

### "DOCTOR, I WANT A C-SECTION." HOW SHOULD YOU RESPOND?

BY CAREN M. STALBURG, MD, MA (MAY)

#### An informed patient should be granted "cesarean on demand"

Every time I read an article written by an "expert" regarding cesarean section on demand, I roll my eyes. Dr. Stalburg regurgitates the tiresome ethics jargon, statistics, and recommendations from our infallible professional organizations. This is a classic illustration of the "town versus gown" phenomenon, in which academic physicians and community physicians most definitely do not see eye to eye. In this age of patient empowerment, does anyone really believe that an informed patient cannot determine the way her baby is delivered? To argue otherwise is old-fashioned paternalism.

My patients are bright and informed. I discuss with them the risks and benefits of cesarean section versus vaginal delivery, as I do with any treatment. A straightforward vaginal delivery is enjoyable, but a difficult one can be horrible. No matter how many studies are performed, it will forever be impossible to accurately predict which "low risk" patients will develop complications such as shoulder dystocia, pelvic floor damage, severe lacerations, dyspareunia, and so on. That is simply the nature of obstetrics.

One more point: If a patient is denied a C-section and a complication ensues....Well, I guess I don't have to spell out the consequences.

**Andrew Broselow, MD**  
Lubbock, Tex

Have a comment to share?  
Send us an e-mail

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» Dr. Stalburg responds:  
*A reflexive response to a patient's request serves no one*

*It seems that Dr. Broselow did not recognize the aim of my article, and I am grateful for the opportunity to clarify it for all who may have interpreted it as biased toward one viewpoint or another.*

*I completely agree that our patients are intelligent and well informed; hence, their presentation to our offices with an initial request for cesarean section. Our challenge, given the unpredictable nature of obstetrics specifically and the future in general, is to provide the best care possible within a patient-centered context. Understanding the request for cesarean section and factoring in future considerations such as family size, confounding medical issues, insurance coverage, and timing of the requested C-section, all fall under our aegis as the patient's expertly informed partner in care. To ignore, deny, or discount those mitigating factors out of fear of litigation or because of one's altered vision meets no one's interest.*

*The intent of the article was to provide a well-rounded presentation of the multitude of issues involved when considering an elective primary cesarean*

*section—a presentation based on available evidence and designed to help each provider partner with his or her patient to determine the best plan of care. One gown-size does not fit all, and rather than reflexively granting or rejecting a patient's request, I would hope that we would engage in a deliberate discussion to provide a focused view of the issues for the patient and ourselves.*

*NOTE: At a plenary session at the recent ACOG annual meeting, there was agreement that a standardized informed consent form for elective cesarean delivery would be useful, and one is currently in development at the College (personal communication MDP).*

#### SHOULD WOMEN ATTEMPT HOME BIRTH AFTER C-SECTION?

BY ROBERT L. BARBIERI, MD (MAY EDITORIAL)

#### VBAC is rare even in a hospital

It is hard to believe that home delivery after cesarean delivery is even considered in the United States in 2008. It is equally unbelievable for the American College of Nurse Midwives and the American Public Health Association to support the practice. I doubt that many obstetricians would attempt vaginal birth after cesarean delivery (VBAC)—even in a hospital—in a patient who has undergone two C-sections.

In Illinois, a bill is pending that would allow midwives to deliver without supervision in a free-standing birthing center. I believe physicians are partially responsible for this development. Some of these midwives have the support of physicians who are mainly interested in getting referrals. The burgeoning of the feminist movement in the 1980s brought many good changes, but it also fostered the attitude that "anything goes."

If midwives want to practice independently, they should shoulder

the same burden that physicians do in terms of malpractice coverage. I hope that very few physicians defend these types of cases.

**Rida W. Boulos, MD, MPH**

Associate Professor of Clinical Obstetrics and Gynecology  
Chair and Program Director  
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### Nurse midwives get an unfairly bad rap

I was very disappointed with Dr. Barbieri's editorial on home birth. Although it was ostensibly about a home delivery after two cesarean sections, it effectively denigrated all home births.

I delivered more than 2,000 patients in hospital between 1988 and 2000 and was also fearful of home deliveries. Then I entered into a collaborative agreement with a certified nurse midwife who attends home births, and I have participated in many of these births myself. More than 25 women—both primiparas and multiparas—have been safely delivered at home. One patient required hospital transfer for pain management, but still had a successful vaginal delivery. No Apgar scores lower than 8, no maternal or neonatal morbidity.

At our Buffalo (New York) hospitals, we have a cesarean section rate in excess of 30%, and these patients will pay the price in terms of current and future morbidity; hemorrhage; infection; placenta accreta and previa; and adhesions. Women undergo induction of labor for every reason imaginable, every patient has continuous electronic fetal monitoring despite solid evidence that it does not improve outcomes, and we continue to blame patients and attorneys for our inexorably climbing cesarean rate.

Dr. Barbieri noted that 10% to 15% of planned home deliveries require transfer to a hospital. Even if every one of those patients ended up with a cesarean section, that rate would be far better than our hospitals'

Women who choose home birth are a select subgroup, both in their personal outlook and in their health. It's definitely not for everyone, but nothing is gained in trying to restrict it further, especially when ObGyns as a group have become ever more interventionist and cannot point with pride to our outcomes. I have been impressed with the skill, judgment, and patience of the midwife with whom I work. We could learn from midwives to the benefit of our patients, but the tone of the editorial makes me suspect that is unlikely.

**Katharine Morrison, MD**  
Buffalo, NY

### >> Dr. Barbieri responds: *Views represent both ends of a spectrum*

*I thank Dr. Boulos and Dr. Morrison for their thoughtful responses to my editorial concerning home birth following multiple prior cesarean deliveries. They provide bookends on the spectrum of expert opinion, with Dr. Boulos against and Dr. Morrison supportive of home birth following multiple prior cesarean deliveries. My main concern remains that home birth, especially in high-risk situations, appears to be associated with an increased risk of newborn morbidity and mortality, compared with delivery at a birthing center or hospital. Based on a review of 1,453 attempted vaginal births following cesarean delivery at birthing centers, unbiased investigators concluded that the practice is not safe for the mother or newborn.<sup>1</sup> If delivery at birthing centers is not safe, certainly home birth is not safe in this particular high-risk situation.*

### Reference

1. Lieberman E, Ernst EK, Rooks JP, Stapleton S, Flamm B. Results of the national study of vaginal birth after cesarean in birth centers. *Obstet Gynecol.* 2004;104:933-942.

### UPDATE ON MENOPAUSE

BY ANDREW M. KAUNITZ, MD (MAY)

### Will we get an apology?

Dr. Kaunitz is to be thanked for concisely stating that, with few exceptions, hormone replacement therapy is safe and helpful to the great majority of women who are suffering adverse effects of menopause. However, he is far too forgiving about the profound misinformation foisted upon our profession and patients by the Women's Health Initiative (WHI) studies. These were poorly designed studies with conclusions that were, in a word, bogus. Sadly, the 2007 studies have not received the same blaring, front-page headlines as the original studies. As a result, women now fear a therapy that is overwhelmingly safe and beneficial. We can only wonder if there will ever be an acknowledgment from the WHI authors that their conclusions were based upon bad science. I believe they owe both the ObGyn community and our menopausal patients a long-overdue apology.

**David Priver, MD**  
San Diego, Calif

### >> Dr. Kaunitz responds: *Others also call for mea culpa*

*I thank Dr. Priver for his comments. He is not alone in believing an apology is due, both to our specialty and to menopausal patients. In late 2007, in fact, Wulf Utian, MD, PhD, executive director of the North American Menopause Society, called for such a mea culpa in the journal Menopause.<sup>1</sup>*

### Reference

1. Utian WH. NIH and WHI: time for a mea culpa and steps beyond. *Menopause.* 2007;14:1056-1059.