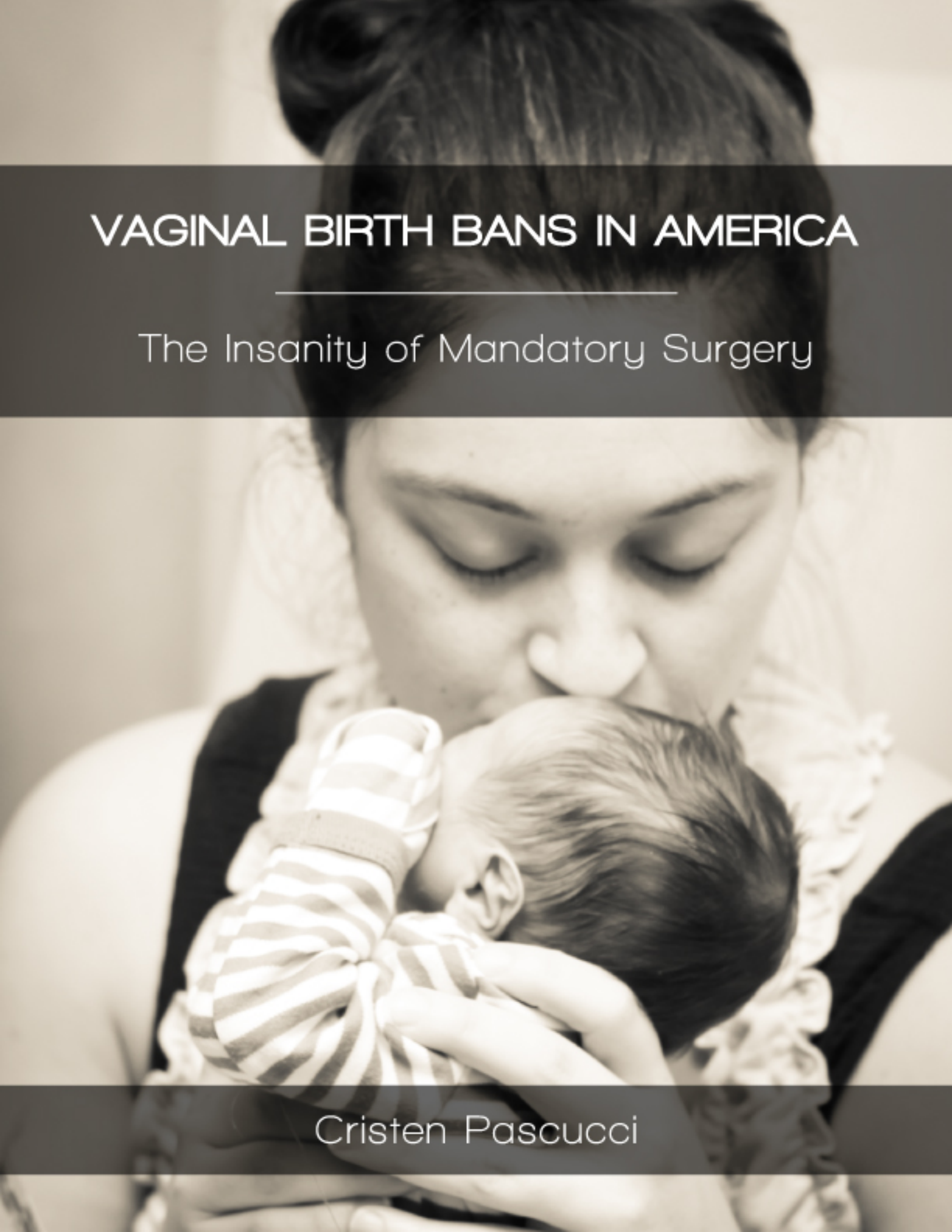

VAGINAL BIRTH BANS IN AMERICA

The Insanity of Mandatory Surgery

Cristen Pascucci

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Acknowledgements

The author would like to thank the following for their expertise and assistance in this eBook: Jen Kamel of VBACFacts.com, Hermine Hayes-Klein of Human Rights in Childbirth, Indra Lusero, and Dr. Stuart Fischbein, and especially to Rebecca Dekker, PhD, RN, APRN, of EvidenceBasedBirth.com for giving me the encouragement, guidance, and kick in the pants to put this together. Many thanks also to Dawn Thompson, president and founder of ImprovingBirth.org for her support and vision.

More important, I would like to thank the numerous women who have faced these bans and shared their personal stories. This eBook is for them.

Contents

Chapter 1: What's the Problem?

"I'm still astonished when I re-read my hospital records and remember my obstetricians telling horror stories to persuade me… or telling me how thankful they were to have chosen Cesarean section for their own birth. All of my obstetricians made notes at each of my visits about having informed me that I could not birth vaginally after a Cesarean there. They even documented my distress at not having a choice in the matter.

One obstetrician there was very, very honest with me, though. He said that their hands were tied and that they couldn't recommend the obviously safest option, based on peer-reviewed studies, because lawyers and other hospital policy-writers determined what would be covered by malpractice insurance. If baby or I died or were injured from Cesarean, they were completely covered. If we died or were injured during a vaginal birth after two Cesareans, they were completely on their own. So the safest medical option for me was NOT the safest financial/business option for them. Therefore, the 'First Do No Harm' principle no longer applies when it puts doctors at an even slightly greater financial risk." – Shaye Miller, Mother of five, Nebraska, 2014

Over one million Cesareans are performed each year in the United States (U.S.) – an all-time national high rate of one in three births, and about one in five first-time mothers [1] has her baby by Cesarean.* What many of these first-time mothers don't realize is that this first surgery has long-lasting health consequences and that they will most likely give birth to any future babies by Cesarean.

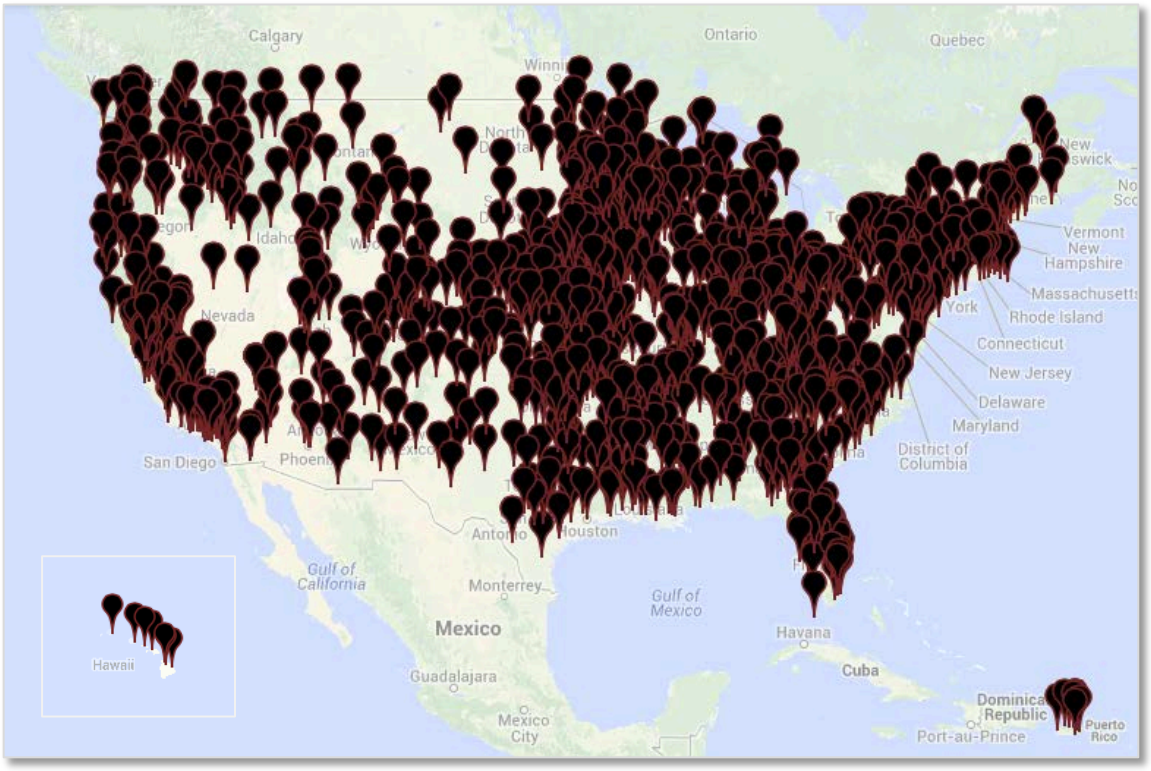
In fact, **ninety percent of women in the U.S. who have a Cesarean give birth to all future children by Cesarean surgery**[2] —with each additional surgery increasing risks of poorer health outcomes not only for the mother, but also for her future children. This situation persists despite the fact that the safety of vaginal birth after Cesarean (VBAC) has been acknowledged by many major health organizations, including the American College of Obstetricians and Gynecologists (ACOG) and the National Institutes of Health (NIH).

So why are only 10% of American women giving birth vaginally after a previous Cesarean? Is it because women are incapable of giving birth vaginally thereafter?

No, it is not. In fact, the majority of these women would go on to have a vaginal birth in future pregnancies—if they were given the chance. However, once a

woman has had a Cesarean, she will have difficulty finding a care provider and hospital to support her in a vaginal birth. In fact, vaginal birth after Cesarean is not allowed in over 40% of American hospitals.[3] That's right: these hospitals and providers tell women they may not give birth vaginally there.

Figure 1: U.S. hospitals with bans on vaginal birth after Cesarean (Alaska not shown)
Full, interactive map available through BirthMonopoly.com



My name is Cristen Pascucci, and I have been listening to women's stories about their encounters with vaginal birth bans for almost two years. As a consumer advocate in frequent contact with women from around the country about issues related to their maternity care, I have witnessed with dismay the widespread effects of these policies on women and their families. The voices of these women are inserted throughout this discussion.

Let's take a look at why VBAC bans are so harmful and so wrong.

Chapter 2: VBAC Bans Are Not Evidence-Based

"My former OB compared having a VBAC to crossing a busy street in the middle of the night with a blindfold on." – Marilyn, Florida

Are VBACs safe?

Major health organizations like the National Institutes of Health [4] and the American College of Obstetricians and Gynecologists [5] (ACOG) use words like "safe," "reasonable," and "appropriate" to describe vaginal birth after Cesarean (VBAC) for most women. The American Academy of Family Physicians states that every eligible woman should be offered a VBAC. [6] Of women who do attempt a VBAC, three out of four will give birth vaginally, while the other one out of four will have a repeat surgery. [7]

Despite these facts, the prevailing public opinion is that VBAC is excessively dangerous.

Actually, it is inaccurate to claim that either mode of delivery is inherently dangerous or safe. Both vaginal birth with a scarred uterus and Cesarean surgery on a scarred uterus carry their own sets of risks and benefits.

Let's put things into perspective. Consider the mortality rates for moms and babies. The definitive 2010 *Vaginal Birth After Cesarean: New Insights* report published by the National Institutes of Health (NIH) found that while maternal mortality is still very rare in either VBAC or repeat Cesarean, "maternal mortality was significantly increased" for elective repeat Cesareans at 13.4 per 100,000 births vs. 3.8 per 100,000 births. [8]

That is, with a repeat Cesarean, the risk of death to the mom is more than three times greater than with a VBAC.

Following the 2010 NIH conference, panel member and director of the women's and children's center at Emory University Carol J. Rowland Hogue, PhD, MPH, said

> Women do suffer complications and their babies do have problems [in pregnancy]. Fortunately these are rare – but they occur irrespective of mode of delivery. The very rare experience of maternal death is higher for C-section regardless of whether it is primary or repeat. [9]

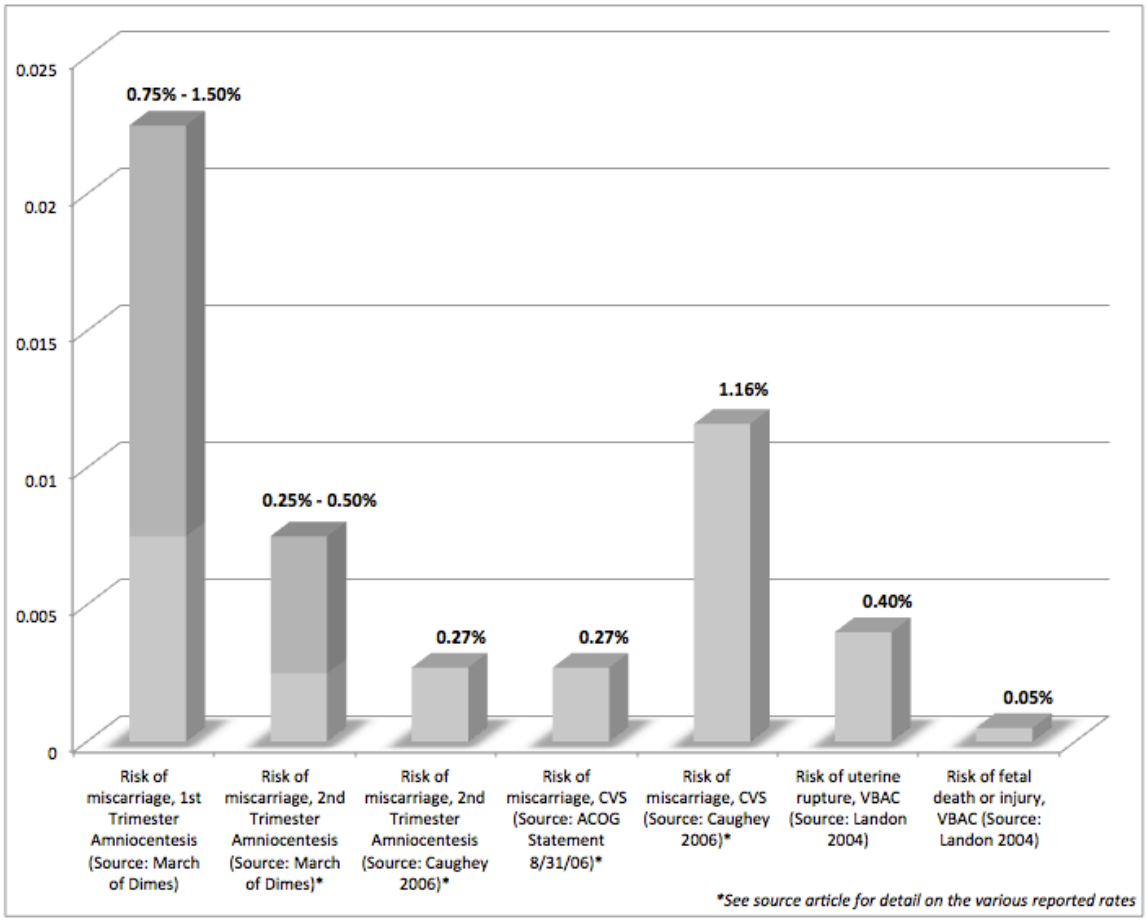
For babies, an important study published in the Journal of the American Medicine Association found that although the risk of the baby dying is slightly higher in the first VBAC compared to a planned repeat Cesarean, the risk of a baby dying in a VBAC is "not significantly greater" than during a first time mom's labor. [10]

(Uterine rupture – an oft-cited and frequently misunderstood risk in VBAC – occurs in a VBAC labor 0.4% - 1% of the time,[11] and of that percentage, 6% results[12] in the death of the baby.)

In other words, VBAC is about as safe for that baby as it is for the baby of a first-time mom.

Meanwhile, the risk of fetal death due to amniocentesis (a diagnostic test during pregnancy), characterized as "small"[13] by ACOG and the AAFP, is more than five times higher than the risk to baby in VBAC. (More here: "Comparing Fetal Death and Injury: VBAC vs. Amniocentesis/CVS.")[14]

Figure 2: Comparing risk of miscarriage in diagnostic testing [amniocentesis, chorionic villi sampling (CVS)] with risk of uterine rupture in VBAC and fetal death or injury in VBAC
Detail at "Comparing Fetal Death and Injury: VBAC vs. Amniocentesis/CVS"



None of these numbers is a true side-by-side comparison of risks, but they are meant to give the reader perspective on the *level of risk* we are talking about. If the level of risk for vaginal birth after Cesarean is unacceptable, should we ban

vaginal birth for first-time moms and amniocentesis, as well? Following this logic, shouldn't every first-time mom have a Cesarean, every time?

The risks of multiple repeat surgeries

Again, vaginal and surgical birth each carries its own set of risks and benefits. But policies like VBAC bans imply that giving birth vaginally is inherently and significantly more dangerous than the "easier" option of a repeat Cesarean. At ImprovingBirth.org, we hear all the time from women that they were told of the "life-threatening" risks to them and their babies of attempting vaginal birth, but were never told of the ever-increasing long-term risks of more surgeries.

> *"After six vaginal births and one emergency c-section, my Ob told me I could VBAC. He backed out on me at 38 weeks. I was too much of a liability. I had a second and third c-section and was never told about placenta accreta or anything . . . . I'm now pregnant and have placenta accreta." – Dawn, Florida*
>
> (Placenta accreta carries as much as a 7% maternal mortality rate and 70% hysterectomy rate.)

These anecdotal reports are confirmed by the recent Listening to Mothers Survey,[15] a nationwide survey of American women who gave birth in hospitals in 2011 and 2012.** Mothers reported that, overwhelmingly, physicians steered them in the direction of repeat Cesarean by only talking about the risks of vaginal birth—and not disclosing the risks of repeat surgery. VBACFacts.com founder and director Jen Kamel[16] says the risks of repeat surgery are "not marketed to consumers" like the risks of VBAC.

In fact, this is what's really scary in the discussion: serious harms from multiple repeat Cesareans. The 2010 NIH ***New Insights*** report goes on to say, "This report adds stronger evidence that VBAC is a reasonable and safe choice for the majority of women with prior Cesarean. **Moreover, there is emerging evidence of serious harms relating to multiple Cesareans.**"[17] (Emphasis added.) In addition to the increased risks of surgery itself (infection, re-hospitalization, etc.), each uterine surgery increases the likelihood of placental abnormalities in future pregnancies – posing a threat to both the mother and her babies.[18]

Perhaps the most serious is placenta accreta,[19] a serious, life-threatening condition, for which the risk, by the fourth Cesarean, is a jaw-dropping 2.13%,[20] or one in 50. Placenta accreta carries as much as a 7% maternal mortality rate and a 70% hysterectomy rate. *Stanford Medicine* recently reported that this condition affected one pregnancy in 30,000 in our grandparents' generation.

Today, it affects one in 500.[21] (Read this March 2014 essay by a high-risk pregnancy doctor, "When a placenta tries to kill a mother.")[22]

> *"What option does this leave women like me, planning on large families, if we can't have informed consent to give birth the way we want to at our own local hospitals? . . . [F]or my fifth baby we had to travel three hours one way to a Phoenix hospital to wait out the last two weeks of my pregnancy." – Brynley, Arizona*

Neither should this information be used in an attempt to scare women away from repeat Cesarean. The evidence shows that the choice between a VBAC and a repeat Cesarean is a very **preference-sensitive one**. This means that there are potential harms and benefits to both ways of giving birth, and every woman should be allowed to decide which set of potential harms and benefits she is willing to accept, based on full, unbiased information.

But with VBAC bans, the hospital applies its own sweeping risk-benefit analysis to the bodies of individual mothers and babies. VBAC bans – mandating surgery for an entire group of women who may or may not need it – are quite the opposite of individualized, evidence-based care.[23]

Chapter 3: VBAC Bans Are Inhumane

Think about the fact that a woman is being told by someone else that she is not permitted to use her own body to give birth – not because she "can't," but because she is "not allowed." It's more than being given advice about alternatives in order to make an informed decision; **it's the complete removal of the alternative.**

To be clear, vaginal births, and vaginal births after Cesarean, are not medical procedures. They are babies coming out of vaginas, something that happens in and out of hospitals, with and without support, every day. They are not "performed" by doctors – women perform them. Vaginal birth is what women do when no one is imposing surgery on them.

> *"I was told right before he was doing the c-section, 'You won't be able to have a [vaginal] birth after this c-section, just informing you,' as if I wasn't upset enough!" – Marie, Florida*

Remember, too, that the bloated and variable Cesarean rate in the U.S is an indicator that many of these first surgeries were preventable. The overall chance of a Utah woman having a Cesarean is just over 22%; for a Louisiana woman, it's just over 40%. (See Birth Map.)[24] Before anyone starts pointing fingers at an "older," "fatter," "less healthy" population, **note that the most variability in U.S. C-section rates is among the low-risk population**.[25]

Even the Joint Commission, the accrediting body for hospitals, states that the wide variation in C-section rates in the U.S. is largely due to physician practice patterns—not women's risk factors or diagnoses.[26] One example of this is the astoundingly high number of women in the U.S. (1 in 10 first-time moms) who are taken to surgery for so-called "failure to progress."[27] In fact, researchers have shown that physicians ***misdiagnose*** women with "failure to progress" or "baby doesn't fit" at alarmingly high rates[28]—leading to half of all unplanned Cesareans in the U.S.[29]

For many of the women who underwent traumatic, unplanned, or preventable surgeries (and it can be a trauma of its own to find out later that a scary "emergency" surgery may have been avoided), it's devastating to realize that what happened in that first Cesarean didn't just mean major surgery with that baby – but major surgeries for every child after that.

(Please note that when I reference trauma, I am including the emotional and mental effects of the experience of childbirth. We hear regularly from women who experience mistreatment in hospital settings,[30] often resulting in depression and even full-blown PTSD, from both vaginal and surgical birth.)

"I was lied to by someone I trusted… my OB! He came in a total of two times during my first labor … and called a C-section. My second OB … scared me into another surgery. When I became pregnant with my third child, I asked my new OB if there was any way possible that I could try to have my baby vaginally and she said NO! with no hesitation. She said the hospitals would never allow it and once you've had two c-sections that was it. … I believed her and didn't think twice to research it. I started looking up VBACs after more than 1 c-section and my heart dropped. I knew I had been lied to. All of the things from my previous births started adding up and I realized my c-sections could have been avoided. I can't explain the hurt I feel inside. I'm embarrassed to even talk about it in front of women who have never had a c-section. … I don't wish this pain on my worst enemy." – Anonymous

In a civilized society, there is inherent value to the wants, needs, and choices of mothers giving birth.

VBAC bans, on the other hand, don't recognize the individual as deserving of her own set of circumstances, health, history, or wishes. They say: "We are imposing an invasive medical procedure on you regardless of who you are, what you value, or what you need, while denying you the ability to actively consent to the risks associated with this procedure."

Chapter 4: VBAC Bans Violate Constitutionally Based Rights

The idea of a ban on a normal, physiological process and forcing women to undergo a major surgical procedure leads to some dilemmas: Who has "ownership" over the body of a pregnant woman? Who gets to perform the risk-benefit analysis around the treatments she is given, and who has the final decision? Who has the legal authority and the moral right to do that?

These are serious questions with serious ramifications.

As United States citizens – or citizens of any constitutional democracy – we have implicit rights about the "ownership" of our bodies.[31] Importantly, in medical care, that includes the right to full information about the risks and benefits of not only a suggested course of treatment, but about its alternatives, including the option of doing nothing. Medical providers may offer advice and opinion, which patients are not obligated to accept. (See Informed Consent in Childbirth: Making Rights a Reality for an excellent discussion on this topic.)[32]

> *"After a long marathon labor at a birth center, I needed to transfer to a hospital and I was honestly too weak to fight with them over their strong VBAC ban, and too focused on my labor and getting my baby out, and so I consented to a repeat Cesarean, feeling I honestly had no choice." – Laura, Kansas*

Do *all* women have the right to informed consent and refusal?

The right of informed consent and its corollary, the right to refuse medical treatment, are fundamental rights based in the U.S. Constitution, and have been upheld by the United States Supreme Court: "A competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment." *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990). These rights mean that women can say "no" to surgery that they do not believe to be necessary or in the best interest of themselves and their babies.

With rare exceptions, medical providers do not have the legal authority to force women to accept treatment, but they may have the right to withdraw care or to not provide services they are not skilled or qualified to provide. What we are seeing in maternity care these days, however, is the increasing use of "withdrawal of care" (even *during* labor) as a way of forcing women to "choose" the doctor's recommendation for surgery. For patients who have no other care options, or are in the throes of labor, withdrawal of care can be a powerful form of coercion.[33]

> *"I was told by my local hospital that they do not allow VBACs as a matter of policy. . . . I was told I'd have to schedule my C-section at my 16 week appointment—to my shock—or they would drop me from their care. . . . The most common reason for the policy in my area has been 'insurance reasons.' I was, at one point, told I could 'knock myself out' and free-birth if 'it means so much to you.'" – Anonymous*

VBAC bans gut the right to refuse surgery and to choose for vaginal birth. Can a woman honestly be said to have "consented" to Cesarean surgery, when her local hospital tells her that it's the only "choice" they will support? Is it reasonable for maternal health care providers to consider themselves "unqualified" to support vaginal birth, in order to enforce that choice?

Professional ethical standards

ACOG, the national membership organization for obstetricians, could not be any clearer on the importance of informed consent, informed refusal, and patient autonomy. Just one example is this statement from ACOG's Committee on Ethics' 2005 opinion "Maternal Decision Making, Ethics, and the Law,":

> A fundamental tenet of contemporary medical ethics is the requirement for informed consent, including the right of competent adults to refuse medical intervention. The Committee on Ethics affirms that informed consent for medical treatment is an ethical requirement and is an expression of respect for the patient as a person with a moral right to bodily integrity.[34]

It's interesting to note that this opinion was not written to address ethical issues of women being forced into surgery for reasons we'll get into shortly, but the issues that arise when a provider recognizes that a mother may be endangering the life and health of her fetus by her risk-taking behaviors, like drinking alcohol or taking illegal drugs while pregnant.

How much more seriously should these ethical standards be taken when women are making decisions fully supported by medical evidence?

Rights and responsibility

Rights and responsibility go hand in hand. One of the fundamental dysfunctions in our maternity care system is the frequent assumption that care providers have both all of the responsibility and all of the rights in the childbirth process. This dysfunction contributes to a dynamic that leads to treatments being administered

to women without their permission, without adequate information, or even after they've denied consent. Providers, meanwhile, toil under an expectation that they deliver good outcomes even in circumstances that are beyond the control of anyone; the responsibility is an overwhelming and sometimes impossible one.

Birth after a Cesarean carries increased risk no matter the mode of delivery. Uterine rupture is real, as are all of the other risks that come along with either vaginal or surgical childbirth. Deciding how to deal with these risks is both a right and a responsibility for providers, but is even more important for pregnant women themselves.

And in the face of a bad outcome following our own autonomous decision, we cannot claim, "I should have been made to have a C-section"; nor can we say, "I should have been made to have a vaginal birth." We cannot expect courts to uphold our rights to such claims, if we expect them to uphold our right to make such decisions as autonomous persons. It is both, or neither.

Chapter 5: Unofficial and Implied Bans

The International Cesarean Awareness Network (ICAN) reports that outright bans exist in about 30% of hospitals, and *de facto* bans in about another 14% of hospitals.[35] A *de facto* ban means that there is no official hospital policy banning vaginal birth, but there are no doctors there who will "allow" one.

> *"I had to drive from Louisiana back to Texas in order to achieve a vaginal birth after Cesarean. I was told by a dozen care providers I was not allowed to attempt vaginal birth, but they would gladly give me a repeat C-section. We moved here when I was 6 months pregnant and I temporarily moved back to Dallas at 38 weeks until I went in to spontaneous labor at 41+3 weeks. As a result, if I get pregnant again while we live in Louisiana, I will be staying out of the hospital and will have a home birth! Absolutely ridiculous!" – Erin, Louisiana*

Out of the remaining 56% or so of U.S. hospitals without official or *de facto* bans, ICAN estimates that only a small number are truly VBAC supportive. That informal assessment is based on calls made to these hospitals from volunteer researchers and reports from women receiving services there. Data from the national Listening to Mothers III Survey seems to support the idea that VBAC support can be elusive: when providers expressed their opinions to expectant mothers in their care (and most did) about the mode of delivery, 88% of the time it was to recommend repeat Cesarean over vaginal birth.[36]

In places where vaginal birth is technically "allowed" but the environment is, in reality, unsupportive, women are told vaginal birth is an option, but they may be discouraged from it in every way possible. Most commonly, in these places, a "VBAC consult" is a discussion only about the dire risks of VBAC, with no discussion about the risks of a C-section or implications on future pregnancies.[37]

A discussion about the risks and benefits of a treatment, of course, is meaningless without a discussion of the risks and benefits of its alternatives, including doing nothing.

> *"When I was 37 weeks my mother-in-law told her ObGyn I was planning a VBAC and he told her, 'If she's planning a VBAC, her husband better get ready to raise their older kids on his own!'" – Amber, Texas*

This type of care may include inaccurate information about VBAC, with the risk of uterine rupture as one of the most commonly cited and misstated risks: women are often quoted risk rates far in excess of what current evidence shows.

"My OB made numerous comments about how VBAC is more dangerous than repeat Cesarean. He said it was like standing in a line and someone picking you at random, for disaster. You never knew who was going to rupture their uterus." – Heather, Texas

Women may also encounter random restrictions like only "allowing" until 39 or 40 weeks for labor to begin spontaneously before it's an "automatic c-section" – a practice not based on any scientific evidence, but effective at completely eliminating the possibility of vaginal birth for the significant portion of women who don't go into labor spontaneously until 40 weeks or later. (The natural length of pregnancy may vary by as much as five weeks.)[38] Women may be instructed to undergo frequent ultrasound measurements of baby's size and may receive dire warnings about how big the baby is getting. These women are inaccurately told that suspected macrosomia ("big baby") means that they "must" give birth by repeat Cesarean—when, in fact, suspected big baby is not a valid medical indication for Cesarean.[39]

Bait and switch

At ImprovingBirth.org, we hear from women all the time who plan vaginal births with their providers' support right up until the 37th or 38th week of pregnancy, when they are suddenly told it is no longer an option and it's time to schedule their repeat Cesarean. They may or may not be given a reason for this sudden removal of support. Among women who are trying for a vaginal birth, this is known as the "bait and switch."[40]

"I was a doula for a woman who was told that they would 'let her try' a VBAC. As it got close to the end of her pregnancy they started telling her that her baby was 'big' and wound up scheduling her for a c-section without asking her first. She was so worn down by that point she just went with the repeat c-section." – Catherine, Oregon

At that point in pregnancy, it's extremely difficult or impossible to find another provider, and these women are left, seemingly, with no choice – and, often, with a profound sense of betrayal during a vulnerable time. For many women, giving birth outside of a hospital is not something they'd consider; for many women who have had prior Cesareans, it is illegal for a midwife[41] to attend them in birth at home; and for many women, the costs or logistics of traveling to more supportive care are prohibitive.

A few women out there understand that their most basic legal rights supersede hospital or provider preference, and may opt to "show up pushing": that is, they labor at home as long as possible and then go to the hospital with the intention of declining surgery against policy. These women knowingly enter uncertain and even hostile environments, where institutional policy and civil rights conflict on their laboring bodies. While a woman may be said to have the right to decline surgery, based on our experience, she takes a chance that her refusal may not be respected or that she will receive punitive treatment.

Situations like this breed mistrust in the patient-provider relationship, and introduce more risk and complications on both ends.

"For most mamas in Nebraska, the options are to have a repeat section, an unassisted homebirth, or travel 2+ hours in labor to a hospital that 'allows' VBACs. And I am SICK of it." – Amber, Nebraska

Meanwhile, there's a chilling effect created by these bans that might extend to any hospital or group of providers. A woman may go to a VBAC supportive hospital in labor, having been seen by a supportive doctor all along, only to find that the on-call doctor refuses to support her plan, or will only do so on strict conditions that limit her chances of success. In these cases, we see a slow but steady stream of women who report being threatened with court-ordered C-sections and/or Child Protective Services as a means of coercion to abandon a plan of vaginal birth. D in Pennsylvania is one; her story is here,[42] and we were notified of three other women in three different states in the weeks prior to publication of this eBook. Such threats carry weight only within a system in which a woman's right to say "no" to surgery is not at all secure.

Chapter 6: Vaginal Birth as a Privilege

What options does a woman have against a ban on vaginal birth? Her ability to pay has a lot to do with it.

Some women are able to travel – with the associated costs of transportation, childcare, and hotel accommodations – to another hospital that allows vaginal birth. For many rural women, that could mean several hours away or to the next state.

> *"There are no hospitals within 2 hours that support VBAC in central AZ. I had two unnecessary c-sections because of it." – Serenity, Arizona*

Some women opt for home birth, where they know the only way they will end up in surgery is if it is truly necessary. But it's not always as easy as Googling your nearest skilled midwife. In many places around the country, where home birth has been pushed underground (ironically, by the very system women are trying so desperately to avoid),[43] it can be like transacting a drug deal: little transparency about who you are contracting with, limited options, uncertainty about what happens if something goes wrong, and the specter of the law hanging over the entire arrangement. And, of course, it's an all-cash deal.

> *"We are candidates for VBAC according to ACOG guidelines, but the local hospital says 'too bad. It's our way or the highway.' So we hit the road, travelling two hours across state lines to meet with a legal midwife for our prenatals and plan our evidence-based VBAC....in a hotel." – D., North Carolina*

Again, the ability to pay comes into play in the access to supportive care. Some women can travel to or import the midwife of their choice. Many cannot. We are seeing more and more women deciding to give birth unassisted – that is, at home without the presence of any professional childbirth attendant at all – not because they want to, but because they feel it is their only option.

Black market birth

Some women may, literally, pay cash to be permitted a vaginal birth at the hospital. We have heard from women in several states that certain hospital providers will allow a woman a vaginal birth for an up-front, non-refundable cash fee due in the third trimester. The fee, usually in the range of $1,000 to $2,500, is over and above insurance or Medicaid reimbursements. Two women revealed

that doctors in their areas also charged $400-$750 an hour for every hour they labored over four hours.

> *"One provider here charges a VBAC or water birth fee. Completely separate and cash. Nothing to do with insurance. … There is another provider that charges hourly … I simply cannot imagine the stress on a mama of reaching each and every new hour. I cannot see myself progressing with that kind of stress … Breaks my heart to see women faced with these decisions: go somewhere without support, or pay outrageous fees to have someone who agrees that this is normal birth." – M., Florida*

These fees may be to cover the time for a doctor who must be in attendance for the entirety of the time the woman is in labor for two reasons: it may be hospital policy for the doctor to be there (which we'll talk about next) – and that's not to say that some well-meaning doctors, in that circumstance, see this fee as their only feasible route to attending VBAC labors – or it may be to assure the attendance of that specific doctor, versus any other on-call doctor who acts as if s/he has the right to simply say "no" to the woman's plans and start prepping her for surgery. Regardless of the reasons for these fees, this kind of black market dealing can only occur where options are so severely restricted as to allow it, and where, again, the unequivocal right of women to say "no" to surgery they do not believe to be in their or their babies' best interest is elusive.

The incentives here are striking. You can pay cash to give birth using your own body, or, if you are not so privileged, you are subject to mandatory surgery that will be billed out to insurance or Medicaid at about twice the rate of a vaginal birth.[44]

Chapter 7: Why Do VBAC Bans Exist?

Now we get to the core of the issue: why do VBAC bans exist, against medical evidence, our best interests, our constitutional rights, and growing consumer demand?

There is a layered and murky history here, related to insurance companies supporting mandatory VBAC (even for women who were not good candidates) and mass, non-medically indicated inductions of VBAC labors with risky drugs like Cytotec back in the 1990s, which led to some women and babies experiencing disastrous outcomes. These disasters resulted in lawsuits that paid big, drove up liability concerns and liability insurance rates, and impacted hospital policies. (There's a great article about this history on *The Well-Rounded Mama*.)[45] Rather than blaming bad practices, unfortunately, VBAC itself was blamed.

However, evidence of the harms of these practices was published. And in 2010, the National Institutes of Health held a definitive conference on VBAC to set the record straight. We now have a whole body of evidence that leads major health organizations to express support of VBAC as a "reasonable and safe" option for most women.

Today, the one thing almost anyone will cite as a major barrier to supporting VBAC is the "immediately available" recommendation set forth in 1999[46] (when national VBAC rates had begun to plummet[47] from a high of 23.8% in 1996) and again in 2004 by the American College of Obstetricians and Gynecologists—the membership organization for obstetricians. This was a non-binding yet still powerful *recommendation* to hospitals that a "physician [be] immediately available throughout active labor who is capable of monitoring labor and performing an emergency Cesarean delivery."

Importantly, the term "immediately available" was never defined, but many hospitals interpreted it to mean that an obstetrician and/or anesthesiologist must remain exclusively at the hospital while a mom is in labor – which could take anywhere from a few to twenty-four hours — and also means that the physician cannot be off-duty or see other patients during that time. That's an onerous burden on providers who are not required to exclusively attend the births of other, non-VBAC patients.

Why the exclusive treatment?

Does a VBAC mom need this kind of special protection?

The "immediately available" recommendation was based on the possibility that a catastrophic event may occur at any time during a VBAC labor, requiring immediate emergency surgery to save the woman's and baby's lives. And to someone who doesn't know anything about childbirth, this may seem like a reasonable precaution. But, if you do know anything about VBAC and birth, you understand that *the risks for VBAC are not unique to VBAC, and all births carry similar risk of catastrophic events at any point in labor – including for first-time mothers and repeat Cesarean mothers*.

If a hospital is not equipped to handle a catastrophic event from VBAC, what protections can it provide to any woman giving birth? How is it handling obstetrical emergencies at all, if it can't provide support for VBAC birth? **Wouldn't you, as a birthing mother, want to know that an emergency Cesarean is not "immediately available" at the facility where you are giving birth?** Because if a hospital is not equipped to handle an emergency that happens at a VBAC, it is also not equipped to handle an emergency that may occur during labor with any woman.

In fact, Dr. Howard Minkoff, said at the National Institutes of Health 2010 conference:

> Instituting the "immediately available" standard might be seen as means to reduce disparate outcomes, but also may merely "pick low-hanging fruit," leaving in place the excess morbidity related to not having an immediately available physician in other, more common, though equally perilous clinical circumstances.[48]

California Ob/Gyn Dr. Stuart Fischbein told us:

> [P]utting a routine VBAC in that [high risk] category is nonsensical. Remember, most emergent crash C-sections have nothing to do with VBAC, like abruption, cord prolapse, fetal distress, and there is no mandate that the private doc needs to be in-house for these laboring women. The policy makes no sense on its face.

Unable or unwilling to support vaginal birth?

But it's much more than the *ability* to handle VBAC; it's the *willingness* to do so. In 2010, panel members from the NIH conference urged hospitalsto reconsider their policies to allow more women access to VBAC.[49] That same year, ACOG softened its "immediately available" recommendation, saying that the recommendation shouldn't be used as a reason to limit VBAC access, and that hospitals, providers, and women could still make plans to accommodate emergency situations related to VBAC. [50] Yet that clarification has had almost no effect on VBAC rates.[51]

"Every time I went for a VBAC – I had 5 – they made me sign the waiver not to sue, and that I was risking my life and my unborn child's life… I had 5, repeat 5 vaginal births." – Anonymous

So why, today, do VBAC bans exist, even when influential national organizations urge against them? There are a myriad of factors, and they start with financial incentives, insurance issues, and perceptions about liability. And there's simple resistance to change: the backlash on VBACs that began in the 1980s has resulted in deeply entrenched beliefs, as well as policies and practices for which no real incentives to change things have yet emerged.

Here's something else that came out of the 2010 NIH VBAC Conference: "We are concerned that medical-legal considerations add to, and in many instances exacerbate, these barriers to trial of labor [or attempted VBAC]. Policymakers, providers, and other stakeholders must collaborate in developing and implementating [sic] appropriate strategies to mitigate the chilling effect the medical-legal environment has on access to care."[52]

One Texas Ob/Gyn told us he recently stopped offering VBAC because he couldn't handle the numbers of women coming to him in an area where C-section rates are between 35% and 60%. "I can do a C-section in 30 minutes in my sleep and get paid more than waiting 24 hours for you to deliver," he said.

Dr. Fischbein talks about the pressures on hospitals, providers, and women:

> The reason that a lot of hospitals ban VBACs anyway – and this isn't very well known to most people—is because their insurance carrier will tell them that if they allow VBACs, their premium will be much higher. Rather than pay higher premiums, they just ban VBACs and do so under the guise of patient safety. The hospital lawyers, the insurance company lawyers, the insurance company executives, and the hospital administrators are making [these] decisions for patients… (See the full interview here at *Stand and Deliver*.)[53]

The Commission for the Accreditation of Birth Centers (CABC) recently changed its policy on offering VBAC in accredited birth centers, to open up access to more women.[54] CABC president Dr. Susan Stapleton told us frankly that political pressures weigh heavily on the ability of birth centers to offer VBAC. If the hospitals collaborating with birth centers don't support VBAC, it's very difficult for a birth center to offer it as a reasonable option.

All that said, when providers who care for mothers and babies witness a catastrophic event, it is only natural and normal for them to want to avoid another

one at all costs. There are real emotional and psychological impacts on the people who care for mothers and babies. But, again, the idea of "perception" comes in. An increased risk of uterine rupture in a VBAC labor is a known risk, and when it happens, the cause and effect are readily identified. But we are not so quick to make the connection with repeat uterine surgeries and the future catastrophes that can result. Would providers who so firmly counsel against a vaginal birth do so if they could foresee the potentially devastating consequences waiting down the road for that woman and her next baby?

> *"I was told right before he was doing the c-section, 'You won't be able to have a [vaginal] birth after this c-section, just informing you,' as if I wasn't upset enough!" – Marie, Florida*

And the reality is, for providers, hospitals, and women, it is never possible to circumvent all risk in childbirth. In the case of VBAC bans, supporting only Cesarean surgery as an immediate option merely sets in motion a different set of future health risks – and, perhaps, a different set of liability risks once these connections are made in the public consciousness. Will it take the rise of placenta accreta to turn this tide?

The specter of liability, real and perceived, looms large over these decisions and very much deserves its own discussion. The threat of lawsuits is a powerful motivator, or deterrent, and it is unfair to dismiss that threat when it has very real impacts. What seems to have been lost in that discussion, however, is the underlying right of women to say "no" to surgery that providers and hospitals readily confess has nothing to do with clinical need.

There are many factors influencing VBAC bans and the accessibility of VBAC, but patient safety is not necessarily at the top of the list.

Chapter 8: The Bottom Line

Incredibly, today, a huge number of women in the U.S. have lost the right to decide how they give birth. But VBAC bans threaten *all* child-bearing women. **These bans systematize the idea that *a third party's self-interest or personal preference* about how a woman gives birth may override her rights to her own body and baby.**

Under any circumstances, that's a stunning precedent.

The practice of banning vaginal birth after cesarean is a microcosm of everything that's wrong with birth in the United States. It's a policy that runs counter to medical evidence, dismisses the best interests of women and babies, and tramples on women's rights to make informed decisions about their own bodies and the births of their own babies.

We've got to hit the reset button on a system that forces us all into corners, and start recreating our practices and standards *beginning with* what's best for the end-users of that care – and upholding as our guiding light that no practice or standard should ever violate the bodies or rights of those being cared for.

It's time to put women and babies back in the center of maternity care, and build from there.

"Now just a little more than 8 weeks from my due date . . . I find that the hospital is reviewing VBAC policy. . . In [my doctor's] words "there are no guarantees for me." He is going to ask "permission" for me to birth vaginally again. . . . I have spent the last two weeks digging to find another provider only to be overwhelmed with what they will "allow" me to do in birth—telling me when they will break my water (regardless of my wishes), how I will have to be induced if I don't start labor "on time," how many times they will "require" [vaginal] checks (even after they have broken my water which introduces more and more risk of infection), how they will augment labor if I don't go fast enough to try to circumvent this infectious environment (that they created) etc., etc., etc. I've had 4 children… not one of which I got to hold after birthing. Moms like myself . . . are without voices in a sea of politics and red tape." – Kim, Missouri

Chapter 9: What Can We Do?

Women facing surgical ultimatums can exercise their consumer power to search out and find another provider willing to inform and support them in their birth choices, when possible. These women may have more options than they realize, but it can be difficult for the average woman to sift through her provider options with no real insight on how those providers practice (it may be possible to get hospital-level statistics on C-sections and VBACs, but it is rare to find publicly available or verifiable statistics for individual providers). By connecting with local and national networks, women may get valuable insight about their options that can mean the difference between a forced choice and a real one.

The International Cesarean Awareness Network, with chapters all over the country and in Europe, is the primary support and information group for women who have had Cesareans. BirthNetwork National is another great place to connect with moms and advocates, and ImprovingBirth.org is an advocacy group working on this and other issues in maternity care related to non-evidence based and inhumane practices.

ImprovingBirth.org is developing a VBAC Bans Toolkit free of charge to consumers who wish to reverse these bans. Get on the mailing list here, and donate to the cause here.

Women can educate themselves about the reality of VBAC and repeat Cesareans – and educate others, including their care providers, family, and friends. There is a good deal of misinformation out there, and women must seek out reliable sources that come from an evidence-based – not a tradition-based – perspective. Childbirth Connection and VBACFacts.com are excellent, balanced sources of information on these topics. Jen Kamel of VBACFacts.com also offers high-quality, comprehensive, and unbiased classes on the history, politics and statistics of post-cesarean birth options to parents, medical providers, birth professionals, advocates, and public health administrators.

Fighting back

Women themselves can reject these bans. They can refuse to swallow the assertion that they are "banned" from undergoing the normal, physiological process of childbirth – that that they can only expect medical support in childbirth if they forfeit their own active decision-making. That starts with each woman standing up on her own and deciding she's going to take action – whether that's working with and educating her provider, meeting with hospital administrators or local legislators, going to the press,[55] or finding lawyers willing to search out novel approaches to asserting their rights (contact Human Rights in Childbirth).

Especially in states where the law is imposing medical policies influenced by big businesses that financially benefit from those policies, there may be courses of action that haven't yet been explored.

"Thank you, Louisiana State Medical Board, for yet again not allowing a midwife to attend a home birth. The mom is now planning an unassisted birth at home after cesarean. That was your desired result?" – H., women's advocate, Louisiana

Around the country, women and families are working hard to change these laws and regulations so that they may have access to supported birth at home and in birth centers. Like some medical policies, these state policies don't always respect the rights of women and families to make their own informed decisions about childbirth. In places like Arizona, physicians, (including the state chair for the national membership organization for obstetricians, ACOG), campaign against the right of women who have had a prior Cesarean to give birth outside of a hospital,[56] but don't address the fact that 22 out of 43 Arizona hospitals don't support VBAC (as evidenced by those hospitals' VBAC rates of 0% to 5%).[57]

The prevalence of VBAC bans suggests that a woman's place in childbirth – 100 years after birth began to move from home to institution – is still devalued to an extreme. It's up to all of us to change that paradigm. Even women without previous Cesareans – like me – who are "allowed" the choice of vaginal birth, can boycott practices and hospitals that impose VBAC bans, and we can let them know why we are taking our business elsewhere.

We *must* let them know, because we don't know who will be next. As it stands today, in many places, women have the lost the right to decide how they will give birth when they've had prior Cesarean or are carrying twins or breech babies. Who will be the next group of women whose pregnancies fall under a third-party risk-benefit analysis that doesn't align in their favor? Where does this encroachment end?

With a one in three average C-section rate across the U.S. – and estimated to be over 56% by 2020[58] – the medical, legal, and ethical problems with VBAC bans aren't going away. The pressure is growing. Mothers, advocates, and policymakers must be there to meet it.

About the Author

With the birth of her son in 2011, Cristen Pascucci left a career in public affairs to find answers to questions that arose during her experience in her maternity care. Why are so many women peripheral in their own maternity care? Why does language like “You’re not allowed” and “We can’t let you” persist, from health care providers to adult women? Why do women’s legal rights and dignity lose such value when we are pregnant or in the process of giving birth? Her mission today is to educate and inspire women to turn this tradition on its head.

Cristen joined the executive board of ImprovingBirth.org in 2012, and began running a support and legal hotline for pregnant women (most attempting vaginal birth after Cesarean) shortly thereafter, in collaboration with lawyers from Human Rights in Childbirth. She is co-founder of a soon-to-launch U.S. legal advocacy network that will formally address some of the critical issues facing child-bearing women.

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References

[1] Osterman, M.H.S., J.K. Michelle, and J. A. Martin, M.P.H. (2014). "Primary Cesarean Delivery Rates, by State: Results From the Revised Birth Certificate, 2006–2012." Centers for Disease Control and Prevention.
[2] "User Guide to the 2012 Natality Public Use File" (2013). Centers for Disease Control and Prevention.
[3] "VBAC Policies in US Hospitals" (2009). International Cesarean Awareness Network.
[4] National Institutes of Health. (2010). “NIH Conference Statement. Vaginal Birth After Cesarean.” *Obstet Gynecol* June 2010 - Volume 115 - Issue 6 - ppg 1279-1295 (Free full text here.)
[5] ACOG Committee on Practice (2010). "Practice Bulletin #115: Vaginal Birth After Previous Cesarean Delivery." *Obstet Gynecol.* 2010 Aug;116(2 Pt 1):450-63. (Free full text here.)
[6] Wall, E., Deutchman, M, W. Hueston, et al. (2005). “Trial of Labor After Cesarean (TOLAC), Formerly Trial of Labor Versus Elective Repeat Cesarean Section for the Woman With a Previous Cesarean Section.” *Ann Fam Med.*
[7] Guise J.M., Eden K., Emeis C., et al. (2010). “Vaginal Birth After Cesarean: New Insights.” Agency for Healthcare Research and Quality. Evidence Report/Technology Assessment; 191.
[8] Guise J.M., Eden K., Emeis C., et al. (2010). “Vaginal Birth After Cesarean: New Insights.” Agency for Healthcare Research and Quality. Evidence Report/Technology Assessment; 191.
[9] DeNoon, D.J. (2010) "NIH Panel: End Bans on Vaginal Birth after C-Section." *WebMD Health News*.
[10] Smith, G.C., J.P. Pell, A.D. Cameron, and R. Dobbie (2002). "Risk of Perinatal Death Associated with Labor after Previous Cesarean Delivery in Uncomplicated Term Pregnancies." JAMA; 287(20):2684-90.
[11] Landon, M.B., J.C. Hauth, K.J. Leveno, et al (2004). "Maternal and Perinatal Outcomes Associated with a Trial of Labor after Prior Cesarean Delivery." N Engl J Med 2004; 351:2581-2589.
[12] Kamel, J. (2012). "Confusing Fact: Only 6% of Uterine Ruptures Are Catastrophic." VBAC Facts.
[13] American Academy of Family Physicians (2005). "Prenatal Diagnosis: Amniocentesis and CVS." *Am Fam Physician.* 2005 Oct 1;72(8):1577-1578.
[14] Kamel, J. (2008). "Comparing Fetal Death and Injury: VBAC vs. Amniocentesis/CVS." VBAC Facts.
[15] Declercq, E. R., C. Sakala, M. P. Corry, et al (2013). “Listening to Mothers III: Pregnancy and Birth.” Childbirth Connection.
[16] Kamel, J. (2012). "Some People Think I’m Anti-this/Pro-that: My Advocacy Style." VBAC Facts.
[17] Guise J.M., Eden K., Emeis C., et al. (2010). “Vaginal Birth After Cesarean: New Insights.” Agency for Healthcare Research and Quality. *Evidence Report/Technology Assessmen*t; 191.

[18] Kamel, J. (n.d.). "Placental Abnormalities." VBAC Facts.
[19] Kamel, J. (2000). "Placenta Accreta: A Risk of Cesarean Section." VBAC Facts.
[20] Silver, R. M., M.B. Landon, D.J. Rouse, et al (2006). " Maternal morbidity associated with multiple repeat cesarean deliveries." *Obstet Gynecol.* 2006 Jun;107(6):1226-32.
[21] Digitale, E. (2013). "Too Deeply Attached: The Rise of Placenta Accreta." *Stanford Medicine*.
[22] Karkowsky, C. (2014). "When a Placenta Tries to Kill a Mother." *The Atlantic*.
[23] "What Is Evidence-Based Maternity Care?" (2013) Improving Birth.
[24] Birth Monopoly (2014). "Birth Map." BirthMonopoly.com.
[25] Phend, C. (2013). "C-Section Rates Vary Widely Between Hospitals, Study Finds." *ABC News*.
[26] Tavernise, S. "Caesarean Deliveries Vary Widely, Study Finds." *The New York Times*.
[27] Boyle, A. (2013). "Primary Cesarean Delivery in the United States." *Obstet Gynecol* 122(1): 33-40.
[28] Zhang, J., J. Troendle, U. M. Reddy, et al (2010b). "Contemporary cesarean delivery practice in the United States." *Am J Obstet Gynecol* 203(4): 326 e321-326 e310.
[29] Dekker, R. (2013) "Friedman's Curve and Failure ot Progress: A Leading Cause of Unplanned C-Sections." Evidence Based Birth.
[30] Hodges, S. (2009). "Abuse in Hospital-Based Birth Settings?" *J Perinat Educ.* 2009 Fall; 18(4): 8–11.
[31] Hayes-Klein, H. (2013). "Informed Consent in Childbirth: Making Rights into Reality." Improving Birth.
[32] Ibid.
[33] Pascucci, C. (2014). "Because We Can: A Year of Inspiration." Improving Birth.
[34] ACOG Committee on Ethics (2005). "Maternal Decision-Making, Ethics, and the Law."
[35] "VBAC Policies in US Hospitals" (2009). International Cesarean Awareness Network.
[36] Declercq, E. R., C. Sakala, M. P. Corry, et al (2013). "Listening to Mothers III: Pregnancy and Birth." Childbirth Connection.
[37] Kamel, J. (2010). "Another VBAC Consult Misinforms." VBAC Facts.
[38] Kuehn, B.M. (2013). "Pregnancy length may vary by 5 weeks." *JAMA.* 2013;310(9):893.
[39] Dekker, R. (2013). "What is the evidence for induction or c-section for a big baby?" Evidence Based Birth.
[40] Kamel, J. (2008). "The three types of care providers amongst OBs and midwives." VBAC Facts.
[41] McMahon, A. (2014). "Real People, Real Life: #SB1157 – Brynley." AttachedMoms.com.

[42] Pascucci, C. (2014). "Forced Choices: PA Woman Backed by National Groups Against Mandatory Surgery." Improving Birth.
[43] Arnold, J. (2012). "Hopes of VBAC out the window?" TheUnnecesarean.com.
[44] "Average U.S. Facility Charges for Giving Birth: Facility Labor and Birth Charges by Site and Mode of Birth, United States, 2009-2011." Childbirth Connection.
[45] Vireday, P. (2009). "A History of VBACs and Cesareans in the U.S.A." WellRoundedMama.blogspot.com.
[46] American College of Obstetricians and Gynecologists (1999). "ACOG Practice Bulletin – Number 5: Vaginal birth after previous cesarean delivery." *Int J Gynaecol Obstet.* 1999 Aug;66(2):197-204.
[47] See Figure 1: "Rates of Total Cesarean Deliveries, Primary Cesarean Deliveries, and Vaginal Birth After Cesarean (VBAC), 1989 to 2007," here.
[48] Minkoff, H. (2010). "The Immediately Available Physician Standard." Retrieved from *NIH Vaginal Birth After Cesarean (VBAC) Conference: Programs & Abstracts*.
[49] DeNoon, D. J. (2010) "NIH Panel: End Bans on Vaginal Birth after C-Section." *WebMD Health News*.
[50] Kamel, J. (2010). "ACOG Issues Less Restrictive VBAC Guidelines." VBAC Facts.
[51] Grady, D. (2010). "Panel Urges New Look at Cesarean Guidelines." *New York Times.*
[52] National Institutes of Health. (2010). "NIH Conference Statement. Vaginal Birth After Cesarean." *Obstet Gynecol* June 2010 - Volume 115 - Issue 6 - ppg 1279-1295 (Free full text here.)
[53] Freeze, R. (2009). "Interview with Dr. Stuart J. Fischbein." Rixarixa.blogspot.com.
[54] Pascucci, C. (2014). "Birth Centers Change the Conversation on VBAC." Improving Birth.
[55] Schroeder, M. (2013). "Mother Protests VBAC Ban." ArkansasMatters.com
[56] Rau, A.B. (2014). "Senate bill pursues midwife restrictions." *The Republic.*
[57] Arnold, J. (2013). "Arizona: Where do VBACs occur in this state?" CesareanRates.com.
[58] Solheim, K.N., T.F. Esakoff, S.E. Little, et al (2011). "The effect of cesarean delivery rates on the future incidence of placenta previa, placenta accreta, and maternal mortality." *J Matern Fetal Neonatal Med.* 2011 Nov;24(11):1341-6.

* This percentage is based on 2012 data from 38 states, the District of Columbia, and New York City – where the "revised" U.S. Standard Certificate of Live Birth has been implemented. The full report is here.

** The Listening to Mothers Survey III surveyed 2,400 mothers giving birth from July 2011 through June 2012. The survey was produced by Childbirth

Connection, conducted by Harris Interactive®, and funded by the W.K. Kellogg Foundation. The full report is here.