Reducing C-sections is all about attitude

Hospitals are taking a natural approach to lowering rates

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BY DEE GIBNEY

"It was a textbook pregnancy until my due date- then suddenly everything went wonko," recalls Marnie Robinson.

It was her first pregnancy three years ago and she had been planning a home birth. But a gall bladder attack landed her in hospital.

"It was an unfamiliar pain, incredible pain, and I was vomiting," she says. Sometime during this upheaval her baby flipped into a breech position.

"She had been making a lot of big movements in my belly but I was in so much pain from the gall bladder attack that I didn't feel what she was doing. It was my midwife who noticed it when I returned home."

There was a danger of the baby arriving feet first or the umbilical cord getting caught or displaced, cutting off the blood flow to the baby. Robinson was 10 days overdue and efforts to reposition the baby had failed.

Doctors began preparing to deliver her baby girl by Caesarean section.

"I was devastated. I was so upset I started crying," recalls Robinson, 29. "She was being taken out of me. It wasn't giving birth. It was no longer something personal. It was surgical."

But with the baby at risk, there was no choice. A C-section (the delivery of the baby through an incision in the uterus) was necessary.

However, women's health advocates insist many C-sections are not necessary and believe some Ontario hospitals perform them "just to be on the safe side" or because of pressure from the public for perfect outcomes.

And they are on the rise again, after declining in the late 1980s and early '90s when steps were taken to curb rates that had soared in the 1970s and early '80s. Europe, by contrast, continues to have lower rates.

One of the reasons for our high C-section rates is to give the perception that doctors have done all they can, suggests Chris Sternberg, a registered midwife who was part of a provincial group studying hospitals where rates are low.

"There's a perception that if you do something and use all your technology and tools, everything possible is being done and you will create a good outcome- and that not using them can lead to a lawsuit.

"It's a complex issue because you have a belief on the part of the public that a Caesarean is a minor risk and that it's used to prevent a bad outcome for the baby. So there is pressure on professionals to create a good outcome and a Caesarean is (perceived as) the ultimate."

The rising rates prompted then-Health Minister Elizabeth Witmer to ask the Ontario Women's Health Council (an advisory/advocacy group that promotes women's health) to develop a plan to decrease the rates.

The resulting report, published in late 2000, examined four Ontario hospitals that have been able to maintain low rates.

"Caesarean birth carries a higher risk of physical and psychological health problems for the mother, not to mention higher health-care costs," says Dr. Ellen Hodnett, a nursing professor at the University of Toronto and spokesperson for the health council.

The risks to the mother include a higher death rate, since a C- section is major abdominal surgery with all the attendant risks of anesthesia, infections and hemorrhage.

But there is no question that Caesareans can be life-saving when things go wrong- which tends to be in about 10 to 15 per cent of all births.

"Anything more than that, you are running into a situation where there is more harm than good," Hodnett says.

The four hospitals studied all had consistently low C-section rates, despite the widely divergent populations they served. "It defies reason to think that women are incapable of vaginal birth," says Hodnett. "Why is it a problem now when it was not a problem in the past?"

What the study found was that one of the most important factors in reducing C-section rates is attitude. All four hospitals embraced policies that acknowledge childbirth as a normal physiological process and offer one-to-one nursing care and support during labour, with little intervention.

This is not the case in most hospitals, Hodnett says, "where procedures show a belief that birth is fundamentally risky and something to be managed rather than supported."

The report notes all four hospitals took a more comprehensive view of maternal care, focusing more on the relationship with the woman and her family than on the task of labour and delivery. That might mean- as is the policy at Scarborough Hospital, Grace Division- having the same nurse from the pre-assessment visit through to postnatal care, and encouraging women to take an active role in decisions about the birth process.

This is important for continuity. It fosters a trusting relationship with the same nurse, which contributes to a calmer labour.

"Birth is not a purely mechanical process," says Sternberg. "It's emotions and feelings of safety. If the mother feels calmer and supported, those things have a positive effect. We're people, complex beings, not machines."

The hospital also made an effort to "de-medicalize" birth, keeping medical equipment in another room, providing aids such as showers and tubs, birthing beds with squatting bars, massage and home-like rooms where mothers could move around during labour- all things that allow the birthing process to unfold more naturally, help manage pain and therefore reduce the sense of urgency "to make things happen" and, in turn, reducing the likelihood of a Caesarean.

Separating the patients and machines makes the experience more personal, suggests Robinson, who gave birth to her second child, Mackenzie John, last month after 29 hours of labour at St. Michael's Hospital.

"If you're hooked up to a machine for your entire labour, the staff tend to look at the machine and not at you," she says. "They tend to trust the machine because it's science, rather than listening to you when you say, 'My contractions are getting stronger.' Yet I know in my case, the machine wasn't registering the contractions consistently so they might not have thought my labour was progressing, even though I knew it was."

After her C-section experience, Robinson was intent on a vaginal birth this time. She discussed the risks at her obstetrical consult, and did a lot of her own research.

But, again, she was carrying a large baby and it was overdue. When she went into labour Jan. 19, it was a long process, the baby had not descended and she was dilating slowly. But she was determined.

She had two midwives, her "doula" (a birth advocate) and her husband. After 24 hours, the obstetrician suggested her slow dilation might indicate the need for another C-section.

"But all I heard was the numbers. I thought 'Wow!' I'm at seven to eight centimetres after being at four all day, then at six. That gave me the strength to keep going.

"You have to believe you can do it," she says. "I don't think it's this cavalcade of technology that in the end really makes a difference. You're a lot better off with someone willing to help you work through it."

Low C-section rates can't be credited to any one factor, says Hodnett.

"It's a system-wide thing. What these four hospitals have done is taken steps to show that they really care about the Caesarean rate as an indication of the quality of care they are providing."

Sternberg says staff pride in low rates also plays a role, as do multi-disciplinary teams with a strong voice.

"You have to have good leaders who recognize the strengths of the people on their unit, where people feel they can have an impact, where the work atmosphere is less hierarchical," she says, adding that the culture of the hospital is very important.

"There can be subtle influences that do not encourage staff to use their clinical judgment, which results in, 'Well, let's just do a C-section'."

Hodnett agrees it's all about the culture of the hospital. "(It's) how they work together and the values and beliefs they hold, and how to use the best research evidence as a guide for their policies. What we found that was consistent among them was the effort to do what was best for mothers and babies. And if you do that, your rates will come down."

But even hospitals determined to reduce C-section rates face funding concerns. The four in the study went out of their way to find funds for their maternal/newborn programs, for everything from ongoing training in the principles of supportive care to the renovation of less-clinical labour rooms.

But they fear they may not be able to afford those programs much longer.

"As hospital budgets are decreased, and with the shortage of nurses, it certainly becomes more difficult to provide one-to-one care," says Dr. Jeffrey Gilmour, chief of obstetrics at Scarborough Hospital.