The Cesarean Section Rate and the Midwives Model of Care

Abstract

The Cesarean section rate in the United States has surpassed 30%, much higher than in comparable developed European countries and much higher than the World Heath Organization recommendation of 10-15%. A Cesarean section is a major surgery that can have harmful consequences, both physical and psychological, for mothers and babies. Although women with high-risk pregnancies can greatly benefit from C-sections, low risk women are better off delivering vaginally. C-sections cost at least a third more than vaginal births in the hospital and can cost up to eight times more than midwife-attended vaginal births at home. Reasons for the steep increase in the percentage of Cesarean sections include liability concerns, increased Electronic Fetal Monitoring and monetary benefits for doctors. In order to halt the medicalization of birth and reduce the percentage of C-sections in the United States, hospitals should adopt the Midwives Model of Care. This model focuses holistically on the well being of the mother throughout the pregnancy and into the postpartum months. It seeks to reduce the number of high-risk pregnancies and thus reduce the need for C-sections. The model also emphasizes vaginal birth as the healthiest, safest method of delivery and advocates C-sections only when absolutely necessary for the health of the mother or the baby.

Introduction

Cesarean Sections have been around since ancient times, evidenced by myths from the Greco-Roman era and documented in drawings, writings, and manuals from medieval times. During Roman times the practice was used only to rescue a child from
the body of a dying mother. The origins of the name “Cesarean section” are obscure. Some people believe that the name comes from the birth of Julius Caesar himself who, legend has it, was born through his mother’s abdomen. Other scholars trace the word back to the Latin root word “caedere” to cut (Cesarean). Wherever the name came from, the fact remains that Cesarean sections were extremely rare until the 20th century and even then they did not start gaining the immense popularity they have today in the United States until the 1980s (US). For the vast majority of history then, a Cesarean section was understood to be a dangerous procedure that was only employed in emergency situations.

Today, however the C-section rate in the United States has surpassed 30%, the highest rate in all of history and by far the highest rate in the world today (US). The reasons for this abnormally high rate are myriad and contentious. Some cite personal choice of the individual woman and high-risk pregnancies as the highest contributing factors, but beneath the surface of these causes lurk liability factors, increased Electronic Fetal Monitoring, tight schedules, and high revenues (Lane).

I argue that the high Cesarean section rate in the United States is due mainly to its revenue generating power, to increased fetal monitoring and to the general medicalization of childbirth. Both mothers and babies can suffer greatly from C-sections and the vast majority of C-sections are unnecessary. In order to reduce the C-section rate to a more reasonable level, like that in many developed European countries (US), I propose that hospitals and birth centers throughout the United States adopt the Midwives Model of Care. The model promotes birth as a natural process that should only require C-section intervention about 10% of the time (Midwives).
**Methods and Materials**

To find out about C-sections in the United States, I looked at information published by hospitals and individual doctors and at writings from women who have undergone C-sections. I also looked at information from European countries, where the C-section rate is much lower. To find out about the Midwifery Model of care I went to the website of Citizens for Midwifery, an organization dedicated to implementing the Midwifery Model of Care in hospitals and birth centers all through North America. I also interviewed Kathi Mulder, a certified professional midwife in the Midwives Alliance of North America (MANA) and former president of the Michigan Midwives Association. She has assisted many women in delivering babies vaginally after having had a C-Section in the hospital. She has also worked to raise awareness about the Midwifery Model of Care and about how hospitals can implement this model.

**Observations**

**Medical Reasons for C-sections**

Doctors advocate and perform Cesarean sections for a number of reasons, including Failure to Progress (FTP), when the baby is breech, when there are multiple fetuses, when the baby is deemed too large to pass through the birth canal, when there is a problem with the placenta or the umbilical cord or when a C-section was performed previously (Mayo). Of these risk factors, FTP and previous C-section operations are cited as the two biggest reasons to perform a C-section (Mulder). A problem with the placenta could be that it has detached from the uterus and covered the opening of the
cervix making vaginal birth difficult or impossible. A problem with the umbilical cord could mean that it is wrapped around the neck of the fetus or that a loop of umbilical chord has escaped the cervix ahead of the baby (Mayo).

**Complications of Cesarean-sections**

Cesarean sections can lead to breathing problems or fetal injury to the baby or increased bleeding, decreased bowel function, urinary tract infections, blood clots, wound infections, and additional surgery for the mother. A C-section is a major surgery that is traumatic to the body and that can affect all the organs in and around the abdomen. Sometimes the incision wound can become infected, or sometimes doctors can accidentally cut or tear other tissues in the abdomen when performing a C-section, mistakes that require additional surgery (Mayo). Also, the recovery time for a C-section is much higher that the recovery time for vaginal birth. The woman may have to stay in the hospital for several days and even when she is allowed to go home she will not be able to engage in normal activities such as climbing stairs, picking up objects, or even holding her newborn (Lane).

Beyond the physical complications, women can also experience intense and prolonged psychological trauma from unanticipated C-sections. Women who planned on having vaginal births but instead received C-sections due to Failure to Progress or to other complications that arose after the onset of labor, report feeling violated. They feel they lost control of the birth process and of their own bodies and that they missed out on an important, life-altering experience. Until recently no long term studies had been done to show the effects of C-sections on women later in their lives. Now however, evidence
is emerging that show long-term health problems connected with multiple C-sections (Mulder).

**Cesarean-section Rates in the Rest of the World**

The World Health Organization recommends a Cesarean Section rate of no more than 10-15%. In most developed European Countries, the C-section rates hover somewhere in this range, but in the United States and Canada, the C-section rate is already past thirty percent in the former and 18% in the latter and is on the rise (US).

**Cost of Birth**

Cesarean section: $11,500 (Merrill)

Hospital (Vaginal): $8,300 (Merrill)

Home Birth: 2,200 (Mulder)

The figures above are averages and the Cesarean Section and vaginal hospital birth costs do not take into account the personal bills of individual doctors. Low-income women can get their hospital expenses paid for by Medicaid. The amount of money a woman receives from Medicaid depends on her income level and the number of people living in her house (Mulder).

“In 2003, private insurance was billed for more than half of all childbirth-related hospital stays, totaling $17 billion, while 43 percent of the charges ($15 billion) were publicly financed through Medicaid” (Merrill).
Recovery Time

“The mean length of stay for all deliveries was 2.6 days. The amount of time women remained hospitalized following delivery varied greatly, ranging from 2.1 days for uncomplicated vaginal deliveries to 4.6 days for C-sections with complications” (Merrill).

Discussion

Many of the causes that physicians say contribute to the high C-Section section rate actually occur rarely, and the ones that occur more frequently don’t necessarily warrant a C-section. Breech births, excessively large babies, and complications with the placenta or umbilical cord are problems that happen too infrequently to account for the 30% C-section rate (Tipton). Failure to progress (FTP), although it is the most frequently cited reason that doctors perform C-sections, does not mean that something is wrong and that a C-section should be performed, but that the baby is not yet ready to emerge. Labor can take anywhere from 2-48 hours, but in the hospital, if the cervix does not dilate one centimeter per hour a doctor will augment labor and if that fails, perform a C-section. FTP, however, is often a symptom of induced labor. The induction rate is over 50% in some hospitals (Mulder). Homebirth statistics show that long labors or false labors happen often. Midwives, at home, in birth centers and even in hospitals, have made safe, natural deliveries after long labors that did not seem to progress (Tipton). Furthermore, although twin fetuses do necessitate diligent monitoring throughout pregnancy and birth, they do not always necessitate C-sections. Doctors and midwives
have often delivered twins safely through the birth canal (Mulder). Thus, these factors alone cannot account for the high C-section rate in the United States.

The other most frequently cited reason for performing a Cesarean section is that the patient has already had at least one C-section. This logic is problematic however, since additional pregnancies do not always resemble previous pregnancies. Furthermore, additional C-sections can put a woman at greater risk of experiencing one of the previously mentioned complications. Also, the repeated trauma of multiple C-sections can be detrimental to the woman in the long term. The only reason that a doctor should prescribe another C-section for a woman is if her current pregnancy is high-risk. If the only risk factor in the current pregnancy is that a woman had a previous C-section and if she is experiencing a healthy second pregnancy, vaginal birth is the best option (Lane). Both midwives and doctors have successfully delivered babies VBAC—Vaginal Birth After C-section (Mulder).

Another myth is that a large number of C-sections are “patient consent C-sections.” In a study conducted by Childbirth Connection, a non-profit information group for mothers and professionals, only .08% of the women surveyed reported asking for a C-section. What, then, explains the 2% or more of birth records that report a C-section performed at the patient’s request? Often, medical professionals will recommend a C-section, not for any medical reason, but out of liability, time, or money concerns. The woman, thinking that the doctor is making the recommendation on behalf of either the baby’s heath or her own health, will then “elect” a C-section. About 10% of women report having been encouraged to have a C-section by a medical professional, even though that is not what they had originally wanted (What).
A doctor may encourage a low-risk woman to choose a C-section based on liability concerns. With medical lawsuits sky rocketing, sometimes doctors fear the consequences of complications during natural birth. Thus, they prefer to medicalize birth by performing a C-section. Unfortunately, C-sections performed on low-risk women carry much greater potential for harm than natural birth (Lane).

Thus, since all these complications can arise from performing a C-section on a healthy, low-risk mother, doctors must have other reasons than liability concerns for encouraging a woman to elect a C-section. Some analysts believe that one of the real reasons for the high C-section rates is that C-sections are an easy way to bring money into the hospital (Lane). A C-section is the most oft performed major surgery in the United States today and the greatest revenue source for many hospitals. Some obstetricians know that they can make a great deal of money from performing C-sections, so there is personal gain to be had (Mulder). Even physicians not concerned with personal gain still recognize C-sections as a way to bring money into the hospitals in which they work. As part of the hospital organization they feel obligated to bring more money in to aid the functions of the institution. Unfortunately, the high cost of C-sections means that insurance companies pay for the procedure and as the C-section rate goes up, so do insurance premiums. Thus, less people can afford health insurance and either Medicaid or the hospital ends up covering the cost of the birth. As shown above, Medicaid currently covers 43% of hospital childbirth costs, totaling $15 million dollars (Merrill). Imagine how much lower this amount could be if the C-section rate were to decrease. Or imagine how many more women could be served with this same amount of
money if fewer women were receiving C-sections and more were having vaginal deliveries, especially vaginal deliveries at home.

Another factor contributing to the high C-section rate could be hospitals’ increase in Electronic Fetal Monitoring (EFM) in the last couple decades. As technologies become more and more advanced, doctors are hooking women up to sophisticated electronic devices and closely monitoring fetuses all through labor. Increased EFM presents a problem, however, in that it allows more medical anxiety and can give rise to greater liability concerns. The doctor feels more responsible for the health of mother and baby if he or she has the ability to observe the fetus throughout the entire labor (Lane).

Therefore, since Cesarean sections carry more potential harm for low risk women, and since they cost more money and require longer hospital stays than vaginal births, the rate of C-sections in the United States is out of control. In order to save money, halt the progress of medicalization and nurture more healthy mothers and babies, something must be done to reduce the C-section rate.

To solve the problem of the rising Cesarean Section rate in the United States, I propose that hospitals adopt the Midwifes Model of Care. This model addresses pregnancy care at every step of the process, from prenatal through postpartum and emphasizes a holistic view of care. Mother and baby receive care specific to their circumstances and needs, including diet, exercise, and psychological consultation. This model is not practiced exclusively by midwives, nor do all midwives practice this model, but the Midwives Alliance of North America along with Citizens for Midwifery have established this model as the one with most closely resembles the care that midwives give to their clients (Midwives).
The Midwives Model of Care focuses on creating and sustaining a healthy, low-risk pregnancy and providing support through the entire pregnancy for the mother and the baby. Specifically as relates to Cesarean Section, the Midwives Model of Care emphasizes preventive rather than reactionary methods for dealing with birth complications that may lead to a C-section (Midwives). Preventive methods include knowing how to turn a breech fetus around in-uterine prior to the onset of labor and knowing how to safely deliver a breech fetus. Most doctors no longer know these techniques, so they just prescribe a C-section when the fetus is breech. In the worst cases, when a doctor is caught off guard by a breech fetus emerging from the birth canal, the doctor will push the fetus back up into the uterus and immediately send the woman into surgery for a C-section (Mulder).

The Midwives Model of Care emphasizes taking as many preventive steps as possible to avoid the medicalization of birth and especially to avoid C-sections (Midwives), but it does recognize that some pregnancies are high risk no matter what the care provider does. In these instances, the Midwives Model of Care relies on the medical community to ensure the health of the mother and baby (Mulder). However, the way things stand, too many pregnancies are being classified as “high risk” and too many women are using advanced medical facilities unnecessarily, putting strain on hospitals and increasing their own chances for complications (Lane). By implementing the Midwives Model of Care, hospitals can reduce the number of C-sections performed, making birth more cost effective and safer for women and babies.
Works Cited


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