C-section Information

Website Resources:
Caesarean Rates
For more information about C-section rates in your state, county by county, go to
http://www.marchofdimes.com/peristats/and use "Create Maps".
Pick your state, and then scroll down to C-section deliveries in the second box.

The ICAN site has lots of good evidence based information on Caesareans and vaginal birth after Caesarean (VBAC), too.
International Cesarean Awareness Network
http://www.ican-online.org

Journal Article:
"Elective Cesarean Surgery Versus Planned Vaginal Birth: What Are the Consequences?"
http://www.madisonbirthcenter.com/docs/elective_cesarean_consequences.pdf

Summary:
New Lamaze White Paper Examines Outcomes of Surgery vs. Vaginal Birth (Lamaze International) Elective or "maternal request" cesarean surgeries pose serious and life-threatening complications for mothers and babies. Despite the risk, the popularity of elective cesarean surgery continues to rise-from 2001 to 2003, the rate increased by 36 percent.

Discussion Group
Topic: Increased Caesarean section rates causes increase in premature deliveries
I have heard that a good portion of the increase is quite possibly related to the increase in caesareans. Dr.'s will often plan electivec caesareans at 37 or 38 weeks (to avoid the woman going into labor on her own). Add to that how many times Dr's are "off" on estimating dates, and you end up with quite a few babies REALLY being born at 34, 35 weeks gestation, instead of 37-38.

We had to go in on December 23rd to have some stitches removed from my little guy's foot. Our pediatrician is our next-door neighbor. We had the 1st apt at 8:30 am & expected to be out by 9 at the latest. Well... it was almost 10:30 before he even got to the office because there were over 25 newborns between the two hospitals he has privileges at who had to have their newborn exams! (apparently, normal for overnight is 3-5!) He said only 3 of them had been natural and the rest induction/c-section birth. A couple he knew were doctors making things easier for themselves and others were moms who wanted to be home to show off their new baby for the holidays! He is a very strong Christian and just shook his head while we were discussing it and said "I don't know what's wrong with people! What are they thinking? It's not a car tune up were talking about-- it's a new life! I'm pretty sure that is NOT how God intended birth to proceed!" I had to agree

Topic: VBAC provider support
The first thing that needs to happen for these moms is that they need to switch doctors. Taking childbirth classes is not going to allow them a VBAC if they are with a doctor who simply will not do one. The mother will not be able to convince the doctor, he may pay her some lip service and say that they can "try" but in the end, the doctor will find a reason to perform the cesarean. The mother needs to educate herself on the safety of VBAC and potential risks and non-necessity of ERCS and to

change doctors. If she's not comfortable switching now, she is likely going to be less comfortable switching in 5 weeks after taking childbirth education classes.

Childbirth: Wales getting it wrong

February 13, 2006
Robin Turner, Western Mail
http://www.walesonline.co.uk/news/wales-news/2006/02/13/childbirth-wales-getting-it-wrong-91466-16696365/

MUCH more must be done to discourage "frightened" Welsh women from choosing Caesarean sections and to help stressed maternity unit staff, says the nation's first Professor of Midwifery. As Professor Billie Hunter takes up her new role, she is provoking a debate on the growing number of women in Wales opting for Caesareans - one of the highest in the UK. Almost one-in-four Welsh mothers goes under the knife rather than have a natural birth, for personal and medical reasons.

The 52-year-old, who lectures at the University of Wales, Swansea, has also warned that Welsh maternity units are facing a serious shortage of staff. The childbirth expert, who has a quarter-of-a-century of experience in the specialty, says experienced midwives are becoming "burned out" and there is a problem recruiting younger people.

Professor Hunter wants home births to rise to 10% over the next few years and she also wants to see more midwife-led maternity units. Professor Hunter, one of fewer than a dozen chairs of midwifery in the UK, and the first in Wales, said that although Caesareans were sometimes necessary, mothers-to- be often chose to have them because they were worried about how much a natural birth would hurt.

She said, "If it's an emergency Caesarean or there's a clinical need, then it's appropriate. But we find that women may have physical or emotional problems after having a Caesarean when it wasn't needed. **My impression is that women are frightened about childbirth, they are frightened of pain and consider a Caesarean an option." Prof Hunter said she thought there was more midwives could do to help ease women's fears over natural childbirth**. "The relationship between midwives and women is key."

The rise of celebrity culture is also being blamed for the rise in Caesarean births. In 1970 just 5% of women opted for a Caesarean birth. By the year 2000 this figure had climbed dramatically to 20%. And the figures have been attributed to increasing pressures on modern mothers to contend with celebrity super mums and the speed with which they recover their slim figures following birth.

With C-section mothers such as Liz Hurley, Jordan, Louise Redknapp and Claudia Schiffer springing back into their fabulous pre-baby shapes in a matter of weeks, new mothers are feeling increasingly pressured to lose weight quickly after giving birth. Another C-section mother, Victoria Beckham, is even reported to be considering plastic surgery for the removal of her Caesarean scar.

Helen Rogers, Welsh board secretary of the Royal College of Midwives, said, "It's not so much that Wales is too posh to push, but that pregnancy and birth is becoming a medicalised service. There is increasing intervention in pregnancy and labour and that is what, to a great extent, is

causing the rise in Caesarean sections. In some cases it will be the woman's choice, but we have to ask whether it is an informed choice - are they being given all the facts. It seems that a Caesarean section is being seen as a perfectly normal process when, in fact, it is abdominal surgery performed, in emergency cases, under general anaesthetic, and it has all the complications of other abdominal operations."

"Pregnancy is not an illness."

Mid and West Wales AM Helen Mary Jones, the mother of a nine-year-old girl, says Caesareans should be a medical necessity not a lifestyle choice. The Plaid AM said yesterday, "There are all sorts of reasons why women should go for natural birth.

"For instance, there are no scars to worry about and there is evidence that breast feeding can be affected by Caesarean section because of the way hormones are triggered. In my own case I gave birth to a large baby, and there was a time when a Caesarean section was a consideration. But I had very good midwives in the Heath Hospital in Cardiff and it was suggested I wait a bit longer and I gave birth naturally. There is no evidence of this happening in Wales, but certainly in the USA there are suggestions medical practitioners are going for Caesareans because it fits in with a nine-to-five schedule. We should never have that situation here. I am also extremely pleased we do have a Professor of Midwifery in Wales because it can only help to improve professional standards."

Prof Hunter said her new role is to carry out research into maternity issues in Wales, but also to educate midwives and parents on choices. She added that she hoped to influence policy on maternity issues.

As well as the increasing rate of Caesarean births in Wales, Prof Hunter said maternity services also faced problems of staff shortages. She said, "There's a big problem of recruitment and retention of midwives in Wales, as elsewhere. They get stressed and burned out after a couple of years. I need to find out why that is and help to stop it from happening. Midwives don't go into it for the pay, it's about job satisfaction."

Economic and social problems also affected maternity care in Wales, Prof Hunter added. "The biggest overall problem in Wales is inequality in health."

"It all starts with birth and how a baby is nourished in the womb has a major impact on that baby's life chances. If a midwife can get there early and influence what people eat and how they look after themselves, then it can help at a very early stage. There is scope for projects working with people in economically-deprived areas, ethnic groups or asylum seekers."

NIH Looks At Issue Of Elective C-Sections http://cbs2chicago.com/health/C.Section.Caesarean.2.265794.html

(AP) WASHINGTON Nearly three in 10 U.S. mothers are giving birth by Caesarean section -- a record number -- and more and more of them seem to be choosing a surgical birth even when there's no clear medical need.

No one knows exactly how many C-sections are purely elective. It's an intense controversy: Some estimates suggest there could be tens of thousands annually, and critics say many of those women were pressured into surgery or didn't know the risks.

Amid the uncertainty, the National Institutes of Health opened a three-day meeting Monday to determine just how much is known about the risks and benefits of a pre-planned Caesarean -- and how to ensure that mothers-to-be get all the facts.

"We all have noticed that women are asking for Caesareans more often. I don't think they always have the best information in making that decision," said Dr. Cathy Spong, pregnancy chief at NIH's National Institute of Child Health and Human Development.

A Caesarean can be life- or health-saving for many mothers and babies. Fetal distress, twins or more, or diseases that make labor risky for the mother are important reasons to have one.

At the same time, it is major abdominal surgery that poses some rare but serious, and occasionally life-threatening, side effects, such as hemorrhage, infection, blood clots. In addition, a prior C-section increases the risk of complications in future pregnancies, such as stillbirth or problems with the placenta, Spong says.

So what's the lure if it's not medically necessary?

Convenience plays a role for busy women. Maybe mothers need to schedule delivery so relatives can visit to take care of older children, or they live far from a hospital and worry about arriving in time. Or they fear something will go wrong and they'll wind up with an emergency Caesarean, considered far riskier than a planned one, especially if performed by a tired physician.

Others worry that vaginal deliveries can cause incontinence, although some studies dispute that the method of childbirth plays any role.

"Women deserve to know that. Whatever their decision, they need to know what the data is," said NIH's Spong.

In 2004, the latest data available, 29.1 percent of the nation's 4 million births were by Caesarean. That's the highest rate ever recorded, a 40 percent rise since 1996.

The rise is partly due to repeat surgeries: Some hospitals fearful of lawsuits refuse to let women who had a prior C-section attempt vaginal delivery with future babies, because about 1 percent may suffer a ruptured uterus, a potentially lethal complication.

But even among first-time mothers considered at very low risk for childbirth problems, the Caesarean rate is rising among every age group — from 21 percent of low-risk women under age 30, to 47 percent of those over age 40.

How many were pre-planned solely at the mother's request? The government figures can't say. A handful of recent studies that examined birth certificates and insurance claims estimate that roughly 80,000 women a year have elective C-sections.

Complicating the issue is the definition of elective, says Dr. Wendy Wilcox of New York's Montefiore Medical Center: More pregnant women are obese, for example, something that can increase childbirth complications but that medical records don't traditionally record as a Caesarean factor.

"I think the American pregnant woman is becoming a lot more high risk," says Wilcox.

There's little good data comparing mothers and babies who have elective Caesareans with healthy women who choose a vaginal delivery — as opposed to a C-section planned because of medical problems or an emergency one.

But proponents of elective C-sections say the worst risks are extremely rare, especially for a healthy, rested woman, and that vaginal birth has its own problems, such as vaginal tears or the use of forceps.

"At the end of the day it should be the mother's decision," said Linda Dyson, a New York public relations executive whose first baby was born by a medically necessary C-section but chose to have her second child the same way. "Honestly for me, I thought a C-section was safer."

On the other side is Barbara Stratton of Baltimore, who says a preventable Caesarean — required after her doctor induced early labor that stalled — left her in pain for months.

"I don't believe that any women should go through this major surgery unnecessarily," Stratton told a news conference organized by midwives who say women aren't adequately warned of Caesarean risks.

Researchers find c-section risk factors

Monday, March 13, 2006; Posted: 1:49 p.m. EST (18:49 GMT)
NEW YORK (Reuters Health) -- The likelihood that a pregnant woman will have to undergo an unplanned c-section delivery after starting labor can be predicted by four parameters, British researchers have shown.

Dr. Elisabeth Peregrine and colleagues at the University College London Hospitals studied 267 women at 36 weeks gestation or later who were scheduled for induction of labor. Eighty women (30 percent) ended up having an emergency cesarean.

Of all the measures assessed, four factors in particular were strongly tied to the need for a c-section.

Having never had a previous pregnancy raised the chances 20-fold. A body mass index over 30 (obese) was tied to 6-fold greater risk, while being tall reduced the chances slightly. Finally, a longer cervix measured by ultrasound was associated with a higher chance of having a cesarean.

When these factors were considered together they were "reasonably" accurate in predicting who would undergo a cesarean, Peregrine's team reports in the medical journal Obstetrics and Gynecology.

Maternal height and BMI "have been known for a while to influence the risk of cesarean section," Peregrine explained. "However it has been difficult to quantify them and combine them together to provide the woman with useful advice."

She also pointed out that measurement of cervical length by ultrasound is not done routinely at the moment, so the obstetrician in routine practice would not have this information.

Before the study's findings can be used to counsel women, they need to be validated, she added, and that is under way. If the results prove accurate, women could be told their risk of having an emergency cesarean delivery -- and those at high risk could be offered the chance to have a planned c-section.

Discussion Group:
Topic: Thoughts on the article above:
It seems to me there are, typically, several jump-to-conclusions issues here and I wish we knew more about the parameters of this study.

1. Never having had a previous pregnancy would seem to make the chances of c/s more likely due to the mother's AND care giver's limiting thoughts surrounding the body's ability to birth -- not the necessarily the factual reality of a given body's ability to birth.

2. A BMI index of 30 or more may not be relevant in a well-conditioned mother, regardless of her BMI.

3. Would a longer cervix indicate a cervix/body not being ready yet - on someone else's timetable - for labor, and if allowed to wait, would become 'appropriate?'

4. If a taller mom - with therefore an assumed longer torso? - has less risk of c/s, perhaps we could help "regular" height moms birth as easily by encouraging labor positions like the hanging squat which not only opens the pelvis but elongates the torso allowing baby to more easily make any last minute positioning changes. I just this week had this very birth. Talking to dad over the phone describing mom at 10 cms., for four hours, I encouraged this position. And though their nurse said she didn't think it would do a thing for them, there was a quick change in the labor and they were holding their baby within the hour, even though, according to dad, "all" other signs seemed to indicate the near probability of surgical birth.

The effect of dystocia and previous cesarean uterine scar on the tensile properties of the lower uterine segment

http://www.ncbi.nlm.nih.gov/pubmed/16522428

Source:
American Journal of Obstetrics and Gynecology
Volume 194, Issue 3 , March 2006, Pages 873-883

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Objective
The remodeling of uterine connective tissue during labor can lead to the reorganization of the extracellular matrix that, in turn, may influence the biomechanical properties of the myometrial wall. We hypothesized that the stretching of the lower uterine segment in laboring women with dystocia changes the viscoelastic properties of the uterine wall.

Study design
We tested the tensile strength of lower uterine segment myometrium in 68 pregnant women at term. The biomechanical, structural, and biochemical properties were compared among 3 groups: (1) 39 laboring women who underwent primary low-transverse cesarean delivery for labor dystocia, (2) 12 nonlaboring women who underwent primary elective low-transverse cesarean delivery and (3) 17 women who underwent an elective repeat low-transverse cesarean delivery at term. The tensile properties were quantitated with a stretching regimen that was designed to mimic the conditions of labor. Parameters such as slope, yield point, and break point were recorded, analyzed, and interpreted. Biochemical properties were determined by the measurement of the sulfated glycosaminoglycans, hydroxyproline, and pyridinoline-deoxypyridinoline. Histologic properties of the connective tissue were assessed by collagen birefringence. Lastly, the association between these properties and biomechanical responses were compared among groups.

Results
Lower uterine segment myometrium specimens obtained from laboring women were stiffer compared with specimens from women who were not in labor ($P = .013$) or had scarred myometrium ($P < .001$). The force that was required to reach the yield point was similar between labor and nonlabor groups ($P = .216$). Likewise, a previous lower uterine segment scar did not alter the yield point. The break point was similar among all groups ($P = .317$). Sulfated glycosaminoglycan levels were unaffected by labor or scarring ($P = .354$). Scarred lower uterine segment myometrium had a higher collagen content compared with unscarred myometrium specimens that were obtained during labor ($P = .025$). Although there were similar degrees of collagen cross-linking among groups ($P = .212$), there was lower collagen birefringence in myometrium from laboring women compared with nonlaboring women ($P < .001$).

Conclusion
Labor alters the viscoelastic properties of myometrium. Lower uterine segment myometrium is stiffest in women with dysfunctional labor compared with nonlabor control subjects. Labor and scarring also alter the pattern of collagen birefringence. Similar collagen cross-linking among the study groups may explain the reason that ****the breaking strength of the tissue is not altered by the state of labor and the reason that the rupture of the uterine scar is a rare event.** ****

Key words: Collagen; Cesarean delivery; Birefringence; Viscoelasticity

Supported by the following National Institute of Health—National Institute of Child Health and Human Development grants: Yale Women's Reproductive Health Research (WRHR) K12 HD047018-O1 and RO3 HD 50249-01(CBS).

New Study Confirms Cesarean Risks (Medical News Today)

http://www.medicalnewstoday.com/medicalnews.php?newsid=41247

A study just published by the journal Obstetrics & Gynecology confirms that birth by cesarean increases risks of two life threatening problems in future pregnancies. The conditions, called placenta abruption and placenta previa, involve the way the placenta attaches to the inner lining of the uterus.

Click here for the abstract
http://www.greenjournal.org/cgi/content/abstract/107/4/771?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=cesarean&searchid=1&FIRSTINDEX=0&volume=107&issue=4&resourcetype=HWCIT; Citation is Obstetrics & Gynecology 2006;107:771-778.

Gene Declercq

Judy Norsigian

One factor regularly cited as contributing to record high C-Section rates are moms who are "too posh to push." Judy Norsigian and Gene Declercq say this drastically distorts the story.

Editor's Note: *The following is a commentary. The opinions expressed are those of the author and not necessarily the views of Women's eNews.*

BOSTON (WOMENSENEWS)--"Too posh to push."

That catchy phrase originated in 2001 headlines of British tabloids and has been echoing through the news media ever since. It suggests a trend toward an increasing number of medically elective Caesarean sections requested by upper-class mothers.

In late March, the National Institutes of Health held a meeting called "Maternal Request Caesareans."

While dropping the emphasis on "posh," the title of the conference and its draft report seem to reinforce the general impression that mothers are fueling the trend toward elective Caesareans, which are at record levels in the United States.

Problem: No systematic evidence of this is available. In addition, focusing on maternal request obscures a more complex story concerning changes in obstetrical practice.

Although some studies do describe an increase in Caesareans without any medical indication, this may not represent real "maternal requests" at all. These studies, based on birth certificates or hospital billing records, have no way of documenting whether the surgery was sought by the mother or based on physician advice.

Childbirth Connection, a New York-based national nonprofit with whom we have each separately collaborated in the past, has conducted the only representative national studies, "Listening to Mothers," that directly survey mothers about their birth experience, including those who had a Caesarean section. The first study was published in 2002, initial findings of the second were completed in March.

In the most recent survey carried out in January and February 2006 among 18- to 45-year-old women who gave birth in U.S. hospitals to a single infant last year, only 1 in 252 women (0.4 percent) who had a primary Caesarean section without a medical reason actually chose this option herself.

Although there are undoubtedly some women who do seek elective Caesareans, they are hardly enough to increase the number of Caesareans by 400,000 nationally since 1996.

Great News Story

With Caesarean rates at an all-time high--accounting for 1.2 million surgeries and 29 percent of all births in 2004--reporters and editors are naturally interested in seeking explanations and "patient choice" makes an attractive news story.

Such stories often include human interest elements, such as following one woman's decision to elect a Caesarean. They also involve broader ethical issues, such as whether individuals should have the right to choose elective surgery and, if so, who should pay for it.

The news coverage, however, too often gives a skewed impression of who is electing to have a Caesarean. Many stories on maternal request, for instance, feature suburban white professional women, often obstetricians themselves.

These stories may be interesting, but they feed an inaccurate stereotype. Mothers with the highest Caesarean rates in the United States--African American women over 35--are rarely featured in such coverage.

So if it's not maternal requests, what then is causing the increase in Caesareans?

Answer: Primarily changes in obstetrical practice.

Long gone are the days when a single obstetrician handled a caseload of women to whom he or she made the extraordinary commitment to attend her birth no matter when that woman went into labor.

Now, the overwhelming majority of obstetrical practices are group-based, substantially reducing that individual bond with a mother.

In Childbirth Connections' 2002 survey, 19 percent of mothers reported they had never met the person who delivered their babies and another 10 percent indicated they had only briefly met their birth attendants.

Reality of Lawsuits

Another factor is the increasing concern about malpractice and the reality of lawsuits that may be brought even in instances when an obstetrician is not really to blame for a bad outcome.

It is not surprising that in the gray area of clinical decision-making during labor, many obstetricians have substantially lowered the threshold for when they would perform a Caesarean.

In cases involving maternal or fetal health risks, a Caesarean can be safer than vaginal delivery. But the core question in elective C-sections is whether they are safer when no medical risk is involved. That answer depends on many variables.

Are we are talking about the baby or the mother? Are we talking about this birth or the risks associated with future births (the more Caesareans a woman has the greater her risk of future delivery complications). Are we talking about short or long-term morbidity for the mother? Are we considering postpartum pain as part of the equation?

Caesareans, especially those that are scheduled and not matters of emergency, allow obstetricians to exercise their surgical skills, appear to decrease the likelihood of malpractice suits and provide more control over the scheduling of hospital and office hours.

Lack of Evidence

Advocates of medically elective Caesareans will also cite an array of health benefits for mothers and infants from Caesareans, although the National Institutes of Health conference made clear that solid evidence of such benefits is not available.

Nonetheless, as we know from survey findings, many women do hold erroneous assumptions about elective Caesareans.

For example, they may think of Caesareans as reducing the pain that they will experience. However, while regional anesthesia such as epidurals can reduce the experience of pain during vaginal deliveries, this pain often pales in comparison to the substantial long-term pain after birth experienced by women who have undergone Caesareans.

There is much we still don't know about the impact of Caesarean or vaginal birth on health outcomes, either for the mother or the baby or both.

We do know, however, that Caesareans cause more respiratory-lung problems in the infant, even with technology to avoid births before 39 weeks when this risk is higher. At the NIH meeting one pediatrician described a rapid rise in the occupancy rates of neonatal intensive care units in Brazil, where some city hospitals are said to have 90 percent Caesarean section rates.

Thus, the information now available makes clear that the growth in Caesareans--which includes mothers of all ages, races and across all medical conditions--is the result of a complicated shift in professional practice that deserves careful scrutiny. It is not primarily about mothers pressuring doctors to take what they perceive to be the "easy" way out, as contemporary media coverage would have us believe.

Gene Declercq is professor of maternal and child health at the Boston University School of Public Health. Judy Norsigian is executive director of Our Bodies Ourselves.

Women's eNews welcomes your comments. E-mail us at editors@womensenews.org.

Website Resources:

For more information:

Childbirth Connection--
NIH Cesarean Conference: Interpreting Meeting and Media Reports:
http://www.childbirthconnection.org/article.asp?ClickedLink=743&ck=10375&area=2

NIH Medline Plus: Caesarean Section:
http://www.nlm.nih.gov/medlineplus/cesareansection.html

Our Bodies, Ourselves:
http://www.ourbodiesourselves.org/

Note: Women's eNews is not responsible for the content of external Internet sites and the contents of Web pages we link to may change without notice.

A British doctor is challenging convention to pioneer the 'natural' caesarean.

Joanna Moorhead watched one baby's slow and gentle arrival
http://www.guardian.co.uk/society/2005/dec/03/health.medicineandhealth

Saturday December 3, 2005
The Guardian

The scent of lavender fills the air and classical music is playing quietly. On the bed, Jax Martin-Betts, 42, is calm, focused and in control. With the birth of her second child just minutes away, the midwife, Jenny Smith, is giving her a massage. Her husband, Teady McErlean, is whispering words of encouragement: just a tiny bit longer, and our baby will be in our arms!

It could be a natural birth at any maternity unit in Britain, but we are in an operating theatre at Queen Charlotte's and Chelsea hospital in west London, and the birth we are about to witness sounds a contradiction in terms: a "natural" caesarean section.

Jax has been on the theatre table for half an hour, and the obstetrician, Professor Nick Fisk, has almost completed the incisions through her abdominal wall and into her uterus. "OK, the baby is about to be born," he says. "Let's prop you up so you can see him coming out."

Smith removes the blue drape between Jax's head and her belly, and the head of the bed is lifted to give Jax a clear view. Fisk cuts into the amniotic sac and a fountain of fluid rises into the air before he rummages around to locate the baby's head. In a few seconds it comes into view, covered with the milky-white vernix that has protected it in the womb. For the next few moments, the atmosphere in the theatre is electric: Jax and Teady gasp in wonder at their new son, who is now looking around, although his lower body and legs are still inside his mother's uterus.

This groundbreaking approach to surgical delivery - Fisk calls it a "skin-to-skin caesarean", or "walking the baby out" - has been pioneered by him partly in response to the rising caesarean rate, which according to recent statistics reached a new high at 22.7% (of deliveries in England, 2003-04). "Whatever your view on caesareans, for some women it's always going to be the safest choice," he explains. "And while couples having normal deliveries have been given more and more opportunities to be fully involved in childbirth, very little has been done to see how we could make the experience more meaningful for those having caesareans."

As Fisk started to examine the conventions of surgical delivery, he was struck by how easily they could be challenged. Why, for example, did they need to be done so quickly, when slowing them down would give the parents more chance to participate in their child's delivery and might give the baby a gentler experience of coming into the world? Why, too, was it so important for the parents to be screened off from the mother's abdomen? And was it really essential for the baby to be whisked off for an immediate medical examination, rather than delivered into the arms of his mother?

"What I realised was that caesareans were done a certain way because they've always been done a certain way, but in fact they can be done differently - and in a way that parents love," says Fisk. Other doctors are sometimes shocked when they hear what he is doing. "They say, but surely you have to get the baby out fast so she can get oxygen straight away? And I say, when the baby is being born she's still attached to the umbilical cord and is still getting oxygen from the placenta. Caesarean birth can be gentle, just as vaginal birth can be gentle.

"Obstetricians are too hung up on getting from the point of incision to the birth of the baby as quickly as possible: that's been the benchmark of a skilled surgeon. But I'm challenging that because, from the baby's and from the parents' point of view, it's not very helpful.

"There's also a view that because the baby's chest hasn't been squeezed going through the birth canal, there are greater risks of breathing difficulties. But by leaving the baby's body inside the uterus for longer once the head is out, the body is squeezed and you see the lung liquid coming out of the baby's nose. Unless there are other risk factors, I've never known a baby born by my method to have problems - going straight onto the mother's chest helps regulate breathing."

Smith, who works closely with Fisk, says it's a hit with parents. "They feel more involved, which gives them a better start to family life. Breastfeeding is easier to establish, and you can see how much calmer the baby is."

For Jax, the birth of Finn - who weighed 3kg 25g (7lbs 3oz) - was "spellbinding".

"I had an emergency caesarean last time around. I'd wanted a natural water birth, but for some women it just doesn't work. This was every bit as magical: seeing Finn there in my tummy was a sight I'll savour for the rest of my life."

How the baby Finn is born
Minute by minute

09.24 Our first sight of baby Finn comes as Fisk gently lifts his head through the incision in Jax's abdomen. In a normal caesarean the baby would be lifted clear of the uterus immediately and the umbilical cord clamped and cut within seconds. The skin-to-skin caesarean gives the baby an experience of birth that is closer to a vaginal delivery. Instead of being pulled out quickly, Finn's emergence into the world is slow and calm, and the cord remains attached for some moments. His body is being squeezed slightly by being still inside the uterus, which helps drain fluid from the lungs.

09.26 Fisk begins to lift Finn up out of the uterus. In a normal caesarean the focus would now be on the baby's ability to breathe unaided, as the umbilical cord would already have been cut. But in the skin-to-skin caesarean the cord is left intact for several minutes during the delivery, so the baby is still receiving oxygenated blood from the placenta. At this point, the birth has been so gentle that Finn still seems to be asleep. Instead of being pulled quickly out of his mother, Finn is able to acclimatise slowly to his new surroundings.

09.27 Finn is now beginning to make tiny spluttering noises and is becoming aware of the fact that his surroundings have changed dramatically. At this moment, though, he is literally suspended between his old life in Jax's uterus and his new life in the outside world. His upper torso is outside his mother, but his lower body and legs are still folded inside the womb. Officially speaking Finn is not yet born, as it is only when his body has fully emerged that he is deemed to be an independent being. Jax now has a clear view of Finn as his head is lifted up.

09.28 The moment of birth, as Fisk lifts Finn clear of Jax's body. He will now hand him to Smith, centre, who will put him onto Jax's chest. Keeping the operation site sterile is a crucial consideration in the skin-to-skin caesarean, and Jax and Teady are warned not to try to touch their baby until he has been handed out of the sterile zone by Fisk. Finn is now moving his arms around and his breathing is clearly audible. Babies born by caesarean are often crying at this point - which is traditionally welcomed as a sign that they're breathing well.

09.29 Within seconds, Finn is placed on his mother's chest for a cuddle. Studies show immediate skin-to-skin contact results in a baby who is less likely to cry, has a more stable temperature, is more able to regulate his own breathing and has better blood sugar levels. In a normal caesarean, Finn would now be on a resuscitaire table, crying and throwing out his arms and legs. The skin-to-skin approach means he can acclimatise slowly to the world beyond the womb: so far, he has not cried. Lying on Jax's chest, hearing her heartbeat and voice, he is a picture of contentment.

Discussion Group
Topic - Emergency Caesarean:
We had an emergency C-section and then another C-section after that with the birth of our daughter. With the emergency c-section we were completely unprepared for the C-section. With the second we knew in advance so we were able to work on fear releasement, surgery recovery, and other issues.

From my experience here are some suggestions to help with the recovery.

1. A C-section is major surgery. Mothering the new mom is really important! So she should accept help from you, neighbors, family, and friends.

2. Keep a close eye on the incision. I know many women whom have ended up with an infection. Keep the wound clean and if you have staples and are using gauze, make sure that is cleaned regularly. Make sure your incision is dry.

3. Keep a pillow near by at all times! Sharon will need it to support her tummy, when getting up from sitting, getting in out of the car, sneezing, and when walking. It can be a life line when sneezing!

4. Keep in mind that you should not being lifting anything heavier than your baby. Use a step stool instead of stretching to reach something. Try sitting in straight back chairs instead of soft cushiony chairs. They are easier for you to get up out of.

5. You can shower or take a bath as long as the edges of your incision aren't open. If you have pieces of white tape on your incision, those can be pulled off once you get home.

6. It is normal to see a little pink watery fluid draining from the incision. I didn't know this until after I saw it and freaked out. You should call your doctor if the drainage smells bad, your incision is more tender or redder than usual, or swollen, the edges of the incision separate, or you run a fever over 100.4.

7. There is definitely emotional baggage that can have an impact on a couple that was preparing for a vaginal birth and then has to have a cesarean. These mothers are more likely to suffer postpartum depression than after a vaginal birth. However, we are all individuals and our reactions can widely vary. Women can feel as though they are a failure, guilt, grief, and even mourning. They feel as though they have missed out on a fundamental life experience by not giving birth through the vaginal method. Some women even blame themselves for the perceived "failure". Finding a support group, class, or a counselor can be incredibly helpful. There are plenty of online forums - some of the ones that were recommended to me was http://www.caesareanbirth.com http://birth.com.au/forum/forumdisplay.php? http://www.csectionrecovery.com/general_information.html

8. A really good resource that I used was book - Caesarean Recovery by Chrissie Gallagher Mundy, published 2004 by Firefly books Ltd. The book breaks down the recovery period by weeks and is very helpful when trying to get back in shape. Below are the book references…

Chrissie Gallagher-Mundy. Cesarean Recovery. Buffalo, NY. Firefly Books Ltd. 2004.
Rita Rubin. What If I have a C-Section?. USA. Rodale. 2004.

9. The most valuable piece of information by far that I have received and used was to get up and walk as soon as possible! Continue to walk! It helps to speed up recovery time.

I am sure you know how important fear release is via hypnosis. You really should focus on this as mom progresses in her recovery. Breastfeeding can be complicated but hopefully you have a doula, midwife, or nurse that was able to show you the most comfortable positions after a C-section.

A link about "humanizing" surgical birth. When a cesarean is decided upon ahead of time by the couple, perhaps sending them these links will allow them to write appropriate birthing preferences.
http://www.gentlebirth.org/archives/icanvbac.html - Humanizing

Timing of Elective Repeat Cesarean Delivery at Term and Neonatal

Study examines moms' C-section complications
http://www.ncbi.nlm.nih.gov/pubmed/20435284
OutcomesA. T.N. Tita and Others
Source: New England Journal of Medicine Volume 360 — January 8, 2009 — Number 2

By Rita Rubin, USA TODAY
As the rate of cesarean deliveries in the USA has risen, so has the rate of rare but severe complications in mothers, researchers report today.
With more than a million performed annually, C-section is the country's most common operation. In 2006, the most recent year available, 31.1% of all U.S. births were C-sections, up 50% from 1998. While a number of studies have focused on C-sections' effects on newborns, few have looked at the effects on moms.

BETTER LIFE: Bioethics, hormones and more on pregnancy
The new study, by government researchers, examined the rate of severe complications in women who delivered in U.S. hospitals in two time periods: 1998-99 vs. 2004-05.

They found a 90% increase in blood transfusions and a 50% increase in pulmonary embolisms, or blood clots in the lungs. They also found about a 20% increase in rates of kidney failure, respiratory distress syndrome, shock and the need for a ventilator.

While the study doesn't prove that C-sections cause complications, tracking those complications could be useful, says co-author Susan Meikle, a medical officer at the Eunice Kennedy Shriver National Institute of Child Health and Human Development.

The actual number of deliveries with at least one complication was 0.64% in 1998-99 and 0.81% in 2004-05. "Even though the absolute numbers are low, the rates are increasing. … We could do a better job at tracking these complications," says Meikle, an obstetrician. "There may be short-

term trade-offs and long-term trade-offs (depending on mode of delivery). We don't know that yet."

Although the average age of women giving birth has been rising, that didn't seem to play a big role in the complication rates, the researchers write in the *Journal of Obstetrics & Gynecology.* But they found that the rising cesarean rate seemed to explain the hikes in kidney failure, respiratory distress syndrome and ventilation. The rise in C-sections only partially contributed to increases in shock, pulmonary embolisms and transfusions.

The authors lacked information about race and whether the women were overweight, both of which could impact the risk of complications. They also didn't know why C-sections were performed and whether moms who had them were sick beforehand.

The study used the largest U.S. inpatient care database, which in 2005 sampled hospitals from 37 states, constituting about 90% of hospital discharges in the country.

Michael Kramer, scientific director of the Canadian counterpart of Meikle's institute, notes that in some cases, a complication might have triggered a C-section, not vice-versa. Still, says Kramer, co-author of a 2007 report that found more severe maternal complications in planned C-sections than in vaginal deliveries, doctors tend to underestimate C-section risks.