

## **"V-Back" to the Dark Ages**

By Elaine Stillerman, LMT

The popular belief that "once a Caesarean section, always a Caesarean section" came from a paper printed in 1916 called "Conservatism in Obstetrics," which cautioned doctors to avoid a primary C-section for fear that it would cause surgical deliveries in future births.

At that time, the national C-section rate was two percent. Further support of avoiding C-sections and urging vaginal births after C-sections (VBACs - pronounced "vee-back) came during the 1980s when studies at large urban hospitals indicated that a vast majority - nearly 80 percent - of women had safe vaginal births after C-section(s).

While not every woman is a candidate for VBAC, eligible candidates were overwhelmingly sought to have vaginal births when given the option. In 1996 in the United States, vaginal births after C-sections went up from 19.9 percent to 28.3 percent, and in Europe to 50 percent in 1997. In this country, government health experts supported VBACs as a way to minimize and control rising C-section rates, which reached 24.4 percent in 2001. The report published in 2000 gave a goal of increasing VBAC rates to 37 percent of births by the year 2010.

But instead of following these guidelines, just the opposite occurred. The rates of VBACs dramatically dropped from 28.3 percent in 1999 to 10.6 percent in 2003. Today, at hundreds of small hospitals across the country, women are being told that they have no choice in the matter and must undergo a surgical delivery or be sent to larger medical centers, often miles away from their homes, families and doctors, to give birth vaginally. This even includes women who have already had successful VBACs. "Once a C-section, always a C-section" has come back to haunt us.

What went wrong? It seems that during the late 1990s, reports started coming in, particularly from rural settings, about women who had ruptured their uterus during labor without the presence of medical staff to

deal with the emergencies. This caused widespread panic among doctors and hospitals and compelled the College of Obstetrics and Gynecology to revise their VBAC guidelines and stipulate that a doctor should be "immediately" available, rather than the previously worded "readily" available, in the event of an emergency. In other words, it required small, understaffed hospitals to have a medical team present at all times just in case of labor complications. Since many of these hospitals don't have that kind of medical staffing, they decided instead to ban the practice of VBAC altogether regardless of a woman's wishes. The other, and possibly more insidious reason, was the rampant fear of lawsuits.

In the majority of instances, the uterine scar from a previous C-section is very tough and able to withstand the contractions of an arduous labor. The rate of uterine rupture occurs less than two percent during a VBAC, the same degree as in repeated C-sections. None of this seems to impact the decision, however.

What doctors are failing to address is why the uterus might rupture in the first place. Some data (although inconclusive), suggests that the use of hormones to induce labor, or speed it up, such as prostaglandins and pitocin (synthetic oxytocin), increases the chances of rupture as much as 15 times. In midwifery practices, where labor augmentation is not used, VBACs are performed without any complications in the majority of cases. Uterine dehiscence (asymptomatic separations of the uterine scar) in a non-induced labor occurs in the same proportion as repeated C-sections, but some doctors and hospitals are still not willing to take the chance on a vaginal birth.

In third world and developing countries where sanitation is questionable, cephalopelvic disproportion (large fetal head size to small maternal pelvis size) is common, and access to medical care may be hours away, dehiscence of the scar may cause further uterine tearing and threaten the life of mother and child. But in the United States, which ranks 11th out of 117 in the world of the best countries to have a baby according to the 2003 survey "The Complete Mothers' Index and Country Rankings," published by Save the Children Foundation, serious rupturing is rarely a problem, particularly if labor-inducing and augmenting medications are not administered.

There are many reasons why women seek a VBAC. There is certainly less trauma to the body and a vaginal birth is easier to recover from than major abdominal surgery. The risks of surgical complications, including hysterectomy, increase with each C-section and the emotional satisfaction derived from a vaginal birth is unsurpassed. When a woman prefers a more family-centered, natural birth experience, she should be able to have one. The choice must belong to the women. Many women are more than willing to assume the risks

and responsibilities of a vaginal birth after a C-section and believe that their decisions are being undermined by hospitals whose primary concern is the bottom line, a fear of lawsuits, and doctors who find surgical births more lucrative and easier to manage than vaginal births.

Little by little, women's reproductive rights are being whittled away by doctors who refuse to learn the necessary, life-saving medical procedure, D & C (dilation and curettage), because it can be used to perform abortions; by insurance companies who put birthing centers and dedicated doctors out of business as a result of their unaffordable malpractice premiums; by misogynistic extremists in Washington who use our bodies as legislative fodder to take away our reproductive choices; and by small-minded hospitals who force women to cede ownership of their bodies and dictate to them how to have their babies. We are indeed going back to the Dark Ages.

#### *Resources*

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