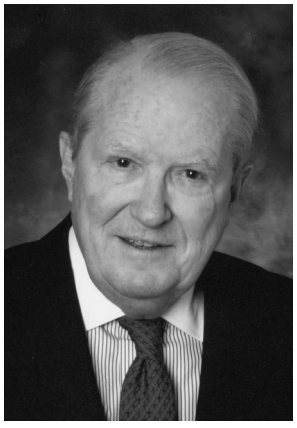
How to Stop the Relentless Rise in Cesarean Deliveries



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In the United States we have experienced a relentless rise in the cesarean delivery rate from 5% in the 1960s to 32% today.[1] It is unclear what an acceptable rate should be. Certainly the 5% level was too low, and the 32% rate of today is judged by many to be too high. However, recent data show that almost a third of primary cesarean deliveries are in nulliparous women,[2] and with the decreasing rate of vaginal birth after cesarean delivery (VBAC) since 1996, the rate is likely to exceed 50% very soon in the United States. How can we curtail this runaway increase in cesarean deliveries? The question is simple, but the solution is complex.

One solution is to make VBAC more accessible and more desirable. In this issue (see p. 342) Dr. James Scott tells us how this can be done.[3] He outlines the dilemma we face today in trying to keep cesarean delivery rates low, covers the salient points of the 2010 National Institute of Child Health and Human Development consensus conference on VBAC, and discusses what is necessary to prepare for an improved climate for implementing VBAC. He presents valuable material on how to conduct the VBAC labor and delivery, and covers the rare but dreaded complication of uterine rupture. This Clinical Expert Series article will be a valuable resource for physicians and departments that wish to improve their ability to offer VBAC to patients.

The struggle to improve acceptability of VBAC will not be easy, as some practical considerations make this choice difficult. The candidate patient may have had such a difficult labor before her primary cesarean delivery that she is unwilling to consider a trial of labor. Another patient may have had such an easy time with a scheduled cesarean delivery for a breech fetus that she prefers not to have a trial of labor. The physician has to devote considerably more time in the labor suite for a VBAC than for a scheduled repeat cesarean delivery. In addition, there is a small but serious risk of uterine rupture, and until there is tort reform the physician may be unwilling to take this risk. Furthermore, the hospital administrator makes a larger financial return on a cesarean delivery compared with a vaginal delivery. Of course, the basis of decision making should be what is best for the patient, but such considerations must be dealt with when organizing a comprehensive system for providing VBAC for patients.

The second and even more critical solution is to prevent primary cesarean deliveries in the first place. At one time, obstetricians wishing to do cesarean deliveries were required to get a consultation from a colleague. Departments reviewed all primary cesarean deliveries. The scene has clearly changed. Today, cesarean deliveries may be done at a patient's request, and vaginal delivery of breech fetuses is no longer taught in many training programs. Modern practices have made cesarean deliveries safer and recovery time shorter than decades ago. However, cesarean deliveries have significant risk for future pregnancies in placenta

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previa, placenta accreta, hysterectomy, and mortality relative to vaginal births. Notably, the maternal mortality is higher in repeat cesarean deliveries than for VBAC.[4]

In 1998 the U.S. Public Health Service Commissioned Corps set forth U.S. public health goals in Healthy People 2010,[5] which included lowering the cesarean delivery rate to 15%. The year 2010 came and went, and the rate has now more than doubled the 15% goal. The ideal cesarean delivery rate is unknown and depends on many factors, primarily the number of complicated pregnancies cared for in the hospital. Some states have low cesarean delivery rates, with Utah at 22.2% and Alaska at 22.6%, while others have high rates, such as Florida at 37.2% and New Jersey at 38.3%.[1] Studying the reasons for these discrepancies could give some clues to lowering the rates. What the appropriate rate should be for the United States is elusive, but a 50% rate seems too high and would draw common sense criticism from many areas. As of now the problem is ours to solve. If cesarean delivery rates spiral upward, our profession will lose both credibility and the opportunity to determine our direction, as third-party payers and the government will become involved.

Many suggestions have been made to curtail the rising cesarean delivery rate:

- Achieve obstetric departmental commitment to lowering cesarean delivery rates. Because over 99% of deliveries occur in hospitals in the United States, the hospital department is the likely force to effect change. A department could decide policies, practices, and target cesarean delivery rates for their own hospital, and conduct self-evaluation, including appropriate review of primary cesarean deliveries. Fewer inductions of labor and not using dystocia as an indication for cesarean delivery before the active phase of labor could decrease the cesarean delivery rate. Meyers and Gleicher reported such an intervention in 1988.[6] Participation was voluntary and required a second opinion for cesarean delivery and adherence to stringent principles. They lowered the cesarean delivery rate from 17.5% (considered high at the time) to 11% over 2 years. During this time the proportion of infants with 5-minute Apgar scores lower than 7 increased from 3% to 4.9%, but there were no changes in fetal or neonatal mortality rates. While some of the criteria would not be acceptable today, they demonstrate that such an initiative can lower cesarean delivery rates.
- Achieve better patient education using evidence-based information so that the risks and benefits of vaginal delivery and cesarean delivery are accurate and understood by the patients.
- Achieve tort reform either at the federal or state level; the threatening professional liability climate forces physicians to practice costly defensive medicine. The limitation of frivolous lawsuits would make it possible for physicians to resort to cesarean delivery less often if any element of risk arises, like nonreassuring fetal monitor tracings.
- Use more nurse midwives. Nurse midwives do not perform cesarean deliveries so their motivation to achieve a vaginal delivery would be stronger. Several countries with nurse midwifery systems tend to have lower cesarean delivery rates.
- Provide equal compensation for vaginal and cesarean deliveries; this could remove financial gain as a factor in decision making. Vaginal birth after cesarean delivery could be compensated higher than a normal vaginal delivery.
- Re-establish teaching and training for breech and operative vaginal deliveries, such that appropriate clinical decisions could be made and unnecessary cesarean deliveries could be avoided.

The rising cesarean delivery rate is a threat to our profession. Remember that the official statistics on deliveries are always a year or two behind. There is no time for complacency. In my judgment, the best action for our profession is to commit to lowering the primary cesarean delivery rate using every practical measure while we are still in control. Improving programs for VBAC will also help in this effort and preserve an important option for appropriate patients.

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