C-sections: 'We want women to feel like they're heard'

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to the following absolute and non-absolute risk criteria." If the mother or baby presents with any absolute risk criteria, they are precluded from out-of-hospital births and midwives have to transfer care to a licensed physician.

Throughout her years of experience, Childress has successfully conducted vaginal, home-birth deliveries for a majority of her patients, which mirrors national statistics.

In a study of roughly 17,000 women conducted from 2004-09, published January 2014, the Midwives Alliance of North America found that for planned home births with a midwife in attendance: The rate of normal physiologic birth was more than 93 percent; the cesarean rate was 5.2 percent; 87 percent of women with a previous cesarean delivered their newborns vaginally; and of the 10.9 percent of women who transferred to a hospital during labor, the majority changed locations for nonemergent reasons. Also, the study found a very low rate of interventions without an increased risk to mothers and babies.

Besides the fact midwives are dealing with more low-risk patients than hospitals — which significantly complicates direct comparisons — trends also exist within the practice that could contribute to fewer midwives' patients needing C-sections. A lot of midwives take a different approach to pregnant patients.

With fewer patients — Childress estimates she will have about a dozen this year — they often can spend more time with expecting mothers during prenatal visits. The focus of prenatal care is education, Childress said, adding, "We really focus on informed choice rather than informed consent" by presenting "patients with a whole range of options."

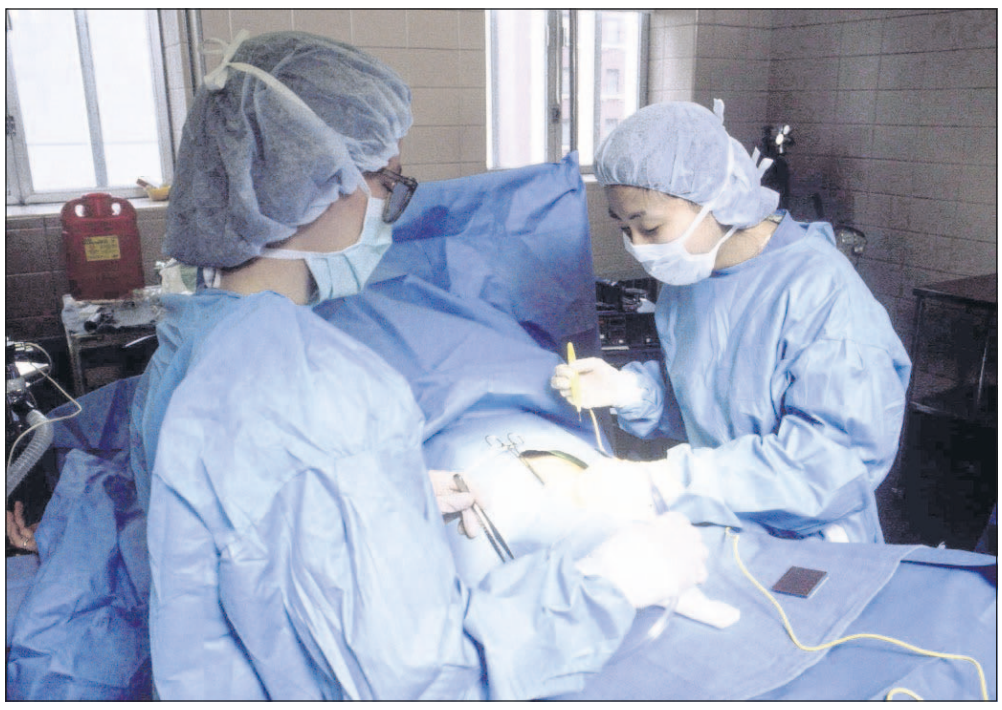
"We realize that spending time in the prenatal period really assists in the end result," she said.

During labor and delivery, midwives are protective of their patients and try to create a safe place for them, Childress said. Doing so helps the women's own hormones guide the process, which can lead to the need for fewer external interventions.

Not to say midwives don't use interventions, but they tend toward natural strategies. "Water is our home-birth epidural," Childress said. That is partly because midwives are limited in what they can do medically, but also because of the profession's dominant philosophy that birth is a natural process, not a medical procedure.

With midwives, birth "is treated like the most natural thing in the world, because it is," Seaside doula Katie Mendoza said.

Rather than ascribing to a strict set of guidelines about what is normal for a birth, which makes deviations seem alarming, many in the home-birth business broaden the definition to include other "versions of normal," said Priscilla Fairall, a local doula or nonmedical birth companion.



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Surgeons performing a cesarean section.

When to intervene

What she and Mendoza fear is happening at the hospital level is the institutions have started relying on early interventions, which sometimes lead to a cascade of further interventions.

Childress agreed that can be problematic.

"You start one intervention, and they just lead to one right after the other," she said.

> ***'At the end of the day, we would like to have all vaginal deliveries, as it is best for the mother and baby.'***
>
> **— Paul Mitchell**
> community outreach manager for Columbia Memorial Hospital

Childress said she believes medical professionals can avoid problems "by understanding how birth works." She advocates patience and encourages women to do most of their labor at home where they can rest, because once they are in a hospital setting, "it's often hard to relax in that situation," she said.

Mendoza feels many things could be improved at the local hospitals when it comes to infant deliveries.

"All the hospital births I've gone to have not been great," Mendoza said. "The celebration has not been there."

Melissa Van Horn, who had her only child at Columbia Memorial several years ago and experienced severe complications, said "sterile" is the word she would use.

"There's a lack of emotion, a lack of connection," she said. "It's all about being pushed through the process — that's how it felt."

However, that could be because "hospitals are in the business of practicing medicine," not recognizing birth for the "incredible experience" it is, Mendoza said. That's where midwives and doulas can add something different to the birthing business.

Not all insurances will cover midwife care or home-births; sometimes they are considered "out of network" so payments will be higher. Certified professional midwives are not required to carry liability insurance, though. It is rare for a midwife to be sued, Childress said, partly because the practice relies on relationship-building and informed choice.

Childress believes the cost for midwife care is less than one would pay for hospital care, because there are not the accompanying hospital charges, which appear to escalate the cost of birth.

Community Outreach Manager Paul Mitchell said Columbia Memorial is interested in reducing the C-section rate and "they routinely evaluate cases and look for improvement opportunities."

"At the end of the day, we would like to have all vaginal deliveries, as it is best for the mother and baby," he said. "We weigh all of this with how best to provide a safe delivery for the individual mother."

Prior to delivery, obstetricians, pediatricians and nursing staff review individual cases, Mitchell said. When a patient is admitted to the hospital, her risk factors "are evaluated by the entire team with an eye on both the mother's and the baby's well-being," he added.

As for interventions, the hospital tries to use integrated therapies, such as aromatherapy, massage and guided imagery, to minimize medical interventions. They also encourage walking and provide a labor tub, he said.

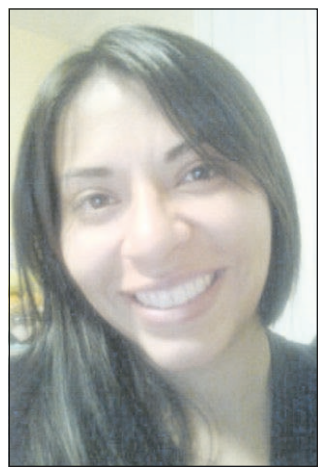
"Our providers, nurses and all other hospital staff are committed to providing care in line with CMH's Planetree philosophy, which boils down to providing care that supports the whole person," Mitchell said. "Many of our returning mothers will request, by name, to be cared for by a nurse that they connected with during a previous birth."

Viable solutions?

While childbirth in general poses potential risks to mothers and babies, regardless of the delivery method, the rapid C-section rate increase without evidence of direct causes "raises significant concern that cesarean delivery is overused," states a research paper by the American Congress of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine.

The trouble is, there is not the research to "tease out which ones really meet the threshold of risk versus benefits," said Dr. Aaron Caughey, who is chairman of the department of obstetrics and gynecology and associate dean for women's health research and policy at the Oregon Health and Science University.

Jennifer Childress



Priscilla Fairall

When considering safe and appropriate opportunities to prevent overuse of cesarean deliveries, sources suggested several methods.

While it would not lower the primary cesarean rate, which is most important, increasing local access to vaginal births after C-sections (VBAC) for appropriate patients could help break the cycle often created after a primary C-section.

Up until a few years ago, CMH and Providence Seaside Hospital had physicians who would conduct VBAC, but the hospitals both changed their policies. Providence's decision was driven by the potential risks associated with such births and the limited resources of a small community hospital, McCoy said.

Among suitable candidates for VBAC, approximately 60 to 80 percent will have a successful vaginal delivery, according to the OB-GYN group.

The other 20 to 40 percent will end up needing another C-section, so the congress recommends hospitals have an anesthesiologist and obstetrician who can do surgery in the hospital at all times.

For small, rural hospitals that are under-resourced, having a team available in case a VBAC attempt turns into an emergency situation is sometimes not a viable option, especially with other hospitals an hour or two away, Caughey said.

Childress, and often other midwives, can conduct VBACs depending on patient risk assessment.

Doula support

The use of doulas before and during the birth process seems to have positive benefits, as well. Doulas are individuals who offer emotional and mental support to women — and their partners — during birth. They are not medically trained, but "having someone by your side, who's an advocate for the mom during the birth process" can be a great option, Childress said.

Using doulas in hospital settings has produced some positive results.

In a research paper by Dr. Ellen Hodnett and others in the Cochrane Database of Systematic Reviews in 2013, 22 trials involving 15,288 patients revealed women given continuous support — such as that provided by a doula — were more likely to have a spontaneous vaginal birth; their labors were shorter; and they were less likely to have a C-section or instrumental vaginal birth or a baby with a low Apgar score, the standard method for testing a newborn's health. The results were best when the continuous care providers were neither part of hospital staff nor in the women's social network.

Group coordinated care also is a practice that's been adopted by certain institutions, such as the Oregon Health & Science University's Center for Women's Health. Under that model, the prenatal care of women who share a similar due date is provided through discussion and support groups led by a midwife and nurse-midwife. Each of about seven sessions lasts nearly two hours.

Not only do group sessions help relieve some of the responsibility for prenatal care and education from physicians, who have numerous patients to see, but it creates an environment where multiple women and their partners feel free to ask questions and learn from one another, Mendoza said.

Women need to feel like they had input and a choice during every step of the way, she said. "We want women to feel like they're heard," and that birth didn't "just happen" to them, she said.

Fairall agreed, adding, "a better birth outcome is not necessarily not having a cesarean." Rather, a good outcome, she said, is when "you're an active part of your health care." For deliveries that require C-sections, she said, women should "feel they can embrace having had a cesarean because they knew what was going on."