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The Misguided Popularity of Unnecessary Cesarean Sections in America

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The Misguided Popularity of Unnecessary Cesarean Sections in America

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Introduction

“I really love to share my story with people who are interested in hearing it, because a lot of people that I tell it to either think I'm crazy, stupid, or radical. I am none of those things; I only wanted to be safe and healthy, and protect my baby as much as possible during birth.”

--Heidi, “VBAC at Home”

The epigraph above is a direct quote from one woman's account of her unconventional home vaginal birth that took place several years after an emergency cesarean section that she underwent after failure to progress in the hospital. During her first pregnancy, Heidi was forced to stay in the hospital bed upon admittance with a 5cm cervical dilation because the nurse had attached the fetal monitor, which prohibited the pregnant woman from moving around to prevent a false printout of fetal distress. Despite her attempt to be stagnant in the bed and cooperate with hospital procedures, her twins were born via cesarean section after eighteen hours of unresponsive labor. She originally hoped to have a natural vaginal birth in a hospital for her second pregnancy, but obstetricians repeatedly told her that they could not promise non-interventive birth due to standard hospital procedures and policies. Therefore, she chose home birth to deliver her third child. When the nurse arrived at Heidi's home to support her during labor, Heidi was surprised:

She helped m(e) manage my pain naturally, without pushing medications or strong drugs on me. She had me taking warm baths, walking back and forth, and rocking on hands and knees to dilate my cervix and progress my labor. I never knew about any of those things before, and doubt I would have learned about them in the hospital from a regular OB or nurse. I was also allowed (encouraged) to eat and drink throughout my labor. When my water broke and I felt like pushing, my doctor and nurse had my husband help me push, watch as the baby's head emerged, cut the cord, help clean the baby, and pretty much completely included him in everything that was going on. Our baby was never taken from

us for a moment. I was instructed and encouraged to nurse my baby as soon as possible, and we were celebrating even before I got out of bed to sit up! It was so different from my hospital experience! (“VBAC at Home”).

Accounts like Heidi's are unfortunately few and far between in today's American society. Due to the absence of support from hospitals and OB/GYNs, pregnant women consistently have been made to feel as if their bodies require constant medical intervention while giving birth. Stories like Heidi's prove that more often than not, women are more than capable of delivering children naturally, whether they've had a previous cesarean section or not.

I hope that this thesis will influence society at large, specifically potential mothers, by discussing the physical, emotional, and mental benefits of natural birth. Current research has led me to the conclusion that a significant percentage of American women is being convinced of the idea that their bodies are not only incapable of naturally delivering a child, but that their bodies are ill-equipped to perform a birth without the intervention of highly-trained doctors and specialized instruments. This current trend of medical intervention is a potentially irreversible fad that women who are undergoing these operations do not investigate adequately. In 1965, the percentage of cesarean sections in the United States was steady at four and a half percent (Taffel 1). In 2009, 32.9% of babies were delivered via cesarean section surgery (Hamilton 1). The alarming rate at which the number of cesarean sections is rising in this country leads me to conclude that without positive reinforcement of a woman's natural ability to birth a child, the percentage of babies born in the United States via cesarean section surgery may soon outnumber the amount of children being born naturally. As VanTuinen and Wolfe argue, “Cesarean section is *the* most common operation performed in the U.S.” (VanTuinen and Wolfe). I believe there is an incalculable importance of reversing this dangerous rise of unwarranted cesarean sections by making

natural, non-interventive birth a valuable and sought-after experience for low-risk pregnant women in America. Herein, I hope to establish the fact that cesarean sections are medical procedures available to women in times of crisis and should not be seen as a viable option for any woman undergoing a routine, low-risk birth. I plan to prove that women, with their instinctive maternal strength, are completely capable of safely delivering their children naturally and without medical interference. By design, birth is a spontaneous and natural process that most American women and their babies can safely endure.

Chapter 1- The Facts

A baby's shoulder, buttocks, or feet have entered the birth canal before the head and there is no possibility of safely delivering the infant in this position. During labor, the baby's heart rate slows and the fetus is under tremendous distress. The mother is preparing for a multiple birth with two or more babies and one or more of the infants appears to be distressed during labor. There is an issue with the placenta, such as placenta previa, prolapsed cord, or placental abruption, which is attached to and nourishes the baby while it is in the womb. The mother has a sexually transmitted disease and wishes to spare her child the same plight.¹ Before or during pregnancy, the woman unfortunately acquires a disorder such as diabetes, heart disease, or hypertension which puts her at an increased risk for maternal morbidity (Dangal).² The aforementioned reasons are all acceptable qualifications for a woman to be considered high-risk and subsequently be a candidate for an emergency cesarean section if labor proves to be arduous and overly stressful for either the mother or the baby. All of the previous issues may be categorized under the term dystocia, which means difficulties in childbirth (Goer 83). There is not one medical professional who could ethically ascertain that an emergency cesarean delivery is unwarranted for any of the preceding situations. As soon as the birthing caregiver recognizes that the mother or baby is at imminent risk for harm during labor, an emergency cesarean will be scheduled.

A cesarean section is a major gynecological surgical procedure in which both an abdominal and a uterine incision are made on the mother. The OB/GYN typically extracts the baby (or babies, commonly) from the uterus with assistance from surgical nurses. The mother might

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- 1 Placenta previa refers to a situation in which the placenta is implanted over the cervix and in this situation, the baby must be delivered via c-section because the baby cannot fit through the cervix past the placenta. Placental abruption occurs when the placenta detaches from the wall of the uterus prior to delivery of the child, which in some situations, sanctions a cesarean to prevent excess bleeding. (Dangal) Prolapsed cord is a condition in which "the umbilical cord is beside or ahead of the unborn baby, cutting off its oxygen supply" (Mitford 141)
 - 2 Hypertension is the medical diagnosis of high blood pressure.

be given general anesthesia (typically used for emergency purposes due to the short amount of time between administration and the onset of unconsciousness) or she may be given an epidural or spinal anesthesia (allowing her to be conscious, but numb from her abdomen down through her legs). If administered properly, the mother will not feel pain, due to the spinal or epidural anesthesia; but she may feel movements and pressure while the doctor is making the incision, handling the uterus, removing the child, and removing the placenta.³ A catheter is commonly inserted into the mother's urethra, as well, to collect urine. Typically, the father of the child or a family member is allowed to accompany the mother into the operating room. In most cases, the mother is able to see the child directly following delivery, though she is usually not allowed to hold him due to numbness from the anesthesia (“Cesarean Procedure”).

A c-section is not a procedure to be taken lightly; “Complication rates [for a cesarean] are estimated to be five to ten times that of vaginal birth” (Goer 22). It is a very serious surgery that requires informed consent from the patient with possible side effects and potential risks to be explained to her by the surgeon. A few liabilities faced by the mother include decreased bowel function, increased blood loss, a lengthier recovery time, possible adverse reactions to anesthesia, and an almost certain possibility of having to give birth via C-section for future pregnancies (if she delivers in a hospital) (Goer 23). Furthermore, “While most mothers who deliver vaginally regain their normal energy by six weeks after birth— 72 percent, according to the Public Citizen Health Research Group— only 34 percent of cesarean mothers feel they are back to normal after six weeks” (Mitford 131). Mentally, a woman who undergoes a cesarean is at a

3 I would just like to mention that the epidural anesthetic does not always work as it is supposed to. There was an unfortunate circumstance in 2006 where a pregnant woman had an epidural administered to her two separate times within 12 hours. Due to an infection she acquired from epidural administration in the hospital, she suffered severe brain swelling and died. (Thompson)

higher risk for postpartum depression and she will have more negative feelings about the birth experience than women who delivered vaginally (Minkoff and Chervenak 3). 4

Babies that are delivered via c-section are swiftly removed from the mother's uterus and almost immediately deprived of the umbilical nutrients that they had become so familiar with over the past nine months. It is common practice in the delivery operating room to cut the cord as soon as the baby has been extracted in order to whisk him over to a resuscitation unit for the nurses to weigh the infant, check for vitals, and attach any tubes/IVs that they deem necessary. It is much more advantageous for the infant to leave the cord attached for a few minutes following birth to allow the infant to become accustomed to breathing on his own: "If we cut the cord immediately, we create a situation that is the opposite of the one Nature intended. By clamping the cord before the lungs are fully operative we deprive the child's brain of oxygen" (Leboyer 63). Additionally, an infant that is surgically removed from a mother's uterus is deprived of the physical compression during labor that helps to remove fluid from the lungs and slowly adapts the child to breathing (Bakalar). It is unfortunate that one out of three children born in the United States is introduced to the world in such a harsh manner.

Women undergo over one million cesarean sections every year in the United States (Hamilton 1). According to the World Health Organization (WHO), the number of cesarean sections in any country should not exceed fifteen percent of births (Chaillet et. al.). As I mentioned earlier, however, c-sections in the United States top the charts at almost thirty-three percent of births – this number is more than double the acceptable percentage recommended by the WHO

4 The common postpartum disorder that many mothers are experiencing has been recently designated (2002) as "birth trauma" (Block 145). Cheryl Beck, a professor of nursing at the University of Connecticut has discovered that 1.5% to 6% of mothers suffer from post-traumatic stress disorder due to a high level of medical intervention during birth and how the birth process was carried out; interventions such as an artificial rupture of membranes, Pitocin induction, catheter insertion, and the highly interventive cesarean section could all lead mothers to feel "stripped of their dignity" (Block 145). Beck found that "[t]he common element is that these women are systematically stripped of their protective layers. They do not feel cared for, they're not communicated with, they're powerless" (Block 145).

(Hamilton 1). An increasing number of cesarean sections is performed in the United States every year due to the number of women who are influenced by their doctors to falsely believe that their bodies are incapable of safely delivering their child vaginally. When women undergo unnecessary cesarean sections, the aftermath produces a negative impact on women's emotional, mental and physical health.

Chapter 2- The Unnecesarean

“I felt depressed. I felt like a failure. I felt like something was taken from me. I knew deep down, that I could have birthed my son if I would have waited for labor to start on its own. So many people told me, 'You should be happy you have a healthy baby'...Maybe if it truly was necessary, I would feel a little more grateful (though even then I would still have the right to grieve the loss of my birth). I was bullied and robbed of a healthy birth that my son and I both deserved.”

– (“Michele's story”)

The issue with today's American medical community is that women are being subjected to superfluous interventions in hospitals that are not only harmful, but also completely unnecessary for the well-being of the mother and/or the baby. These interventions, if not carefully monitored and controlled, can and do lead to unnecessary cesarean sections—as Michele discussed in the epigraph. These interventive hospital practices are imposed by doctors who tend to believe that technology is a cure-all; these technologies, in fact, have not been statistically proven to benefit mothers or babies. Instead, I hypothesize that these technologies are being utilized as a result of impatience, convenience, and lack of respect for the beauty of birth by the American medical community at large.

There is a multitude of common hospital practices that will inevitably lead a woman to the operating room for an 'emergency' cesarean. For example, putting women in the lithotomy position is a positive reinforcement for fetal distress because not only is the woman least able to push in this position, but she is attempting to birth her baby against the force of gravity. The lithotomy position “means lying supine with legs in air, bent and wide apart, supported by stirrups” (Mitford 59). The lithotomy position is, in fact, only beneficial for the doctor. Almost all pregnant women are also hooked up to an external fetal heart monitor (EFM) to observe fetal

progress. Invented in 1958, the EFM documents any and all fetal heart rate changes. It also requires the woman to remain in bed for the extent of labor and a catheter to be inserted into her vagina in order to excrete urine waste because if she moves around, the EFM printout will be compromised. The most striking feature of the EFM is that “it is yet to be proved of value in predicting or preventing neurologic morbidity” (Rosen and Dickinson 746). In fact, the restraining nature of the EFM tends to decrease toleration of labor pain and require more sedation—which if not controlled, will eventually lead to an unnecessary cesarean due to an abnormal fetal heart rate (Mitford 160).

Several hospital protocols were established at the National Maternity Hospital in Dublin, Ireland in the 1970s and are referred to as 'active management' (Goer 83). The Dublin protocols state that “(o)ne hour after admission, progress is assessed and amniotomy performed” to further accelerate the speed of labor (Goer 84). The majority of women who attempt vaginal birth in a hospital are eventually given an amniotomy- which is sometimes referred to as an artificial rupture of membranes, or AROM. Active management also entails that a laboring woman be given an IV of Pitocin if cervical dilation is not progressing on its own following the amniotomy “by at least 1cm per hour” (Goer 84). When a woman is given 'Pit', as they say in the hospital, she is dosed intravenously with Pitocin which is “used to replicate or accelerate the body's own childbirth sequence” (Block 5). The issue with this artificial hormone is that, unlike its natural counterpart, oxytocin, a Pitocin induction is capable of producing “one contraction after another, like bulldozers and gangbusters driving through her body” (Block 136); whereas the body and its natural hormone oxytocin will produce consistent contractions with time in between for the mother to relax, breathe, and prepare for the next one. Many women find it very difficult to deliver their babies vaginally when they are being dosed with Pitocin because the contractions

are so close together that they are drained of all the energy needed to push. Consequently, the stress and energy deprivation that the mother is feeling will lead the fetus (or fetuses) to be under tremendous stress, as well. Since fetal distress almost inevitably leads to a cesarean, it has been proven that, “the strongest correctable predictor of cesarean section is labour induction” (Soliman and Burrows 1315).

Additionally, another common intervention that hospitals utilize is epidural anesthesia. It is administered into the spinal canal through a thin catheter in order to establish numbness in the lower abdomen (“Cesarean Procedure”). Many women are given an epidural because, as described previously, the artificial contractions created by the Pitocin are too painful. Negative side effects of the epidural include a lengthened labor (due to numbness from the epidural, the woman is unable to push during contractions), an elevated demand for Pitocin, and an increased necessity for an 'emergency' cesarean (Block 171). The epidural tends to contribute to an abnormal, and oft severe, fetal heart rate. As I explained earlier, when the EFM printout establishes that the child is in distress, the doctor will appropriate this verifiable truth with one conclusion: a cesarean. As with the former interventions I have mentioned, the epidural is just another cog in the wheel of needless interference that is en route to the operating room for an 'emergency' cesarean.

The hospital staff, of course, consider these interventions an inevitable course of action for any admitted pregnant woman. In fact, these interventions are all just traditional acts of established hospital practice. The Dublin guidelines even state that the major advantage of these interventions for hospitals is that this “newfound ability to limit the duration of stay has transformed the previously haphazard approach to planning (staffing) for labor” (Goer 85). But in fact, “labor induction, electronic fetal monitoring, and epidural anesthesia all increase

cesarean rates without improving outcomes,” which is a tragic injustice to women across the United States who deliver their children in hospitals and are subjected to these interventions with no evidence-based medical indication (Goer 22).

The ever-increasing trend of elective cesarean section has led the medical community to create a new category for method of delivery. Cesarean delivery upon maternal request, or CDMR, has been formally defined as “a cesarean delivery for a singleton pregnancy on maternal request at term in the absence of medical or obstetrical indications” (Lee and D'Alton 1). The CDMR, which allows a low-risk mother to bypass the labor process, is a telling illustration of the misguidance in the modern maternity system in America. Non-emergency cesarean section surgeries allow both the physician and the patient to choose a convenient date and time for the delivery to take place thanks to medically-induced induction. An obstetrician is able to prevent any unforeseen difficulties that may arise during a natural birth by delivering a patient’s child via cesarean delivery, an action which requires him to be both wholly responsible and capable. A cesarean section surgery is performed in approximately 60 minutes, while a vaginal delivery involves anywhere from 30 minutes to 24 hours of labor (“Cesarean Procedure”). In 2007, the American College of Obstetrics and Gynecology, or ACOG, estimated that only two and a half percent of all births in the United States that year were CDMR (Lee and D'Alton 1). An article published by the ACOG, *Elective Primary Cesarean Delivery: Attitudes of Urogynecology and Maternal-Fetal Medicine Specialists*, focuses on the willingness of health professionals to perform CDMRs. The authors created a questionnaire that was sent via email to members of both the American Urogynecological Society and the Society for Maternal-Fetal Medicine. The authors' research found that less than twenty percent of physicians surveyed would "choose an elective cesarean delivery for themselves or their partners" (Wu, Hundley, and Visco 302). A

mere sixteen percent of the physicians surveyed said that they would not agree to perform an elective cesarean delivery. The common reasons for denying the surgery were “concern for potential complications in future pregnancies, an increase in maternal morbidity and mortality, and the feeling that elective cesareans will not prevent pelvic floor disorders” (Wu, Hundley, and Visco 304). Perhaps those physicians who deny elective cesarean requests and additionally, those who openly acknowledge the risks of cesarean surgery, should be more candid about their position on CDMRs and discuss their opinions with the percentage of physicians who willingly perform elective cesarean surgeries.

Obvious rewards for a physician who allows his patients to deliver via elective c-section include a more solidified schedule, fewer physician-induced complications, and expediency of surgery— rather than waiting for the natural order of childbirth to occur. With this convenience in mind, the physician may strongly assert that a CDMR is a great option if the woman has had a previous cesarean section, is pregnant with twins, or has macrosomia (more commonly referred to as 'big baby syndrome'). The mother may quickly consent to the physician's advice, even though "scheduling a cesarean to 'prevent' complications neither produces accurate results nor improves outcomes" (Jukelevics 255). In fact, "less than one quarter of all obstetric practice recommendations...were categorized as Level A" (Jukelevics 255). The U.S. Preventive Health Services Task Force sets criteria ranging from strongly recommended (Level A), to insufficient evidence to recommend for or against (Level I). For the same rewards, an obstetrician may convince his laboring patient that continued vaginal labor may be harmful for the baby after a certain period of attempted vaginal birth. The doctor may suggest an emergency cesarean section and justify his opinion in the medical chart as dystocia. Dystocia, known commonly as 'failure to progress', accounts “for as much as one half of cesarean sections in first-time mothers” (Block

21). I believe that this type of 'emergency' cesarean section is completely unnecessary for both the mother and her unborn child. If the woman would be given more time to attempt natural birth, "9 times out of 10 her body will birth a baby with minimal interference or injury" (Block xxiii). There are, of course, some women who welcome the convenience of a scheduled cesarean for reasons discussed in the following section.

Some benefits for a woman who decides to have a CDMR include "a decreased risk of postpartum hemorrhage and transfusion, [and] fewer surgical complications" (Lee and D'Alton 3). Also, "the potential benefits of preventing pelvic floor disorders must be weighed" into this decision (Wu, Hundley, and Visco 302). A pelvic floor muscle disorder is a situation where the tissue on the pelvic floor become weak and the bladder, urethra, uterus or other lower-body internal organs drop down- sometimes referred to as incontinence (Neergaard). The only correction is surgery and about one in eleven American women suffer from the disorder. Aside from these few medical benefits, some women elect for a CDMR in order to choose the date of birth or because the elevated pain of vaginal birth is a frightening thought. The neonatal benefits may include fewer birth injuries such as "neonatal asphyxia and encephalopathy" (Lee and D'Alton 2); both are potentially fatal brain disorders.

The WHO conducted a global study which gives conclusive evidence from other countries to suggest not only that elective cesareans were highly risky, but also that the American medical community would benefit from more extensive tracking of such data. According to the study, which evaluated 24 countries in Africa, Latin America and Asia between 2004 and 2008, "when cesarean section was performed without medical indication *before* the onset of labour, the risk of short-term adverse outcomes was nearly sixfold compared with spontaneous vaginal delivery" and even more disheartening, "when cesarean section was performed without medical

indication *after* the onset of labour, the risk of short-term adverse outcomes was 14 times above the level of risk for spontaneous vaginal delivery” (World Health Organization, emphasis mine). Both of these conclusions support the need for auditing and/or monitoring of these operations. The study did not take into account the discrepancies in medical care across the globe, but it did make adjustments for any associated conditions that could skew the data. Although this study does not include women from the United States, I still believe this information is viable. At the very least, this study should be a revelation for the American medical community because, as I discuss below, American practices result in unnecessarily high cesarean rates. The United States has a much higher cesarean rate (due to our allowance of cesareans without medical indication) than the countries included in this study and therefore, our risk of adverse-outcomes is undeniably much higher.

Many women in America are told that once they have undergone a primary cesarean (whether elective or emergency), there is no turning back—all of their future children must be delivered via repeat cesarean, even if there is no medical indication that would suggest an increased risk for vaginal birth. In 2003, 88.7% of low-risk women who had a previous cesarean surgery went under the knife, once again, for their next birth (Menacker). The issue with this fact is that many women are unaware of TOLAC, which stands for trial of labor after a cesarean. The majority of women who have had a previous cesarean with a low transverse uterine incision can safely deliver their subsequent children vaginally. The low transverse incision, a side-to-side cut across the lower abdomen and lower part of the uterus, is much safer than vertical incisions because the risk of rupture is less than 1% (“Vaginal Birth After Cesarean Delivery”). The major obstacle for women who seek this option, is hospital refusal.

Quite possibly the most unjustified reason for unnecessary cesarean sections in America is a hospital's refusal to allow a vaginal birth after a previous cesarean, referred to as VBAC. In the past, allowing VBACs was dangerous because there was a risk of rupture for the cesarean scar. Nowadays, the suturing technique has been perfected and the risk of rupture during a VBAC is actually very low. In fact, "study after study has shown, it [the prior incision] rarely gives way, and when it does, the separation is usually like opening a zipper: neat, bloodless, and benign" (Goer 39). Hospitals across the United States, however, still appropriate this fear to their exemption of VBACs. Interestingly enough, "The first known cesarean birth in which mother and child survived was achieved by Jacob Nufer, a Swiss pig-gelder, who in the year 1500 put his handy gelding tools to good use, operating on his wife after the doctors had given her up. Not only did Frau Nufer and her baby come through the ordeal, but she went on to have four more children by normal vaginal birth, thus disproving the twentieth-century medical dogma 'once a cesarean, always a cesarean'" (Mitford 45,46). VBACs, in fact, have an upwards success rate of eighty percent in America and are just as safe as a normal vaginal birth ("Vaginal Birth After Cesarean").

The ACOG has published guidelines for women who choose to attempt VBAC. The only stipulation, which is the same for spontaneous vaginal birth, is that a cesarean must be able to be performed within 30 minutes. Due to this modest requirement, Goer understandably proclaims that, "Hospitals have no excuse [to refuse a VBAC]. If a hospital does not think it can meet the ACOG guidelines, then it is saying it cannot handle labor, period" (Goer 42). According to the Centers for Disease Control, the number of VBACs was actually rising until 1996 when the numbers began to steadily decline. The last figure, documented in 2003, notes that only 10 out of every 100 women who had undergone a previous cesarean birthed their next child/children

vaginally. Simultaneously, the overall cesarean rate in 2003 was 27.6%. This means that in 2003, the probability of a woman with a previous cesarean delivering subsequent children with a repeat cesarean was 90% (“Quickstats”). If hospitals in the United States were to acknowledge the success of VBACs and allow women a trial of non-interventive labor after cesarean, the number of repeat cesareans—which contributes greatly to the cesarean rate in America—would be notably reduced.

An important aspect of a patient's agreement to undergo a cesarean surgery, whether elective or otherwise, is her comprehension of the surgery and recovery process thereof. This agreement is called informed consent—and it should be a very important facet of a woman's decision to undergo a c-section. Dr. Cathy Spong, pregnancy chief at NIH's National Institute of Child Health and Human Development, stated that “We all have noticed that women are asking for Cesareans more often. I don't think they always have the best information in making that decision” (Neergaard). Informed consent requires that a patient be aware of “the risks and benefits of a proposed treatment or procedure” and “the risks and benefits of the [any] alternative treatment or procedure,” according to the American Medical Association (“Informed Consent”). The informed consent form also notifies the woman that “If I [she] gives birth in the United States, I am [she is] highly likely to have no other option than a repeat operation with my [her] next pregnancy” (Jukelevics 256). Following a cesarean surgery, she may also encounter “greater complications in subsequent pregnancies” and even the risk of additional surgeries, like “the need for a hysterectomy” (“ACOG Committee Opinion”). So if a patient is truly familiar with the pros and cons of a cesarean section surgery, why would any woman choose to put herself, or her baby, in danger?

There is reason to believe that some doctors might misrepresent the pros and cons of a cesarean section as a technique of encouraging women to concede to the surgery. This approach, referred to as defensive medicine, would protect them from potential lawsuits that coincide with vaginal birth. Some obstetricians even allocate “defensive medicine as an excuse for the astronomical U.S. cesarean rate” (Goer 23). The habitual use of EFM would certainly be a tool of defensive medicine because it protects doctors from malpractice suits due to “beliefs that tracings [the printout] are valuable courtroom evidence and that not using EFM renders doctors liable” (Goer 133). The problem with this reasoning is that “malpractice did not become an issue until the late 1970s- *after* the cesarean rate had already tripled” (Goer 23). It is clear that many doctors, due to fear of liability and uncertainty (that they have been unjustly convinced coincides with natural birth), perform cesarean sections at the first opportune moment of risk during labor. Goer proceeds to condemn the obstetric community by adding that, “deliberately performing unnecessary surgery in the belief it avoids lawsuits is indefensible. That many obstetricians seem oblivious to this profound violation of ethical principles is shocking” (Goer 23). Goer makes the valid argument that the only ethical justification for performing a cesarean is medical indication—not as a defensive tool to prevent malpractice.

It is justifiable for obstetricians to be wary of high-risk situations during birth. If they were truly putting the mother and/or baby's safety above all else, an emergency cesarean would be justified. However, “The astronomic rise in malpractice insurance premiums is ascribed variously by the medical community to the general litigiousness of American society, the rapacity of personal-injury lawyers with their wily ways of persuading juries to award outlandish damages, and the publicity given to such huge awards, which encourage further lawsuits against doctors by dissatisfied patients” (Mitford 154). What the general public, and apparently medical

doctors, don't know is that these “awards are often drastically reduced by the trial judge, news that generally goes unreported; and that the plaintiff's legal fees will eat up to a third to a half of the amount awarded” (Mitford 155). Obviously, an obstetrician's fears of malpractice claims should never be an excuse for the rise in cesareans in the United States.

The number of cesarean surgeries performed for emergency reasons versus the number performed as elective procedures is not clearly chronicled for public record (as far as my research has determined). The best approximation comes from “A handful of recent studies that examined birth certificates and insurance claims [to] estimate that roughly 80,000 women a year have elective C-sections” (Neergaard). In 2006, the New York Times reported that, “A recent study of nearly six million births has found that the risk of death to newborns delivered by voluntary Caesarean section is much higher than previously believed” (Bakalar). As I will discuss in the next section, cultural influence is a central factor in the rise in elective cesarean sections.

Chapter 3- The 21st Century American Birthing Culture

I postulate that many American women today regard their bodies with trepidation, (mostly due to the unsupported, biased information supplied by the medical community) leading them to doubt their bodies' ability to successfully and to safely deliver a child in a natural setting, and without medical intervention. Our culture in the United States is very influential in the life of the average American woman. The American media's portrayal of birth, the dominance of medicalized birth, and the barriers created by health insurance agencies are all cultural influences that lead women to have these negative opinions about birth. I hope my thesis is able to instill pride in women and the strength of their bodies. It is unfortunate that so many women lack faith in their instinctive capabilities as child-bearing mothers to the extreme that they are requesting major gynecological surgery—cesarean sections; but it is not surprising, given that “[i]n the age of evidence-based medicine, women need to know that standard American maternity care is not primarily driven by their health and well-being or by the health and well-being of their babies. Care is constrained and determined by liability and financial concerns, by a provider's licensing regulations and malpractice insurer. The evidence often has nothing to do with it” (Block 271). It is imperative that pregnant women are informed of evidence-based birthing facts in order to dissuade any fears or adverse opinions about birth in the United States.

I believe that any woman who deems herself capable of raising a child should also realize that she is physically strong enough to deliver that child without medical intervention. I also assert that many women who elect to deliver their child via c-section are not making this choice with fully-informed consent from their doctors. I believe that these women are not making their decision based on sound ethical judgment, but rather by their physician's coercion or by their personal necessity for convenience. In a journal article published by the *Journal of Advanced Nursing* titled *Elective cesarean sections as a transformative technological process: players, power, and context*, the authors contend that "elective cesarean section is a socially constructed technological process" (Hewer, Boschma, and Hall 1763). Hewer, Boschma, and Hall are referring to the fact that women who opt for a CDMR do not need to give any clarification to the doctor; and if the OB/GYN is willing, they will have their cesarean scheduled for a time near their due date. Without clarification, they could have simply heard from a friend that vaginal birth was painful and gone straight to their OB/GYN to make their request—which is completely absurd when one considers the risks of a cesarean surgery. Our culture, however, concedes to these desires.

I am thankful to have had personal experience in the maternity realm. As a senior in high school back in 2006-2007, I participated in a student internship program with the Women's Center at Helen Ellis Memorial Hospital in Tarpon Springs, FL. I spent anywhere from 10-20 hours per week there for about eight months. While there, I was fortunate enough to witness over twenty five cesarean sections and a handful of vaginal deliveries, as well. In terms of medical interventions—I have been witness to all of them. I cannot recall one woman who came to the delivery ward without being hooked up to an EFM and eventually, being dosed with Pitocin. I was also present for several AROMs and the few women who I saw deliver vaginally were, in

true hospital form, in the lithotomy position. From my personal perspective, I found it much more enjoyable to watch a mother [along with her family and close friends surrounding her] deliver her child vaginally through her own perseverance than to watch a sedated woman be hastily [once again, this is my personal opinion] cut open so her child can be removed by a third party. On top of my fortunate internship experience, I currently volunteer in the Pre-Admission Testing area and the Post-Anesthesia Care Unit at St. Joseph's Women's Hospital in Tampa. It would be advantageous for me to note that in the past eight months that I've volunteered there [once a week for four hours] I have seen not one emergency cesarean section listed on the surgery board. I have, however, noticed an outrageous number of primary and repeat cesarean section deliveries listed. I find it imperative to reiterate my belief that a woman post- vaginal delivery is a much more delightful image than a post-cesarean woman who tends to be attached to a breathing tube, electrode patches, and a catheter. The 'glow' of a pregnant woman, that so many people refer to, is completely lost in a mother who has been sedated and under the knife for the extent of her child/children's cesarean birth.

The intensifying medicalization of pregnancy and childbirth suggests that the women in our culture have shifted from a strong feministic society, where women feel empowered and autonomous, to a more submissive and apathetic population. This declaration is, of course, debatable and not a representation of the entire feminine population; but it is a situation that garners consideration. Most likely, the reason many women silently comply with excessive interventions in hospitals is because they are made to feel ineffective by the domineering medical community. Sheila Kitzinger, a professor and birth activist, says it best: "By viewing women as defective machines to be managed on the fetus's behalf, by draining warmth and sensuality out of the experience, by converting it to a timetable-driven mechanical process, by becoming the

central figure in the drama and controlling every aspect of a mother's behavior and activities down to the sounds she may make, birth comes to feel safe to the doctor” (Kitzinger). In essence, she is declaring that modern, interventive hospital birth is only advantageous for the doctor. It is clear that in order for women to feel safe and comfortable during labor, a supportive role must be demonstrated by the medical staff; and yet, low-interventive support for birthing mothers in American hospitals is difficult to find.

It's understandable for a pregnant woman in America to be faced with anxiety about giving birth based on film and media's distorted, and sometimes terrifying, representations of birth. With the often harrowing situations demonstrated in shows such as TLC's “A Baby Story” and Discovery Health's “I Didn't Know I Was Pregnant,” it is not very surprising that the average American woman associates birth, specifically vaginal birth with fear and helplessness. In one episode of “A Baby Story,” the doctor tells the mother that “the baby's head never really descended into the pelvis and also now, in the last hour, the baby's heart rate has started to drop with most of the contractions—it is evident that she will not be able to deliver vaginally and that we will have to proceed and do a cesarean” (“The Armstrongs”). The mother expresses disappointment for the loss of her natural birth experience, but like most mothers who are convinced that a c-section is the only option, she says “as long as the baby is healthy and I'm healthy, it won't even matter in the end” (“The Armstrongs”). Shows with conclusions such as this make interventive, hospital birth seem appropriate for all types of women across the United States when in fact, only a select few high-risk women are in need of interventions during labor.

In an episode of “I Didn't Know I Was Pregnant,” the mother goes to the hospital with what she thinks is a terrible case of food poisoning. What she discovers is that the excruciating pain she is experiencing is actually pregnancy contractions, and that she is in active labor. She is

forced to lay supine on the bed with her legs in stirrups so that the obstetrician can break her water. She eventually delivers the child vaginally, but the mother becomes understandably upset when the doctors “immediately put her in a warming tray and [take] her away to a different room” (“Pizza Baby”). This type of show might make women viewers feel uncomfortable with the idea of being pregnant, in general, simply because it makes birth look unbearably painful and almost impossible without medical intervention—but the only reason women on this show need excessive intervention is due to the unforeseen nature of their pregnancies. Fortunately, there are individuals devoted to sharing the positive benefits and beauty that accompany natural vaginal birth. Actress Ricki Lake's documentary “The Business of Being Born,” for example, was created to educate women “with surprising historical, political and scientific insights and shocking statistics about the current maternity care system” (Lake). Lake's documentary exposes modern maternity care's insensitivity, in addition to directing positive attention to supportive labor for low-risk pregnant women in America.

Additionally, many women who would prefer non-interventive, supportive birth (such as at home or in a birth clinic with assistance from a midwife) are forced to abandon their plans due to the fact that many health insurance agencies won't pay for them to give birth outside of a hospital. This is a flagrant misdeed to society at large. Insurance agencies, citing the ACOG's recommendation of hospitals as the safest place to deliver a child, tend to consider “planned deliveries at home and associated services not medically appropriate”; and therefore, they deny home and clinic birth as part of their health insurance coverage (Piard and Stockman). By simply requiring that a woman in America give birth at a hospital, these agencies are subjecting her to many interventions that are unnecessary, and that therefore have the potential to lead to unnecessary future cesarean sections.

Chapter 4- Improvements for the Future of Birth

The United States has one of the highest maternal mortality rates among all industrialized nations, as well as the second worst newborn death rate in the developed world (Lake). If all medical professionals in America were truly concerned about the impact that birth has on mothers and babies, the percentage of cesareans in our country would be drastically reduced—subsequently, our infant and maternal mortality rates would be much lower. In order to reverse the annual increase of cesareans performed in America, it would be beneficial for medical professionals to possess a perspective on labor that allows for non-interventive, evidence-based, supportive birthing care in an atmosphere that is uninhibited by time constraints and entirely focused on the well-being and comfort of both the mother and the baby. Furthermore, the common interventive care that women are receiving in most hospitals across the United States must be carefully documented and controlled by a national organization—which should be fully funded and supported by the federal government.

The ever-popular trend of unnecessary cesareans would undoubtedly decrease if all medical professionals viewed pregnancy and birth as a “fundamentally healthy and normal part of a woman's psychosexual life” (Goer 4). Even more beneficial for women who may request an

elective cesarean due to fear, there is evidence that the presence of a knowledgeable birthing caregiver (such as a midwife and/or doula) reduces the number of women who, during the pain of labor, ask for a CDMR. An article published by *The New England Journal of Medicine* suggests that: “With appropriate counseling [from her birthing caregiver], anxiety can be assuaged, and when it is, the request for cesarean delivery is often withdrawn” (Minkoff and Chervenak 4). The reason that many women become fearful during hospital labor directly results from the fact that maternity nurses are unable to spend an ample amount of one-on-one time with the laboring mothers. Each nurse on duty may be responsible for several women at one time and it is impossible for them to devote the necessary amount of constant care to each woman in labor. If hospitals accepted supportive labor as an inimitable method of delivery, more women would have their fears diminished and consequently, the request for an elective cesarean would decrease.

Another effective way to decrease the number of cesarean sections performed in the United States would be to nationally delineate standards by which an emergency cesarean can be performed. In an article proposed by the American Public Health Association, they suggest that “[e]fforts to reduce unnecessary c-sections should focus on identifying the appropriate clinical indications for c-section and disseminating this information to physicians” (Burns). If this plan was enacted, many obstetricians' declarations of emergency cesareans as results of 'failure to progress' or 'fetal distress' would be considered irrational unless they had properly followed the national clinical indications (which may include additional time for natural labor to advance, the recognition of birthing positions aside from lithotomy, and perhaps the discretionary use of EFM's).

If hospitals were to increase the amount of time granted to women who attempt natural labor and allow them freedom of birth position and movement, this would inherently reduce the risk of intervention and as a result, decrease the chance of having to undergo an unnecessary cesarean section. If women were allotted more time for their bodies to naturally perform their inherent functions, they would be under less stress during labor. When women are given the option to change positions and move around during labor, they are more likely to find the appropriate birthing position “to help guide the fetal head into the pelvis, put the fetus and pelvis in line with the directional force of contractions, increase contraction force, increase pelvic diameters, reduce pain and stress, and rotate posterior fetuses into the favorable anterior position” (Fenwick and Simkin).⁵ In fact, “[m]uch of the stress of labor is preventable because many of the stressors are not inherent to labor; they are imposed in the form of thoughtless routines, unfamiliar personnel, and technological interventions. Benefits will be gained by exploring non-interventive ways to preserve the normal maternal-fetal adaptive responses to labor by minimizing stress and pain in the laboring mother” (Simkin 227). Time constraints and the limitation of movement in the modern maternity ward are antiquated protocols that could easily be adjusted to more suitably accommodate the birthing woman.

American women are fortunate to have many pro-baby and pro-woman groups and programs at their disposal to assist in the decision-making process that accompanies birth. More federal funding for these programs would be a great start to reversing the high cesarean rate in our country. Programs such as the Association of Women's Health, Obstetric and Neonatal Nurses have been created “to lower cesarean rates by enhancing in-hospital reviews, improving quality of care, and standardizing terminology” (Goer 37). Potentially, the number of

⁵ Posterior position is unfavorable because the baby is then facing the mother's belly and this slows labor progress.

unnecessary c-sections could be significantly reduced if this plan were implemented in all hospitals across the United States to ensure that hospitals and their staff are held accountable for the outrageous number of cesarean surgeries that they are performing without a reasonable medical indication.

For women, vaginal birth is not only the most physically empowering, natural experience that she can endure, but a privilege that is exclusive to her sex. Females have the intrinsic advantage of being the central figure to the most essential function of human life and love-reproduction. The hormones produced during birth, called oxytocin, are quite literally love hormones: “In general, if you disturb the hormonal balance of a female giving birth, it's simple- the mother does not take care of her baby. It's simple. If monkeys give birth by cesarean section, the mother is not interested in her baby. What about the future of humanity? If most women have babies without releasing this cocktail of love hormones- can we survive without love?” (Lake; Michel Odent). Author and maternity ward administrator, Michel Odent, raises a valid question about the effects of Pitocin. *The Journal of Child Psychology and Psychiatry* conducted a study in which women were given MRI brain scans while listening to their infants' cries. The research proved that women who delivered via cesarean section exhibited lower levels of parent-response brain activity versus women who delivered via vaginal birth. The researchers suggested that perhaps the women who had delivered their children via cesarean had been deprived “of this [vagino-cervical] stimulation and associated neurohormonal experiences, [which] might decrease the responsiveness of the human maternal brain in the early postpartum” (Swain et. al.). Although the answer to Odent's question has not been specifically answered by this research, the potential effects of this artificial hormone and the lack of natural oxytocin release during childbirth could conceivably be devastating to future generations.

Cesarean sections are medical procedures available to women in times of crisis. They serve as an important means of preserving both the mother and baby's life in the event of significant complications. In complicated situations, emergency c-sections are not only pertinent, they are vital. In America, however, the convenience of c-sections has led to a drastic increase in superfluous surgeries. Informed consent requires physicians to disclose the risks of a c-section in the event of a patient's decision to forgo a traditional vaginal birth for the convenience of a scheduled cesarean. The implications of these risks, which range from inevitable permanent scarring to possible death stemming from complications, are often ignored due to the ill-advised popularity of the procedure. I have discussed the negative effects resulting from unnecessary c-sections and the necessity of change in both medical practice and women's opinions about childbirth. I realize that most pregnant women will not be reading my thesis and therefore, I think the best alternative to dissemination of my lengthy argument would be to make pamphlets available to women in OB/GYN offices that give evidence-based information about vaginal and cesarean birth. As a future midwife in America, I am hoping that the women in our society and the medical community at large soon realize that cesarean sections are only advantageous in emergency situations. I hope that they will discover natural birth as one of the most beautiful processes to be endured by any individual in the animal kingdom.

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