

A Butcher's Dozen

by Nancy Wainer

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I'm so tired! Exhausted. It's the wee hours of the night and it's dark and freezing cold. I am driving home slowly—darn, the roads are icy—from back-to-back births. I realize that both of the women whom I have just attended would have had cesareans had they been with typical American obstetrical care providers. Two more women who weren't cut, who birthed their babies powerfully and naturally. Two more babies who were born into calm and joy. I'm not quite so tired anymore. In fact, I begin to feel exhilarated. The roads aren't icy, they're sparkling, and I'm going to build a (pregnant, of course) snowwoman before I go inside!

I have been asked to write on VBAC—vaginal birth after cesarean. Good. I'll use this invitation to share some stories, pass along some information, give a quick retrospective history on the subject, and, OK, yes, to vent a little steam.

VBAC. A victory and a relief for most of the women who have one. A deep and generous healing for many of them. And still, very much a sham, because most of the women never really needed to be cut in the first place, so they didn't really need to be VBACs after all. In that respect the whole concept of VBAC is actually, unfortunately, pathetic. In this country the subject of whether or not VBAC is "safe" is also subject to the obstetrical fashion of the hour.

I receive thousands of inquiries about VBAC every year. This week I have gotten several calls from midwives throughout the United States who tell me that the hospitals they work for no longer want to do VBACs, or that doctors who have been backing VBAC are getting a lot of heat. Today I received a letter from the coordinator of a cesarean education and support group in Australia.

She writes that South Australia has a section rate of 25 percent—so I guess we in the United States aren't the only ones who are ignorant and knife-happy. She writes that "the vast [majority] of doctors are scared of VBAC. Current hospital policies do not support VBAC women's needs. ...[T]he general statement [from the heads of all hospital birth units] is that they do not need to address the issues of VBAC because there is no issue! . . . I would like to ask you for your advice on how to make 'them' listen to us 'mere women'"

Mere women. Without us, my dear new Australian sister, they wouldn't be here, cutting women. We must remember that cesareans are just one more reminder that we live in a misogynistic world—they are a form of violence and abuse and they are symptoms of fear, hatred, greed, misuse of power, and sexual dysfunction.

For the moment, let's just arbitrarily begin with the last 12 women who have used me as their midwife. They all had homebirths, and let's get one thing straight: I did not deliver their babies—they delivered their babies. I did not do their births—they did their births. But I did assist, and I did work hard, and I did influence, and I did suggest, and I did listen, and I did trust, and I did support, and oh-dear-God/dess yes, I did love.

Dawn had had two previous sections. She was two weeks past dates. She had prodromal labor for several days, during which time we made many suggestions to keep her relaxed and trusting and to help line up the baby ([see addendum](#)); then, when she went into labor, she birthed her baby in two-and-a-half hours with a big smile on her face. She said people thought she was crazy having a homebirth at all; after learning she'd had two sections, they thought she was stupid. But they were really convinced that her

wiring was crossed, she says, when she told them she loved being in labor and wants to do it again! She'd have been sectioned.

Deb, sweet and tiny, five feet tall, had had a section for cephalopelvic disproportion (CPD). This time she had a five-and-a-half hour labor. She went into labor two weeks prior to her due date, on the day her three-year-old was having his birthday party. There were 20 guests, and an entertainer who brought animals to her child's party. Deb had her baby with a ferret, a boa constrictor, a tarantula, and some bunnies very (very!) close by. She had the exact same difficulty during pushing that she'd had last time. But we do things differently and she had a nine-pound baby. She would have been sectioned, sans ferrets.

Laura, small in stature as well, had been sectioned for CPD the last time. That baby was nine pounds, 14 ounces; so, of course, with such a big baby—sarcasm dripping here—that section must certainly have been "necessary." This time, she had a four-hour labor, an 11-pound baby with a huge head circumference, and no stitches.

Jean had a nine-pound, seven-ounce VBAC baby last month; in fact, many of our mothers have babies that are nine pounds or more and have them in less than five hours—love that HypnoBirthing™! I am so glad that I learned early on from one of my wonderful mentors (thanks, Val) that larger babies come through very easily when their heads are lined up—and how to help them line up!

By the way, Laura was past dates with this very big baby—like most other VBAC hopefuls in this situation, she most likely would have been induced, Pitocin'd, and well, you know the rest of the story. But most of the people who are involved in birthing in this culture don't know. They don't understand that when you induce a woman, her body isn't ready to give birth—if it was, it would be in labor!—and so you are, in effect, trying/hoping to blast a square peg through a round hole. And at what cost? At cost to the woman's insurance company (ah, but that is a major subject for a different day . . .) as well as to her physical and—if she is a conscious individual—emotional health. And at cost to the baby as well.

Pam birthed last night. Another tiny woman, she and her husband and 20-month-old son moved all the way across the country so she could birth with me. I wanted desperately for her, as I want for all of my couples, a wonderful and healing birth. I knew they must have had a very traumatic birth last time for them to sell everything so they could move here.

Last time, she had a posterior baby and had pushed for hours and hours with absolutely no progress and was cut. This time she also had a posterior baby; however, we continually tweaked this baby's head position. She pushed 45 minutes and had an eight-and-a-half pound baby. The only song that Pam's toddler, Oliver, knew was "The Wheels on the Bus," so to that tune, we were all—including Pam—singing "The mommy in the bed goes push push push" as she was birthing. Pam was laughing as Mack's head, and then his body, was born. When we came back the next day for the first postpartum visit, Oliver started laughing and singing again. What joy. A healing for him, as well. An hour after the birth she commented that her baby hadn't cried, and I repeated what I had learned: "Why would he cry? He hasn't left your side, his cord has not been cut, he feels the love and joy in this room, and no one's been mean to him!"

Amy had a section for fetal distress the last time. This baby was as happy as a pig in mud all throughout the labor. This baby was fed during the entire labor—at six centimeters his mom was eating a sandwich and scrambled eggs. This baby had no drugs to contend with and had no one disturbing/distressing his mother. We see almost no fetal distress at any of our births. But Amy would most likely have been sectioned because she had high blood pressure for much of the pregnancy. She would have been induced for sure. She said to me, "If you think my blood pressure is high now, take me into a hospital and you'll really see it soar." We (my apprentice midwife and my assistant) spent gobs of time with her and worked diligently with nutrition (Much love to you, Dr. Tom Brewer!), herbs, relaxation, homeopathics,

chiropractic and other natural means to keep her blood pressure at a manageable level. She birthed at home.

The other women would also have been sectioned for a variety of reasons. One had her water leaking for several days. We waited until she went into labor on the third day and had a homebirth. We have never had an infection, even last summer when one woman's water released at 32 weeks and she waited and had her baby at home at 36. One woman had very poor muscle tone—the doctor told her that her uterus did not have the tone to birth and scheduled her for a section—she birthed at home and had a four-hour labor. One woman's waters contained meconium. We do not necessarily transport for this—it depends on a variety of factors. Our suggestions often work, and within a short time the meconium is cleared. She had a lovely homebirth.

One woman was 42 years old. She didn't think she was a good candidate for a homebirth. I told her that some people aren't good candidates for the presidency, but that doesn't stop them! (OK, so I'm not a political humorist, so shoot me.) She had her VBAC baby (last child was born 17 years ago!) in under five hours. She lives in one of the oldest houses in Massachusetts—it is 275 years old, and very beautiful. There was a borning room!!! as well as the original beam floors in much of the house. We thought about all the babies that had been born in that house—and there were plenty of them—and all the midwives who came to attend the mothers there over the centuries. What a travesty it would have been for her to have been in a chrome and plastic hospital bed with the "potluck (or un-luck) OB of the day" who had to look at a chart to see what her name was.

Here's one: Mary came to see me two days before Christmas. Because her baby was breech, her doctor insisted on a cesarean and had scheduled her for one. She wanted suggestions from me as to how to turn the baby and asked if I recommended she go in for an external version. My first suggestion, of course, was to not have the version done at a hospital! They do it all wrong and it hurts like the dickens and it's rarely successful, and they give drugs that are actually counterproductive to the turning, but who cares, the docs get hundreds of dollars whether or not the baby turns anyway. She came to see me for a consult, and I palpated her and told her that her baby was not breech. She was surprised. To make a long story short, every time she went to see her doctor the baby was breech or transverse; she would come to me and the baby was head down. This happened three times. I made several suggestions, including chiropractic, homeopathy and so on and sent her on her way with good wishes. She called five days ago, and asked to come and see me again. She said she was considering a homebirth (she was "overdue" at this point). I told her to go home and think about it. The next morning she called and said they had just made the decision to stay at home. I told her that I had already fallen in love with them and they would be fine. I apologized and said that we would not get to know them as well as we know most of our clients. She said, "Are you kidding? In the first hour [we had spent four altogether] you spent with us, you had already spent more time with us than our OB has spent with us in the nine months of this pregnancy!" She went into labor two hours after she called, and had a two-and- a-half hour labor!

And last summer, VBAC—hopeful Bettina would have been re-sectioned because her baby was breech. We invited our expert breech midwife to come to Boston and teach us as she assisted Bettina. Bettina's eight-and-a-half pound breech daughter slid out of her body. She was "lucky," the doctors say? Lucky to have birthed safely outside the hospital? No, Bettina was lucky not to have been in the hospital getting cut. The same experienced midwife assisted Emma, who would have been sectioned as well—for twins; instead, she had them at home, gently and easily.

Ah, and Anna. She'd had two cesareans. At 39 weeks pregnant she decided to drive eight hours to have her baby here. The doctors in her area seemed itchy to cut her again. They had no faith in her ability to birth. Instead, this beautiful, large woman (over 300 pounds) had an eight-pound, 11-ounce VBAC baby four full days after her water released. She is so happy. Soooooo happy.

A while back, I had a true shoulder dystocia with one of our small (under five feet) VBAC moms. Her baby was large, 10 pounds, four ounces (although our three, over-11-pound babies have slid out). This is of course every midwife's nightmare—I'm talkin' real dystocia and not just sticky shoulders here. We did the

Gaskin Maneuver—flipped her onto her hands and knees—and we were able to help the baby out; he is now an active, healthy three-year-old. During my training I was an observer at a hospital when there was a shoulder dystocia and the baby died. In hospitals, laboring women are usually medicated and epidural'd—they have monitor belts around them and are entwined in IV lines. IVs create a continually filling bladder (big deal, right, we'll just catheterize) which compromises the amount of space for the baby. Women are often weak from lack of food. It is almost impossible to get them turned quickly and efficiently over onto their hands and knees—the position that often helps dislodge the shoulders.

Don't we get it? Women have babies! Even when there are situations that arise! There are billions of people on the planet—they get here without being cut into the world! All our ancestresses had babies or we wouldn't be here, and they all birthed outside of the hospital. I will say it again and again and again until I no longer have the breath: Hospitals are for sick people, and birth is not an illness. Every study that has ever been done has shown that planned homebirth is as safe (safer, I think safer) as hospital birth. Best kept secret in the country, wouldn't you say?

Oops. I'm sorry. Please pardon the sarcasm—it just slipped out. Get me talkin' about birth and VBAC and a whole lot of emotion comes up.

I have counseled thousands of VBAC mothers. They understand that they were robbed, and that birth is joy. They are exuberant—for years after their VBACs. Their bodies work, there is nothing wrong with them, they are normal. The "voices of VBAC" are profound and passionate. VBAC mom Megan proclaimed, "I want to do this again!"—much to her husband's shock, since only the head of this baby was out at this point. Brenda wrote, "When I met you, I had little faith in my ability to birth a baby. You gave me confidence and courage to let go and trust my body. Ryleigh's birth was more powerful than I ever could have imagined. During Ryleigh's birth, I found a strength within me that I did not know existed. I now find that strength extending into all areas of my life . . . Being surrounded by so much love and support was the key to my success. I wish I had the words to describe the impact your touch and encouraging words had on me during my labor. From that point I never doubted my ability to birth my baby . . . I am so grateful and I look forward to the day when all women can expect to receive the loving care I did throughout my pregnancy and birth." Marcia said, "You have healed me of the trauma I experienced two years ago and given me back my birth rite. You granted my heart's desire to push my baby out and feel it." Rachel wrote: "I feel that you are the gardener who tended me while I blossomed. I'm sitting here with this bundle of flesh and bones, hands and feet, blood and smiles, eyes and ears, love and spirit on my lap. I stroke his head, and know that he is nothing less than a complete miracle. I know that it was the grace and power of my body and the creative force within it that carried him into the light. But I also know that you do whisper magic that makes miracles happen. And that your love and mothering nature tends to make things bloom. My experience of giving birth made me whole in a way I wasn't aware of being broken."

Obstetrical Conference

A few years ago I learned about a big, two-day obstetrical conference on VBAC. Even though I was one of the first planned VBACs in the country, coined the term VBAC, wrote the first book on the subject—which, by the way, won the best book in the field of Health and Medicine by the American Library Association the year it was written—had more experience with VBAC than anyone else in the country—or the world!—and lived in the city where the conference was being held, I was not asked to speak at, or attend, the conference.

Although I may occasionally be sarcastic—to cover up the frustration and rage I feel about women getting unnecessarily cut and erroneously diagnosed with failure-to-progress (FTP) and CPD—I am not arrogant. I wasn't insulted that I wasn't asked to speak: I was sad. I have so much that I want to share about my research, information, and experience with VBAC. And yet I recognize that this oftentimes happens in a patriarchal system—that key people, mostly women, are ignored, dismissed. Anyone whose experience does not fit the script is dismissed. But birth, to be natural, powerful, cannot be scripted.

The conference was being held at the swankiest hotel in the city. The cost was prohibitive. I learned that there was no quota for obstetricians, but there was actually a quota on midwives. As it was, there were few midwives who could afford the cost of the conference anyway. I knew that going to the conference would probably not be good for my blood pressure and decided that staying at home and writing was the best way to spend my time.

The night before the conference I got a call from a woman who is a birth researcher/writer. She was ill and could not attend the conference. She asked if I would go in her place. She said she knew that I would find much of the information difficult to swallow, but that at the very least, I'd learn firsthand what they were saying. "Nancy, just think—you'll be able to use all their incorrect assumptions and information as ammo for your next book!" she said.

Believe it or not, I don't want "ammo." I want shared information, communication and understanding. I want others to be interested enough—intrigued enough—to find out why so many of the VBAC women with whom I work have large, healthy babies and normal, natural births in such short periods of time. I want them to be inspired enough to be able to assist women in having wonderful, fun (yes, fun!) births that are healing and empowering.

A man who had written a book on VBAC and was speaking all over the country on the subject was going to be there as a presenter. I had called him years earlier, and in effect, was told that his association with me could reduce his chances for his work to be respected by the medical community. I had understood then that this man was becoming a VBAC guru—I was glad that someone was, although I had concerns about some misinformation in his book and the fear that that information engendered. I wanted to dialogue with him, to help him, if I could, along his path. I knew that while obstetricians might have little regard for my work and my knowledge, this man was "one of them," and so they might pay attention to VBAC through him. VBAC has been my baby for almost 30 years, and if he was going to talk about it, write about it, and be the authority on the subject, I wanted him to understand aspects of it that I knew he didn't know, aspects that I know are essential to its success.

A note here: The American College of Obstetricians and Gynecologists (ACOG) wanted to take credit for having introduced VBAC into mainstream consciousness. Nothing could be further from the truth. It was a grassroots movement of women who had been cut and were enraged by the cesarean epidemic. It began with people like myself, Jini Fairley, Lynn Richards (who called VBACs "Very Beautiful and Courageous"), and a few pioneer midwives such as Kay Mathews and Valerie El Halta who were attending VBACs long before any "research" was done to "prove" their safety. We did sit-ins and letter-writing campaigns and wrote articles for magazines and spoke out to anyone who would listen. We birthed in vans outside of hospitals and in motel rooms across the street from hospitals and then in our homes. We found a few (a very few) sympathetic doctors across the country who supported VBAC and who were willing to assist us in quiet, yet powerful ways, many of whom were ostracized by their peers for doing so. After a period of time we had attended thousands of women who'd had VBACs; many of them birthed babies who were significantly larger than the babies for whom they had been sectioned. Many had VBACs even after more than one, two, three or four (or more) cesareans, even with twins (and one woman with triplets) and with breeches. We did research on the safety of VBAC in other countries, on the dangers of anesthesia, and on the types of incisions that were being done.

We talked about the convenience/advantages of scheduled/repeat cesareans for American doctors, and we talked about money, power and control. Eventually, reluctantly, sheepishly, annoyedly—ACOG had to pay attention. They began to talk about "trials of labor" and VBACs under specific conditions. After a while they owned VBAC as their own, as if it had been their idea. The same doctors who had told me (18 of them) that either I or my baby (or both of us) would die if I dared to try for a VBAC began advertising that they indeed promoted VBACs as the safest alternative for most previously sectioned women.

Doctors may have acquiesced and even later, boasted, but they never really liked attending VBACs. And because they tried to orchestrate VBAC, control it and manage it, they never had the kind of success with it that others of us did. But they could at least say that they tried it and it didn't really work, so why not just

have another cesarean without all the (as one doctor said) "muss and fuss." Women were deprived of food during their VBAC labors—we all know that during labor women must eat for strength and to keep their babies healthy! VBAC women were given IVs, "just in case"—we all know that IVs interfere with normal labor, cause a woman's body to tire out, and deliver a message of fear that affects the labor as well. In addition, no one seemed to pay attention to head position [see addendum], and so women who'd had cesareans for FTP or CPD were once again trussed and prepped: Hi ho, hi ho, off to the O.R. we go...

I went to the conference. There were perhaps 150 or more people there. With the exception of three other women, all were men, mostly obstetricians, with a few hospital administrators. I raised my hand many (many) times to ask a question, discuss or argue a point or make a statement, and was completely overlooked. I almost stood on the table at one point. I was hearing things about VBAC that were so blatantly untrue, so fear inducing, so ridiculous, that I wanted to shout: "You don't understand VBAC! You don't understand women! And you don't understand birth!" I also wanted to vomit. But as Sonia Johnson first noted, solid gold platters and Waterford crystal glasses are not appropriate for puke.

By the end of the first day of the conference, I wasn't sure I could return. I felt physically sick; I had spent the day listening to "research" and recommendations on VBAC that had not taken into account one, not one, of what I know to be the most important aspects of this kind of birth. And yet I felt a responsibility to return. Perhaps if I returned I would be able to ask a question, or make a statement. At lunchtime the next day, at which point my raised arm had been passed over yet another 20 times, I decided to introduce myself to some of the keynote speakers in the room and tell them that I had great interest in talking with them about VBAC, if not now, then at some point in the immediate future. I suppose I had a delusion or two of grandeur—I thought, maybe later, one of them would say, as he was presenting his VBAC-related topic: "Oh, by the way, we are most privileged today to have here in our audience the very person who coined the term VBAC, the person who had one of the first VBACs in this country, who founded the organization C/SEC, Inc., and who was instrumental in the formation of the Cesarean Prevention Movement [now ICAN], the person who has devoted her entire adult life to the subject of VBAC. Ms. Wainer-Cohen, would you be so kind as to stand up and say a few words?" In fact I was treated just the opposite: it was as if I didn't belong there and had nerve even going up to talk to the speakers. Two of the men actually turned away from me, and one refused to talk with me (after he had made a rude comment). I was stunned—honestly, not from a place of ego, honestly—but from a place of pain. It was clear once again that the "powers that be" were not really interested in the truth about VBAC, but more in their own gain, and I heard the quote "the master's tools will never dismantle the master's house" echoing in my broken heart.

It was clear that according to the presenters at the conference, they thought that VBAC was dangerous, and most would prefer to just cut women open and be done with it. VBAC may be dangerous, the way most obstetricians do it! It was even clearer to me that their ignorance and fear are going to be the downfall of us all. They don't think that the process of birth works, they think that women's bodies are defective, and they pay no attention to preventing cesareans in the first place (so that VBAC isn't even an issue).

They pay no attention to nutrition, the cornerpost of healthy mothers and babies and good, safe, births. They don't understand the differences between their inductions of labors and helping VBAC women go into labor naturally. With so many of their "attempts" at VBAC failing, why should they continue encouraging VBAC? Why should they think at all that VBAC works?

Why should VBAC work in America? American obstetrics doesn't work! What can you even begin to say about a country with an ACOG conference entitled "Promoting Medically Unnecessary Cesarean Sections"? We rank number 24th in the world: there are 23 other countries that have better birth outcomes than we do. This is a disgrace! And the countries with the best outcomes use midwives and encourage out-of-hospital births! Here, women think nothing of sitting in waiting rooms for 45 minutes with no nutritional food or naturally delicious snacks in sight in order to have a six-to-10-minute appointment, if that, with an OB who has never had a baby, or who has had a drug-induced, Pitocin-augmented, epidural-"enhanced" labor—an OB who doesn't know them and may never even see them again. These

"care providers" cut the baby's cord immediately, depriving babies of their own stem cells and a good portion of their own supply of blood, wonder why babies "need" vitamin K and why so many of our kids become anemic, for starters—and then charge thousands of dollars to bank the stem cells in case the kid needs them later. We are nuts! Ah, but I digress....

Birth does work. Almost all of the time. When we trust that it will and when we are respectful and relaxed. I remind women over and over and over again that they come from strong and proven stock, that their grandmothers had babies, and their great-grandmas, and their great-great-great grandmas—all of their ancestresses since the beginning of time have birthed—and they have been designed to birth, as well! I also remind them that contrary to what we have been taught (oh Oprah, would I love a private session with you, sweet woman!) and shown on TV programs like ER, when you are respectful of the process, birth is not a disaster waiting to happen.

I am extraordinarily grateful for the help that we are given by skilled, attentive and supportive doctors when there is a situation that needs additional expertise. However, with healthy mothers it is rare to have an emergency that is not preceded by a situation, which, had it been addressed, would not have escalated into a complication or an emergency (this, too, is a subject for another day). And being in the hospital does not preclude birthing women from having problems; in fact, being there often creates the problems that are then "solved" with devices—and knives.

So, back to VBAC. In order to appear progressive, and in response to demand, doctors began accepting VBACs. The ones who did were getting more clients (remember, patients are sick people), and of course, money talks. Some would agree to VBAC, but only if the woman herself brought it up. Others would agree, but only under certain conditions: for example, if there was an anesthesiologist in the hospital at the time. I always questioned this: what did they do if there was a car crash or a shooting and they needed to operate right away? There was more of a chance of these things happening than the need for assistance with a VBAC! Many doctors even charged more for a VBAC than for other labors. I wanted to spit.

Most of these obstetricians didn't understand certain aspects of successful VBAC—excellent nutrition, the absence of fear, the importance of the energy in the birth room, and faith in the birth process. Many of them told women that they had to have their babies by 40 weeks—or they would be induced. But since more and more women were having/demanding VBACs, this is where the money was, and doctors began to get more comfortable with the idea. For doctors, more VBACs equaled more time with less money, less power and less control. OBs who were attending VBACs were merely "baby catchers"—something any ol' midwife could do; performing surgery was lucrative and awe-inspiring. They could schedule cesareans at a time that was convenient for them, instead of possibly being disturbed in the middle of the night. They couldn't understand what was so important about a vaginal birth, and they oftentimes used scare tactics to get women to comply, that is, agree to schedule a repeat cesarean. They accused women who wanted normal deliveries of compromising the health and well being of their babies for their own aggrandizement and at the expense of their babies. Of course nothing could be further from the truth.

One of the VBAC mothers I attended writes, "As we know, many doctors, even medwives, have never even seen a normal, natural birth, let alone experienced one themselves. But, not only have they not/won't experience it, they have no incentive to change, based upon their experiences—scary, frustrating, 'unsuccessful.' Your VBAC clients refuse to be limited by their own, often frightening first birth experiences, and find it in themselves to trust and believe in the very different experiences real midwives and their clients have, and plan and succeed at VBACs. Experience is powerful, and informative, and . . . thank the goddesses, some of us find ways to overcome our negative Experiences, to create the Experiences we know are possible."

We all know that birth in this country is big bucks. Cesareans are extraordinarily profitable for doctors and hospitals. Initially, we were all told how dangerous VBAC was. Then, when we noted that other countries did not find this to be the case, and when thousands of women here started having "uneventful" VBACs, the doctors began telling us, well, yes, perhaps it was, after all, safe. As their section rate decreased, so

did their bank accounts shrink. As they began losing money, because more and more women were delivering vaginally, they had to find a way to scare us back into more cesareans. At the same time, the more comfortable they became with VBAC, the more risks they began to take. Before, no one ever induced a VBAC woman, and certainly no one ever used Pitocin, but now, Pitocin was used frequently. Isn't it interesting, by the way, that although we are told that Pit is safe, as soon as the drip is started, a woman must be strapped with electronic fetal monitor belts in order to "make certain" that everything is OK? There has been an increase in uterine rupture with the advent of induction and Pitocin. I find it incomprehensible and wicked that instead of understanding how obstetrical directives create problems and decrease the safety of VBAC, obstetricians in the United States believe that the danger is inherent within VBAC. In fact, it has come to our attention that recently, instead of taking the time to suture the incised uterus in layers, doctors have been taught a "short-cut" technique that uses only one layer. This method compromises the integrity of the scar and predisposes a woman to greater incidence of uterine rupture. So now they can tell you with a straight face that VBAC is dangerous: they are making it so. We are at their mercy—they cut us up and they sew us up.

We all know that while major abdominal surgery is safer than it used to be, there are a variety of major complications that can and often do occur. The risks of anesthesia alone are pretty mind-boggling. A c-section is not simply just another way to have a baby—it is major abdominal surgery. It is not so much that c-sections are so safe as the fact that they have become comfortable. Comfort and familiarity is equated with safety, much as the thinking that the more gadgets, machines, whistles and beeps at a birth, the safer the birth must surely be. If women knew the real truth about birth, obstetrics as we know it would be vastly different—this may be a threatening thought to those who have been in-doc-trinated to believe that machines, technology and computers always make things better.

Laura, VBAC-with-a-beautiful-11-pound-baby-and-no-stitches-and no "gestational-diabetes"-either, worked hard to get the VBAC homebirth she wanted. She interviewed many doctors and midwives before making a decision to travel to Boston to have her baby here. Recently, she wrote to me. "Knowledge is power, Nancy, which is why they cannot allow [emphasis hers] us to share ours: They know that allowing real midwives' knowledge to be shared would take away from their power. It's not enough for them to do the initial cuts, then leave the VBACs to us. They want it all! They want the repeats-scheduled ones at that-too! Thus their need to silence the midwives who have knowledge about VBAC (not to mention natural birth, the first time around!). To borrow a phrase from the book of AIDS' activists: Silence equals death. The docs (not all, but seemingly most) want to silence us, because they want women's knowledge to die. Doctors often scare women with words like 'you might die.' What they don't understand is that the surgery itself represents a kind of death: death of our dreams, death of normalcy, an excising of our power-after all, they are cutting that part of us which creates life!"

Life has risks. Not everyone who plans a VBAC will have one, and not everyone who has one will have a perfect experience. Some women who desperately want VBACs end up with repeat cesareans. But after almost 30 years of researching, writing, counseling and teaching cesarean prevention and VBAC, I know that most women can have safe, gentle, sacred, delicious VBAC births, and that they are safer than repeat cesareans. It is a travesty that the majority of sections and repeat sections are unnecessary. It is a tremendous sadness when women have been so indoctrinated with fear about birth that they choose numbness and technology to "get the baby out" rather than their own power and efforts.

We must continue our efforts to stop the alarming number of primary cesareans and to increase the VBAC rate for those who have been cut. Spiritually conscious women want to feel the full scope of their feminine experience. They do not want to be ripped open. VBAC makes an immense difference in their lives, and it makes a positive and impressive difference in the lives of all those who are witness to that experience, as well.

Addendum: Heading In The Right Direction!

One of the reasons that so many of the women with whom I work have successful VBACs, even with very large babies, is that we pay strict attention to the position of their babies. Information about tuning in to the baby's position during pregnancy, in early labor, and then paying careful attention to it throughout the labor, makes a tremendous difference in birth and in VBAC outcomes. I suggest that you pay very close attention to Valerie El Halta's article "Posterior Labor: A Pain in the Back" [Midwifery Today Issue 36 and Wisdom of the Midwives] and the booklet Understanding and Teaching Optimal Foetal Positioning by Jean Sutton and Pauline Scott [available through Midwifery Today].

OK, so we know the baby's head is down. But that information alone is not enough. We need to know where the baby's back is, what side the baby favors. It is appalling to me how many care providers are unable to ascertain this information without ultrasound. This is disturbing to me for a variety of reasons, not the least of which is that ultrasounds themselves may influence the position of the baby. In addition, and most women whose babies have been exposed will verify this: babies do not generally like to be ultrasounded. It seems to disturb them, causing them to become overly active: mothers will tell you it was "as if the baby was trying to get away from the ultrasound." It is often easy enough to ascertain the position of the baby externally. But if there is a doubt, midwife Valerie El Halta asks: "What do you think suture lines and fontanels are for?" Answer: "They are God's directional signals for midwives!" The anterior fontanel is diamond-shaped and the posterior fontanel is triangular. By feeling the fontanels and the suture lines, we can determine the baby's head position.

[Note: I was most interested to receive Doris Haire's note this week: "On Dec. 13th I posed the following question of David Feigal, MD, Director, FDA Center for Devices and Radiological Health: 'Dr Feigal, it is my understanding that no one knows the delayed, long-term effects of diagnostic levels of ultrasound on human development. Is that still true?' Dr. Feigal's answer: 'Yes, that is correct, no one knows the long-term effects of diagnostic levels of ultrasound on human development.'"]

When the baby's back is on the mother's left, or to her front (anterior), labor will most likely be short and productive. When the baby and head are "lined up" properly, the waves [contractions] are generally regular, with time in between, and the cervix dilates well. This is because the smallest part of the baby's head is presenting, and it is the part of the head that molds most easily. In addition, this part of the baby's head presents as a circle that applies direct, equal, and even pressure to the circle that is the opening cervix-voila!: 10 centimeters and pushing. However, if the baby's back is on the mother's right, or the baby is facing front (that is, posterior), we must pay close attention. Unless this is rectified, either naturally or with assistance, several things most likely will occur: the mother will experience prodromal "on again-off again" labor, which is exhausting and discouraging; the waves will be on top of one another, occurring every two or three minutes, lasting only 20-30 seconds with sharp peaks and excruciating pain but very little accompanying dilation; mothers often complain tearfully how much their backs hurt; there is often pain even in between contractions. These are warning signs of a posterior or asynclitic (one of my midwife mentors, Clare, calls these "caddywampus") babies. In these situations the largest part of the baby's head is presenting, and it is the part of the baby's head that does not mold as easily or naturally. It is not a circle that is applying to the circle which is the cervix, but a large, convex, irregular oval that creates pressure only on random segments of the cervix. The result is that the cervix becomes irritable, contracting often but unevenly, and without much (or any) progress.

Without the presence of the correct part of the baby's head, the woman's cervix usually dilates only to three or four centimeters, with little further progress. She is in a situation that requires diagnosis, attention and correction. Techniques and measures such as visualization, relaxation, chiropractic, acupuncture, homeopathy, herbs, putting the mother in a hands and knees position, having the woman hold her own stomach and then redirecting the baby's position externally, tennis balls, hot (or cold) compresses on her back have all helped certain labors, but more often there is little change, and the woman, discouraged and wracked with unremitting pain, anguished and defeated, begs for relief in the forms of drugs, anesthetics and cesareans.

If the woman is in the hospital, the obstetrician will most likely suggest Pitocin, which often causes other

problems: maternal and/or fetal distress; stronger, but still ineffective contractions which are more difficult for the mother and so she needs-begs for-drugs or an epidural; and then we get into that whole CASCADE of interventions, and, most importantly/ominously, forcing the baby down in-and thus actually committing the baby to-the unfavorable position. Others suggest that the woman squat if she is not making progress-this may also encourage the baby to come down in the unfavorable position, causing a deep transverse arrest. Doctors often break the bag of waters, hoping to get things going-this is not generally recommended either, as this, too, often commits the baby to the unfavorable position.

Prevention of posterior babies is possible! We are all beginning to pay attention to this fact. We are telling pregnant women: Never recline during pregnancy-if you are going to sit and read or watch TV, for example, make certain that your back is absolutely straight. Put a wedge or a book or lots of pillows behind you. Follow this advice when you are in a car as well-make certain there is a pillow behind your back to straighten it. If you work at a desk with a chair that leans slightly backwards, find a straight-backed chair. Reclining can weaken back muscles and create a situation that encourages babies to hang out in unfavorable positions (and look at how all our little American babies are carried around in bucketed car seats for hours at a time, creating generations of girls who will later be predisposed to posterior babies as a result!) However, if a woman has entered active labor and is not making progress, it is important to begin to (literally!) turn things around, to intercede.

Midwife Valerie El Halta teaches the difference between intervention and intercession. An intervention is done without any regard for whether or not this action will assist the mother in having a natural birth. Interventions are not natural; for example, Pitocin and epidurals. They are often done for the convenience and comfort of the obstetrical staff, or to speed things along. They are often advocated in an atmosphere of mistrust of the natural process and in an environment of birth-related fear. An intercession, however, is something that is done with both safety and natural childbirth in mind. It is done with the unwavering belief in the woman's ability to give birth. We intercede on behalf of the laboring mother to assist her in having a natural birth. Repositioning the mother and/or helping to rotate a posterior baby is an intercession, not an intervention.

The position that we find most always rotates posterior babies is called the Polar Bear Position. This term was coined from a magnificent picture in National Geographic magazine of a polar bear who is birthing her baby. Her front paws are down as low as they can go, as are her shoulders, and she has a big arch in her back with her knees apart and her butt way up in the air. (It has also been called the Playful Puppy Position, or Sleeping Baby). Women assume the position in early labor, when the contractions are established. If after 45 minutes or so the baby has not turned on its own, it is easy to go in (with the woman still in that position) and reposition the baby by gently but firmly pushing the baby back in. Many obstetricians tell women that the baby's position cannot be adjusted until the woman is at least seven or eight centimeters or more, and unless the baby's head is quite low in the pelvis. The problem, of course, is that many women never get to seven or eight with a posterior or asynclitic baby, and if they do, it has usually taken hours and hours. Adjusting the baby's head position in early labor is imperative: it saves the mother from exhaustion, saves the baby from distress and eliminates the problem of a baby that is unable to turn. It is not unusual to have a mother who has been "stuck" at four or five centimeters for a while to automatically progress very quickly, because the head is now well applied to a cervix which has very much wanted to cooperate but has been unable to do so due to unequal (or non-existent) pressure.

Helping to rotate a posterior baby is safe. It is most likely as enormous a relief to the baby as it is to the mother. In thousands of tweakings/adjustments, there have been no incidents of fetal distress or stress or cord entanglement. In fact, it is far better for babies to have their heads positioned correctly, well applied to the cervix and dilating it symmetrically, so they can be born, rather than being "jammed" asynclitically or posteriorly without progress. Many babies who don't get turned end up with meconium and other signs of stress—and off to the OR they go.

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Prevention and Vaginal Birth After Cesarean and the author of *Open Season: A Survival Guide for Natural Childbirth and VBAC*. She is currently working on her third book, *Birthquake: A Childbirth Book for Strong Women and Women Who Want to Be Strong*.