter has three goals:

1) Try your best to avoid a primary section.

2) If you were not successful, try your best to avoid a repeat section.

3) If you had a section--and if you or your baby suffered damage--get hold of your hospital and doctors' records. Review them yourself, with another doctor and with a lawyer. If your doctor failed to inform you of the risks of Caesarean sections, or if the section was performed without legitimate reason, take the legal action necessary to gain justifiable compensation for the damage suffered and to place all doctors on notice that, while they feel they are in danger if they don't perform a section, you will make sure they are in even greater danger if they do. Only when mothers and fathers place the obstetrician's feet to the fire will this doctor-produced epidemic that threatens the health and lives of millions of American mothers and babies begin to abate.

Dr. Michelle Harrison's blockbuster, "A Woman in Residence," turned a bright light on the dark side of American obstetrics. Adapted from a diary she kept during her Ob-Gyn residency at Boston's Beth Israel Hospital, Dr. Harrison's book described the process of birth as "a sacred act that has been turned into an ugly ritual, not just because of the procedures--which are sometimes necessary and life-saving--but because of the attitude with which they are performed. It's like considering the beauty of those moments when sexuality takes on a spiritual quality and comparing that with pornography. The medical birth is pornographic. The woman is degraded. The physician intimidates her and forcefully takes from her both the act of birth and that which she herself has nurtured. All day long, I watch women who have been violated and who don't even know it."

Doctors give plenty of reasons (abnormal waves on fetal monitors, fear of malpractice suits, desire for perfect babies, etc.) for performing Caesarean sections. But look at Dr. Harrison's insight: "Performing a Caesarean is the one time that truly gives you the feeling of delivering the baby. I remember having my hand in the uterus. Pressure was being applied by Dr. Joseph at the top of the uterus while my hand grasped the

head of the baby and assisted it out through the incision. I felt a sense of excitement and of power and of personal accomplishment that is not present in a vaginal birth. This is the time the obstetrician truly delivers the baby; in a vaginal birth, it is the mother.

"These feelings of mine help me in trying to understand current obstetrical practices and the spiraling increase in Caseareans...."

The information and insights of "A Woman in Residence" make this book an essential part of the "prepared childbirth kit" for every woman who is planning a hospital birth.

Q

Last year, I became pregnant with my first child. Because I was 20 years old and had had a history of hypertension since I was 17, I decided to stay with my gynecologist at a well-known clinic. I went through pregnancy very well; my blood pressure did not increase, and I was on no medication. The only problem was that the baby stayed in a breech position until two weeks before my delivery date, and the doctor hinted I would need a Caesarean. Knowing this, my husband persuaded me not to attend Lamaze classes because he thought it would be too disappointing for me if my doctor did a C-section.

When the delivery day arrived, my doctor was on vacation, and an associate did the honors. My baby's heart rate was about 90 and was very irregular, according to an internal fetal monitor. After the heart rate stayed at 110, it was decided the child was safe, and I was given an epidural. The heart rate again went down and up, the epidural wore off and my contractions stopped. I was given pitocin, and half an hour later, the doctor decided to do a Caesarean because of cephalopelvic disproportion.

How do you feel about this delivery? Will I be able to have a trial labor in the future and practice Lamaze or Bradley methods? Can I do anything about my midline incision scar since I have developed keloids, and the scar is really quite ugly? Can I obtain my medical records--everything happened so quickly that I really don't know exactly what went on.

I would like to commend your work--I breastfeed my baby, and your Newsletter has really encouraged me. At a prenatal class I attended, a resident made jokes about your being insensitive to women's feelings by encouraging prepared childbirth. Well, he was the one who, right from the start, kept insisting to the attending doctor that he perform a C-section on me. So just who is the insensitive one?--N.O.

A

Was C-section necessary?

There is no point in talking to the doctor who delivered your baby because he has every reason for attempting to justify his treatment. Rather, you should obtain all your medical records, both office and hospital, and get yourself to an expert home birth doctor or midwife who can review your case with you.

The home birth specialist (who refrains from using anesthesia and analgesia, and who does not use pitocin to stimulate the uterus) may give you a different slant, although he or she may possibly exclude you as a candidate for home birth because of your history of a previous Caesarean section. You will then have the opportunity to challenge each side with the other's information. This kind of rational process will enable you and your husband to judge not only the circumstances of your first delivery but also the route you will choose for your next one.

As far as the bizarre comments of that resident are concerned, every hospitalized patient should bear in mind that the resident on their service may have been working for the past few days and nights without any sleep. Therefore, his remarks cannot be judged by the same standards applied to people who are fully awake.

Q

Two years ago, when I was 39 years old, I gave birth to my first child. I had an ideal pregnancy and delivered a healthy baby. But two things bothered me.

First, three weeks before my due date, the doctor said I had to take x-rays to see if I could deliver naturally. After the x-rays, he announced, "You are borderline. How do you feel about it?" I told him I felt the same way as I had when I first went to him--I wanted to have the baby naturally.

I went through 12 hours of labor. My water bag was broken by an intern, who I believe did this procedure for the first time. Then a Caesarean section was performed. While I was being prepared for the operation--a period during which no doctor spoke to me--I told the nurse, "Don't take out anything else." "No, we wouldn't," she said.

Well, they did. The doctor removed my healthy appendix, and he never informed me that this was done. I only discovered it after I started asking questions about the gas problems I had developed after the surgery --my digestion just isn't the same as it was before.

I know it does no good to worry about the C-section and the appendectomy, but it does upset me when I think these actions weren't necessary and weren't in the best interests of either the baby or myself. What is your opinion?--E.K.

A

Were C-section and appendectomy necessary?

Any woman who delivers a healthy baby and who has had an ideal pregnancy has the right to be suspicious if the baby is removed by Caesarean section. And she also has a right to know why a healthy organ was removed during the surgical procedure. So let me point out some information you might not be aware of:

1) While some doctors continue to take x-rays near the end of pregnancy and even during labor, there is plenty of medical evidence which demonstrates that such x-rays are practically useless in determining the baby's capability to go through the pelvis.

2) Doctors have continually been shortening the duration of what constitutes "normal" labor so that today, any labor that continues for more than 12 hours is likely to be called "prolonged." Yet plenty of medical evidence is in conflict with this kind of "creative diagnosis."

3) The removal of a healthy appendix during Caesarean section is one of the most hotly-debated issues in medicine. Since doctors don't seem to agree on the value or the danger of this procedure, this is one instance in which patient consent becomes very important. Therefore, you should obtain your hospital records and carefully examine the operative consent form you signed so you can determine whether you specifically agreed to an appendectomy. If not, legal questions, including that of assault and battery, may be raised.

Q

Two years ago, my first child, a 10-pound 6-ounce boy, was delivered by Caesarean section. After his birth, the doctor said my pelvis was too small, and our future children would have to be delivered the same way.

Both my husband and I wonder whether there is even a remote possibility that I can deliver a baby normally.--D.G.

A

Are repeat C-sections necessary?

Many items have appeared in scientific journals in which prestigious hospitals and reputable obstetricians report successful vaginal deliveries in mothers who have had previous Caesarean sections. Therefore, the old maxim, "Once a section, always a section" is no longer valid.

Certainly, it is important to avoid unnecessary repeat Caesarean sections, and it is equally important to avoid an unnecessary original Caesarean section. Denver Medical Center obstetrician Albert D. Haverkamp, M.D., has concluded from his research that fetal monitoring increases the rate

of C-sections. He points out that information produced by the fetal monitoring increases the physician's anxiety, and he states, "C-sections are done by conscientious people who are nervous, not knife-happy."

In your specific case, I would advise you to shop around for an obstetrician who has a good record of delivering previous sectioned mothers vaginally and then discussing with such a doctor whether you are an appropriate candidate.

Q I am an extremely healthy and active female of 24. I am 4 foot, 10 1/2 inches tall and weigh 78 pounds. I am tiny absolutely everywhere. I am not a dwarf or midget, but smallness does run in my family. I'm very rarely sick, I have never had any serious illnesses, and I've never undergone surgery.

I am now two months pregnant, and I wonder whether I am doomed to have a Caesarean section (my hips measure 32 inches). My mother, who is slightly larger than I am, has had four very healthy children. We all were induced before reaching full term, thereby avoiding a Caesarean delivery of a full-term baby.

Is there a good chance that I can deliver naturally at full term? If not, which is better--induction or Caesarean? In case you think the induction of labor might have caused my brothers, sisters and me to be shorter than average, I should tell you that I'm taller (by two inches) than both my maternal grandparents.--D.N.

A If smallness does indeed run in your family, then at some point in your genealogy, someone (your grandmother?) must have been delivered without a Caesarean section and without induction of labor. Therefore, I reject the theory that you MUST have either of these forms of obstetric intervention. Instead, I advise you to find a doctor who has a low Caesarean section rate, who shuns delivering babies by appointment, and who preferably is experienced in home births. Your search for this kind of expert physician (or midwife!) can be aided by David Stewart, head of the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC, Marble Hill, Missouri 63764). Challenge any doctor who tries to sell you a Caesarean solely on the grounds that he believes you are too small or the baby is too big.

Q Our 21-year-old daughter just gave birth to her first baby by Caesarean section. Her husband and I were with her throughout her labor. She went into the hospital at 8:30 p.m. when she had dilated to three centimeters, was put on intravenous, and was connected to a machine which monitored her pains and the baby's heartbeat, which was very strong throughout the labor. At about 11:30 p.m., she was given two shots for pain--one in the arm and the second in her buttocks. Two hours later, she was given another pain shot on her opposite side.

At about 4:45 a.m., when she had dilated to six centimeters, she was given an epidural, and she received booster shots until 10 a.m. when she had dilated to nine centimeters. The doctor said that if she hadn't dilated to 10 cm by noon, he was going to do a C-section. At 11:30, the nurse claimed she was not dilating well, called the doctor, and was told to get my daughter ready for a C-section. This despite the fact that she had dilated to 10. The baby has a cut on his right cheek, but he is all right otherwise.

Does a woman have to dilate to 10, and couldn't doctors wait a little longer before performing a section? My daughter has been told her other births will have to be by Caesarean. That same night, all babies born at that hospital were delivered by C-section, except for one twin who was born normally (the second twin was sectioned). The next day, a lot more

C-section births took place at that hospital. I just can't believe there are that many women who can't give birth normally, and I've even heard that epidurals slow down dilation. What is going on?--Mrs. E.D.

A You certainly are raising the right questions, since any kind of analgesia or anesthesia--epidural included--can slow down labor. As a matter of fact, as every doctor and most mothers know, simply walking into the front door of a hospital can lead to cessation of contractions. Furthermore, the limitations of laboring time which doctors place on women before performing a section gets shorter and shorter. This is one reason why the Caesarean section rate now has skyrocketed to unprecedented heights.

The warning your daughter says she received to have her future births by Caesarean section flies in the face of most learned opinion. It is debatable which was "the most unkindest cut of them all"--the cut on your grandchild's cheek or the cut down your daughter's abdomen.

Q I've had two babies--one by vaginal delivery, the second by Caesarean section. I would like my next baby delivered vaginally. Do you think a trial of labor would be unwise in view of the fact that I have a low classical incision?

I have read many articles about normal deliveries following a C-section. They've all been very positive, but they refer almost totally to the low transverse abdominal and uterine incisions. Only the Dublin study reported a classical section to be more risky, but it was considered within reason to try a trial labor with an I.V. started, cross-matched blood and staff close at hand.

Can you help me? I'm confused, filled with lots of statistics and desperately in want of a vaginal delivery. I'm 31, in excellent health, exercise regularly, am not overweight, and am anxious to have another child. My husband and I have a close friend, a general practitioner, who is willing to go along with us if we decide on a trial of labor. He has a lot of requirements--obstetrician on hand, etc.--and we feel he is doing us a favor by letting us go for a trial delivery. He has done 30 vaginal deliveries following Caesarean sections without one case of uterine rupture.--G.D.

A I applaud your decision to explore the possibility of vaginal delivery, even though you apparently had a classical Caesarean section. I also congratulate you on finding a doctor who will go along with you. If you or your doctor need another opinion from a nationally-renowned obstetrician, try Dr. William Matviuw of Schaumburg, Illinois, who has an outstanding record in delivering babies vaginally to women with previous sections. He therefore attracts many patients from out-of-state.

We already know that "once a section, always a section" is nothing more than an old obstetrician's myth. Perhaps, as a result of your careful investigation and forthcoming personal experience, the prejudice against vaginal birth following classic Caesarean section will be relegated to the same category.

Pelvic exams can cause breakage of water bag

Another example of how doctors can endanger the birth process appeared in the medical journal Obstetrics and Gynecology in January 1984. Dr. John P. Lenihan, Jr., M.D., of the Department of Ob/Gyn, U.S. Air Force Hospital, Royal Air Force, Lakenheat, U.K., disclosed that the examining hand of the doctor is a major cause of premature rupture of membranes or PROM (too early breaking of the bag of waters). This common complication of pregnancy subjects the mother and fetus to the risk of both illness and death from infection (chorioamnionitis). The routine internal examinations

carried out by many obstetricians open up a pathway for bacteria to enter the cervix and produce infection and ruptured membranes.

In Dr. Lenihan's study, the incidence of Caesarean sections was more than twice as high in women with PROM as in those whose membranes remained intact. In 175 patients in whom no pelvic examinations were performed until term, the incidence of PROM was six percent, but in 174 patients in whom pelvic examinations were performed weekly (after the 37th week), the incidence was 18 percent.

If you are a pregnant woman, when the obstetrician says he wants to perform a pelvic examination to determine the condition of the cervix and other organs, ask him whether he is aware of the published hazards of this kind of examination.

Doctor-induced hyaline membrane disease

A study conducted by a team of physicians at the neonatal intensive care unit of the Milton S. Hershey Medical Center in Hershey, Pennsylvania, has shown that doctor-induced hyaline membrane disease (a serious lung condition of babies) could be reduced at least 15 percent if obstetricians scheduled Caesarean sections and other kinds of induced delivery more carefully.

The report stated that at least 6,000 of the estimated 40,000 cases of hyaline membrane disease which occur annually in the United States could be prevented if doctors did not induce delivery until they were sure the fetus was mature enough to leave the womb. The study concludes that "a reassessment of current practices with regard to the artificial termination of pregnancy seems appropriate."

I've just read about a new technique that will use metal staples to close up the uterus after Caesarean sections. What do you think about this latest "breakthrough"?--L.F.

Is stapling dangerous?

In accordance with the rule that one never learns the truth about one medical procedure until a new one comes along to take its place, I call to your attention a statement from the American College of Surgeons on the stapling technique for Caesarean sections.

Researchers at the University of California in San Francisco are developing an automatic surgical device which they claim may simplify the performance of this now-common operation. Michael R. Harrison, M.D., associate professor of surgery at the University of California, comparing his new device with present methods, begins his explanation with, "Instead of just cutting the uterus open with a knife and letting it bleed, which is the current approach...."

That's a very graphic description from one who knows just what happens to one's womb at the hands of one's obstetrician. Of course, Dr. Harrison then told about the great advantage of staples. But, if one reads far enough into this medical puffery, one learns that in animal studies, metal staples placed into uterine tissues led to a reduction in fertility.

The statement continued: "Although the metal staples did not appear to significantly damage uterine tissue, they did frequently migrate through the uterine wall, and the researchers speculate that fertility was affected by the exposure of the endometrial cavity to a foreign object." Therefore, the investigators are presently conducting a study using absorbable staples. What have they learned thus far? "The research team does not yet know, however, if absorbable staples will have an effect on fertility."

When doctors just "cut the uterus and let it bleed," they would tell patients, "Once a section, always a section." But now, if they turn to

staples and their resultant possibility of sterility, they can tell their patients, "Once a section, once a section."

C-sections don't lower infant mortality

If your doctor tells you that Caesarean sections are responsible for saving babies' lives, ask if he knows of the work of Dr. Jack W. Pearson of Indiana University Medical Center's Department of Obstetrics and Gynecology.

Reporting on nine years of experience in a teaching institution which serves a high-risk urban population, Dr. Pearson said that, while the Caesarean section rate ranged from five to eight percent, well below the national averages the infant mortality rate dropped from 35 per thousand to 18 per thousand (American Journal of Obstetrics and Gynecology, 1984). In other words, with very little change in the section rate, there was a huge decrease in the infant mortality rate.

The same finding was noted by Dr. Robert H. Usher of McGill University in Montreal, Canada: "The rise in the Caesarean section rate from five percent to 20 percent over a 15-year period had little justification."

Dr. Usher's study, reported at the Ninth European Congress of Perinatal Medicine, is particularly important for mothers who face breech births. If your doctor should tell you that Caesarean section is necessary to protect the oxygen supply to your breech baby, ask him if he knows that Dr. Usher has found that "increased Caesarean section has not improved the asphyxia (suffocation) rate in breech presentations."

Herpes and C-sections

After studying records from 3,000 U.S. hospitals, the Centers for Disease Control have discovered that one-third of the 184 herpes-infected babies born at those hospitals had been delivered by Caesarean section (Physician's Weekly, August 25, 1986).

This contradicts the conventional medical wisdom that expectant mothers who have herpes MUST have a Caesarean section in order to protect their babies from serious skin problems, abnormal mental functioning and death.

Why doctors do C-sections

Why is today's Caesarean section rate at least 10 times higher than it was when I received my training 35 years ago? In the 1940s and '50s, any physician whose C-section rate exceeded three or four percent was called on the carpet. Today, the section rate nationally is around 30 percent, and in many large research and teaching hospitals it is 40 percent or even higher.

Cynical critics of modern medicine attribute this explosion in Caesarean sections to the greed of doctors who get paid more to perform a C-section than to assist at a vaginal birth. Yet in Canada, where doctors get paid just about the same for either route of childbirth, the Caesarean section rate is also around 30 percent.

Critics claim that the epidemic of C-sections is a result of the doctor's desire to schedule his life in a more orderly fashion. And while it is true that, in some hospitals, many more sections are done between 9 a.m. and 5 p.m. Mondays through Fridays, in other hospitals there is a more even distribution between day and night, weekdays and weekends.

Doctors themselves have a long list of reasons--including fear of malpractice suits--for the escalation of Caesarean sections. Because all of these explanations portray the doctor as venal, money-grubbing, hedonistic, and less-than-honorable, I am not happy with them. For years, I have argued that, even though it's nice that the money goes the right way, the doctor (with exceptions of course) isn't in it just for the money. He does not operate on a Marxist basis, i.e., motivated exclusively by his own economic interest.

If such were the case, one could change the behavior of doctors by altering their economic incentives. But, over the years, experience with many different compensation schemes (fee-for-service, salaried practice, HMO's, DRG's, etc., etc.) has demonstrated the futility of trying to change physician behavior by altering economic incentives. No, the physician is not in it for the money. Rather, he does what he does because he believes in what he is doing. In the case of Caesarean sections, the physician deeply believes that he is doing the right thing.

The question is--the right thing for whom? For the mother? For the baby? For both?

In whose interests were Caesarean sections done years ago? Obviously, in the overwhelming majority of cases, they were done in the interest of the mother (toxemia, contracted pelvis, etc.). Doctors did Caesarean sections to save the life--or to preserve the health--of the mother. And legitimately so. After all, with few exceptions (e.g., German measles), no one knew what was going on with the baby. The primitive stethoscope gave little information about the baby's condition. There was no ultrasound or other form of fetal monitoring. Sections were seldom performed for fetal indications.

In contrast, today the doctor has all kinds of technologies at his command to give him information about the fetus--the Doppler (ultrasound) stethoscope; ultrasound scanning; amniocentesis; certain maternal blood tests; chorion villus sampling, and external/internal fetal monitoring. This information explosion about the baby has led directly to the explosion in the Caesarean section rate.

Today, most Caesarean sections are done for fetal indications rather than maternal indications. The obstetrician promises the mother "a perfect baby." He regards (whether correctly or wrongly) a Caesarean section as the best guarantee of a perfect baby.

He threatens the mother and father with a brain-damaged baby if they refuse to consent to a section. Yet, in reality, the Caesarean section is one of the most effective methods of <u>producing</u> a brain-damaged baby--through four mechanisms:

1) The depressant effect on the vulnerable infant's brain of the analgesic and anesthetic agents used to carry out the section, which travel right from the mother through the placenta into the baby's blood stream and central nervous system.

2) "Iatrogenic (doctor-produced) prematurity," i.e, the doctor guesses incorrectly and delivers the baby too early. Low birth weight babies are particularly prone to mental retardation and cerebral palsy.

3) Hyaline membrane disease (HMD), also known as respiratory distress syndrome (RDS). This lung condition, which interferes with the transport of oxygen into the infant's blood stream--and hence to the brain--occurs in full-term babies born by section. RDS is practically unheard of in full-term babies delivered vaginally.

4) The baby delivered by section is far less likely to be breastfed --thus exposing his developing brain to the deficiency of crucial nutrients (taurine, DHA, etc.) and the high lead levels of infant formulas.

Thus, the doctor tries his best to frighten you of what he considers the risks of vaginal birth while concealing the risks of Caesarean section. But, let us for the purpose of argument concede that the obstetrician is right in his belief that Caesarean sections really do save infants from death and disability.

The obstetrician then is faced with a serious ethical decision. He knows that the maternal mortality from vaginal birth is in the neighborhood of 1/30,000 to 1/50,000. He further knows that the maternal mortality from Caesarean sections is in the neighborhood of 1/2,000 to 1/4,000.

Although the exact statistics are a matter of controversy, no doctor will disagree that, as far as the mother's life is concerned, Caesarean sections are more dangerous than vaginal births. Therefore, the obstetri-

cian should know that, in order to get that "perfect baby" (the quotes are here because the infant mortality rate has dropped just as much in countries with low Caesarean section rates as here in the U.S.), he must sacrifice a certain number of mothers. This should pose an ethical problem, i.e., whose life takes precedence, the mother's or the baby's?

Throughout the ages, various ethical systems have addressed this dilemma in different ways. My Jewish tradition teaches that fetal interests are held subservient to the life of a mother. If necessary, the fetus must be destroyed if he/she threatens the mother's life. Other religions have their ethical systems. And today's doctors, consciously or unconsciously, have their own ethical system. They have decided that the "perfect baby" takes precedence over the life of the mother.

Obviously much, perhaps all, of this decision making remains subconscious. Otherwise, a doctor who was concerned over a fetus' well-being, or even its life, would spell it out for the husband: "I am worried about the baby. We can try to save the baby, but the trade-off is an increased chance of your wife dying. What is your choice?"

I wonder whether any doctor puts it this way to prospective parents--or to himself. How does he himself evade this reality? Does he waffle by saying, "We can save them both." Does he substitute his limited personal experience ("I've never had a mother die") for the reality of a large statistical sample? After all, doctors have seen plenty of babies die during birth. But how often do they see a mother die? Even with a 30 percent Caesarean section rate, the average obstetrician could practice for decades (his entire professional lifespan) without having a maternal death. But the fact that he himself has never seen such a catastrophe must not lead him to deny that it can, and does, occur.

My conclusion is that the basic issue in the ever-increasing Caesarean section rate is not the personality of the physician, not malpractice insurance, not new technology. The basic issue is ethical--which life is worth more? And this ethical issue deserves to be highlighted so that every mother and father will be able to make a fully conscious decision. Those who opt for a perfect baby at the expense of an occasional maternal death will do as much as they can to find out how the baby is getting along before birth. On the other hand, those who place the mother's interests paramount will shun monitoring and will go for midwives and home births. In both cases, parents must ask doctors about the documented risks of their interventions--Caesarean section in particular--to the mother's life.

Maybe the silver lining in this dark cloud will emerge when the bloom is off the rose of both obstetrical interventions and pediatric interventions (neonatal intensive care units). When high-tech births are revealed as unproven methods of achieving perfect babies, what now appears to be an ethical issue will turn out to have a simple medical solution. (Repeated from The People's Doctor Newsletter, Volume 10, Number 1.)

Bibliography

The following books can help you plan for a healthy delivery without Caesarean section intervention:

1) "The Five Standards of Safe Childbearing," by David Stewart (available from P.O.Box 267, Marble Hill, Missouri 63764).

2) "What Every Pregnant Woman Should Know," by Tom Brewer, M.D. (Random House, $8.95).

3) "A Woman in Residence," by Michelle Harrison, M.D. (Random House, $13.95).

4) "Silent Knife: Caesarean Prevention and Vaginal Birth after Caesarean," by Nancy Wainer Cohen and Lois J. Estner (Bergin & Garvey, $14.95).

Another View

by Marian Tompson

Despite clear evidence of risks that include death and serious questions about claims of improved pregnancy outcome, it is truly a scandal that Caesarean sections continue to increase in this country.

At a Baby Fair attended by thousands of women in Chicago, exhibitors at a childbirth display were shocked to discover that more than 50 percent of the women who stopped at their booth had had at least one C-section. As a result of this trend, we have growing numbers of angry women who are asking why this happened to them after they had carefully prepared for a normal delivery. On the other hand (and even more frightening), complacent groups of uninformed women now think that because Caesareans have become so common, they must be o.k.

Because I wondered what to do about this situation, I contacted Nancy Wainer Cohen, co-author of "Silent Knife" and a founder of the Caesarean Prevention Movement. I also got in touch with some local Chicago women--Linda, a midwife; Joy, a nurse and Bradley teacher, and Kathy, co-chairman of a Caesarean support group.

"There's something terribly wrong in the world when women have to be cut in order to have their babies," said Nancy. "And despite all the research showing that VBACs (vaginal birth after Caesarean) are safe, 98 percent of those women will have Caesareans for their next baby."

"Cephalo-pelvic disproportion (CPD) is the reason most often given for doing a section," Linda pointed out, "but 'failure to progress' is a close second, as the length of time a woman is allowed to labor gets shorter and shorter. The trouble is most doctors have never witnessed a normal, non-interfered with birth."

Joy was concerned that women weren't getting the help they needed to work through belief systems that could prolong labor. "If a woman has had a bad experience with a previous birth or if she has listened to birth horror stories, she might need help with coming to that place where she can trust her body and herself."

"Couples have to take more responsibility," Kathy observed. "They tend to leave too many decisions in the hands of their doctors."

Out of our conversations has come a number of recommendations to help decrease your chances of having a Caesarean section: 1) Be well informed. 2) Choose your birth attendant and place of birth very carefully, being aware that a low C-section rate at a hospital might mean increased use of forceps and vacuum extractors during delivery. 3) Know how comfortable your birth attendant is with a long labor and how long pushing in the second stage is allowed. 4) Eat well during pregnancy, using as a guide Tom Brewer's, "What Every Pregnant Woman Should Know." 5) Use visualizations and affirmations during pregnancy and labor. 6) Don't go to the hospital too early. If you live fairly close, Joy recommends that you wait until contractions are two minutes apart and last 60 seconds. 7) Stay away from fetal monitors, IVs and all other interventions. 8) Stay out of bed as long as possible; keep walking. 9) Engage a labor coach or experienced relative or friend for support and help with assessing the situation when decisions must be made. (Be sure to make this arrangement ahead of time because some hospitals object to an extra support person.)

Nancy Cohen encourages couples to have their babies at home: "You have to decide how badly you <u>don't</u> want a Caesarean," she explained. "For just by walking through the door of the hospital, where you have a 30 percent chance of having one, you already are sabotaging yourself. It's becoming less and less likely to get a vaginal birth in the hospital."

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