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VBAC & Choice: Many Questions and a Few Answers

by Nancy Wainer

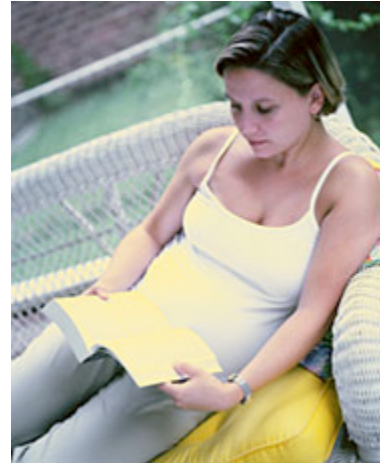
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When is a "choice" truly a choice, and when is it not?

Recently, I received an e-mail from a VBAC client. "When I agreed to have a cesarean, was I really making a choice?" she asked. "First of all, I, the chooser, was not truly informed; second, my doctor lied to me. Third, my insurance company limited my choices in many ways. Many of us women are so acculturated as to be unable to think outside the box, so if our insurance doesn't pay for midwives or cover homebirth, we think we can't choose it. Fourth, my family and friends were also ill-informed and thus played into the hands of the doctor; and in fact, I didn't even have the doctor I chose—I ended up with the one who happened to be on call that evening."

She went on: "[M]any women just like me end up *having* the primary c-section because of the 'choices' they made, even though, again, many of those choices were false and ill informed! Then, they are really stuck when trying to plan a VBAC in this climate and culture. The truth as I see it, Nancy, is that the choices are false, the lies are rampant and the truth (some c-sections are needed; some babies will die) is simply hard for people to face."



Each baby has only one opportunity to be born, there are no second chances; so whenever possible, the experience ought to be safe, wonderful, natural, empowering and amazing. I have a sincere passion to assist women in having the best births possible. VBAC feels like my baby. Having had my own VBAC in the early seventies and having coined the term, I've spent my adult years researching the subject—teaching it, talking about it, thinking about it and writing about it. Along with many other midwives and childbirth educators, I've done my best to bring the subject of VBAC to light and to assist women who choose to birth normally after having been surgically delivered. My heart still drops into my toes every time I learn about a woman who received a c-section and leaps with delight when I either hear from, or am able to assist, a woman who has had a VBAC.

When Barbara birthed her 9 lb 4 oz son (vaginal birth after two cesareans—VBA2C) out of her supposedly contracted pelvis, in the privacy of her own bedroom, five hours after I walked through the door, and when I saw the look of relief-accomplishment-ecstasy on her face, I was happier for her than I could express. Ditto for Laura's 11 lb VBAC daughter, who slipped out of her body one crisp winter night. In one capacity or another, I've assisted thousands of women who have chosen to have a VBAC; many have had births that exceeded their wildest expectations. Sadly, some of the women who have sought my help didn't have the births they were hoping for, and some have had a repeat c-section.

We have learned in newspapers across the country this month that the cesarean rate has been consistently increasing. It is well documented that the rate has increased at least 48% in the last nine years—one in three women are now having c-sections. Before that I remember someone telling me that the rate was "barely twenty percent."

Barely? Many of us remember back to the days when the c-section rate was approaching 15% and the headlines

all over the country stated that the cesarean epidemic was indeed upon us and something had to be done! We were told that, conservatively, at least three-quarters of the one million cesareans that were being done were preventable and that this major abdominal surgery was far more dangerous than vaginal delivery.

Was anybody listening?

A few, but not enough, of us were.

Before beginning a dialogue on this subject, we must start from the understanding that birth is, in one sense, a “first beginning,” that how a baby comes into the world is important, and that the birth experience creates life-long sequelae. Unfortunately, not everyone understands this, and many seem not to care.

All of us have met women who just loved their cesareans and who don't bat an eye when their obstetrician tells them, weeks ahead of time, that they are being scheduled for the c-section on a certain date. We also have run into our fair share of women who believe that a woman should be able to choose a cesarean whenever she wants and for no good reason except that it's what she “wants.” I suggest, for starters, that these women read ICAN's *Cesarean Voices*, a magnificent, informative, educational and sobering booklet that I believe should be given to every middle school student.

The Compleat Mother's Jody McLaughlin often reminds me that we all know that given the “kind” of vaginal delivery that is being “offered up” at most hospitals these days, “choosing” a cesarean can seem, at least on the surface, the best of the alternatives. However, we know that a decision that is made out of fear, or based on a traumatic past experience, is not a decision at all; it is a forced reaction. A decision that is made without adequate information can't be considered a true choice.

We know that birth choices offered by those who have little understanding about or experience with natural birth—and have no personal investment in creating an environment in which this kind of amazing experience can evolve—are not choices but opinions turned into edicts. We also know that, for some women, going back into a hospital and having a “repeat performance”—enduring an experience similar to the one they had before—takes a lot of courage. Other women choose to return to the hospital without understanding that the reason they had such a painful or horrendous experience in the first place may have been due to the setting itself and the rules, routines, policies, beliefs and regulations there. Instead, they believe that the hospital saved them from birth-hell and that birth is, indeed, hell, however you cut the birth day cake.

For many women, the act of giving birth is as close to heaven as we can get here on earth. “It was amazing, I'd do it over again in a heartbeat” is music to a midwife's and to babies' ears.

“I wouldn't have missed this for the world,” remarked one VBAC mother, as she paid tribute to Jeanine Parvati Baker. “I was one of those women who'd had a near-birth experience,” she said. “This time, I bought a ticket for the right ride and it was the ride of my life.”

Rather than discuss the subject of choice ad nauseum perhaps we need to ask some questions.

Who would *choose* a cesarean?

What type of woman would choose to be cut open? Who would choose to be totally numb from her breasts down and to have major abdominal surgery, rather than to give birth normally? A woman who is into convenience and control?

C-section is an ultimate example of lack of control: The woman is totally immobile while another individual wields a sharp object and starts to slice. Have the dangers of anesthesia to mother *and* baby been fully explained, or have they been downplayed? Does the woman know what happens to many women sexually when they have a c-section? Does she understand how traditional childbirth education classes, given late in the pregnancy, support cesareans and increase the chance that it will be the mode of delivery? What brochures and information have been left out of her packet of goodies? Who disseminates the information that creates her “choice” of a c-section? What kinds of births did her mother, her aunts and her sisters have? Does she know that what is considered

normal prenatal care in this culture—waiting in a waiting room and then being seen for six minutes by whoever happens to be “on” that day—is often worse than no care at all? Does she know that one blood pressure (BP) reading does not clinically prove pre-eclampsia? Does she know what to do if she does have a higher BP reading than normal? Does she have any idea of the vital role nutrition plays in the outcome of her pregnancy? Does she understand that many of the tests that are part of her routine care are unnecessary? Does she know what kind of births her obstetrician had, or what kind of births his wife had? Did she ask, does it matter and does she understand that the answer to that question may influence her care provider in many ways? Why is she willing to have to “recuperate” (as opposed to just rest) after having her baby excised from her body? Does she understand that all living consists of risks? What information is missing when a woman in our culture thinks it doesn’t make any difference in bonding when a mother has a cesarean?

Plenty. Pulling the wool over someone else’s eyes is easy, and goodness knows that the sheep continue to march to slaughter. No, pain doesn’t make a mother, but the process of meeting fear head-on and conquering that fear just might. Sadly, many women “choose” a c-section, desperate to get it (the pregnancy, the fear) over with and not willing to find strengths within that will help them as they parent and travel the rest of their lives.

How many of us know that, as mammals, we do not birth well with strangers close by? Our bodies close up/contract/stop laboring when we are in unfamiliar places; in case a predator is near, we have to be ready to react. Do women know not to cross their legs during pregnancy, not to sit with their knees higher than their pelvis, to sit straight and not recline—do their obstetricians tell them these things? Do they know to reduce milk intake and to read authors who actually understand pregnancy and birth, such as Ina May Gaskin, Marsden Wagner or Henci Goer? Do they understand how they become oh-so-compliant patients? Do they “get it”—that new mothers who have had major surgery are at a distinct disadvantage for so many reasons?

Do any of us consider what a c-section is like from the baby’s point of view? Of course, the way babies are often treated in this culture is appalling, regardless of the mode of delivery, but that isn’t the point here—or maybe it is. Do we understand that a hospital cannot be “mother-friendly” unless it is “motherbaby” friendly? Do we see that withholding food during labor, putting in IVs, having no idea how to adequately support a perineum, cutting cords too soon, taking babies away from mothers, bottle feeding, bright lights—the myriad of interventions that have become “normal” in childbirth—are not baby *or* mother friendly?

Why bother doing research when most of the evidence-based research is ignored anyway? Why does it take more than a decade for policy to change after we know that something being done in hospitals regarding birth is wrong? Why is secondary infertility not discussed as a reason to avoid a cesarean? Why aren’t obstetricians, as well as CNMs and labor and delivery room nurses, required to attend at least ten homebirths so that they can see what birth *is* in the most normal of settings?

The first definition in most dictionaries for “choose” is “to select from a number of possible alternatives.” Another definition includes the phrase “to decide.” In most situations, women are not presented with a number of alternatives. They are told that *the* only alternative, in order to “guarantee” a healthy baby, is a c-section. They have little choice but to “decide” to be cut. When the “dead/damaged baby card” is played, even the most stalwart of women break down.

Jody McLaughlin reminds me that if we had a system of maternity care with just midwives (not *medwives*) learning and passing authentic birth knowledge from one to another, and doctors and hospitals weren’t even an option, more babies would live. Of course, some babies who are now living would have died; but more babies who now die would live.

Amy told me that all the doctor had to say to her was that her scar *might* open up and she “chose” to have a second cesarean. Maryann “chose” a c-section when the ultrasound report noted a possible problem with her baby’s brain that would be exacerbated by a vaginal birth. Her baby was healthy and well: The “problem” that the ultrasound had reported did not exist.

This evening, a woman e-mailed me. She is thirteen days “past dates” and in early labor, but her hospital midwives now refuse to attend her and have scheduled her for a c-section tomorrow morning. They have

frightened her about the ability of her placenta to nourish her baby one more day, even though all of the tests they put her through came back normal and her baby looks fine. She told me, "I'm getting really tired of fighting and am ready to give in to the c-section."

Is "giving-in" a choice, or will she be one of the many women who felt pressured into having a c-section, even though they "agreed" to it, and in that sense "chose" it? Did the woman who had "a shot of who-knows-what" put into her IV during the cesarean without her permission "choose" the drug?

We know that the rising maternal death rate is largely a result of the increase in c-sections, as well as in the drugs used to induce labor. We also have known for decades that maternal mortality in our country is grossly underreported and is much higher than it should be. Did *you* know that?

Do you quilt?

(This refers to Ina May's Safe Motherhood Quilt Project [www.rememberthemothers.net]*—*many of the squares honor women who died after non-emergency cesareans.)

We probably all remember a phrase that we first heard a number of years ago: patient-choice cesarean section. Women don't choose the operation in a vacuum; they "choose" it in a culture where the benefits of natural birth are all but lost and the "benefits" of surgical birth are grossly exaggerated. They choose it because they are removed from their own selves in some basic, feminine way. They choose it because they have chosen, in the first place, care providers who don't care if women get cut, would prefer that they get cut or are afraid not to cut. They choose it because they haven't heard Michel Odent's brilliant explanation about how a woman is different, a baby is different and the bond between the two is different when the path that is "chosen" is the one that puts them on a table in the OR. They choose it because they haven't met obstetricians like Leo S., Beth H. or Dr. John Stevenson. They "choose" cesarean—some enthusiastically and with relief, some reluctantly and with ongoing and lasting emotional pain—for a number of reasons. What about patient-choice vaginal birth or patient-choice homebirth?

Once a woman has a cesarean scar on her uterus, she then has a number of questions to answer and choices to make concerning future childbearing. Does she want another baby? If she does, but is one of the women who suffer secondary infertility as a result of the c-section, will she have to "choose" her response: anger, frustration, acceptance, grief, or all of the above?

If she becomes pregnant again, is she willing to climb onto the operating table on a prescheduled day, or will she go into labor and *then* hop onto the table? Will she do her best to stay home long enough so that she *can't* have a c-section once she arrives at the hospital? Will she decide to return to the same hospital and use the obstetrician who performed a c-section on her in the first place or choose a different site and surgeon? Who will take care of her two-year-old while she is "inhospitated" (incarcerated + hospitalized—a term used for women who wanted to have a homebirth but were unable to find midwives to support them in their decision and so, reluctantly, went to a hospital) and what kinds of ideas and feelings will that child incorporate about birth as a result of the choices that his/her mother makes?

I truly appreciate the knowledge, skill and expertise of obstetricians and other hospital staff who are able to handle true childbirth emergencies. Having said that, we all know that the vast majority of c-sections are preventable and that the incentives and awareness (political, spiritual, nutritional) necessary to decrease the number of surgical births are dutifully ignored, seemingly unavailable and/or seem monetarily impossible.

Many women tell me that they chose not to go to a hospital and be a sitting duck for all the interventions and interferences that caused them to have a cesarean in the first place. Many have told me that they would almost rather die than be cut again. These are pretty strong words, but quite common. Do they mean it?

In one sense, women *do* die when they are cut, or at least a part of them does. The normal-birthing woman inside of them disintegrates, dissolves and disappears. More women are choosing to birth at home, many of them unassisted. These women are conscious and committed to VBAC—they know of the risks involved with most

decisions in life and have decided that the best choice for them is to go into labor in their homes.

Do we understand that we alter birth when we interfere, observe, control and/or disturb the woman who is birthing? Do we see that one of the most valuable aspects of giving care to a laboring woman is “holding the space”—keeping things peaceful and calm and mirroring confidence? Do we know that everything we do and say matters and influences this time when a woman’s entire being is opening and richly, emphatically vulnerable?

I attended the 25th anniversary conference of ICAN and spoke to many women from all over the country who had birthed normally after having had one to five previous cesareans. These women had to make choices: Where would they feel safest? Who, if anyone, would be their care provider? What would they do if they went beyond the “guess date”? What would they do if their water released and they were not in active labor? What was most important to them? How could they help to ensure the best possible outcome? What would they do if things didn’t go well this time? Whom would they “blame”?

Once a woman chooses to have a VBAC, many additional questions must be asked, some with answers and some without. What type of incision did the woman have? (Did she get to “choose” this?) What “week” was she in when her labor began? (Or this?) How big was the baby? How long did labor last? How long did the woman push? All of these factors need to be considered.

Regardless of the “particulars,” some women plan for and reach for VBACs and HBACs. I’ve had many women travel to my area to be given what they consider to be the best possible opportunity to birth normally, including several women who had had more than one cesarean. Not all these women have been able to birth normally; but none have regretted the decision to “try.”

A woman who was 36 weeks pregnant and who had had two c-sections selected me as midwife. She said she didn’t want to undergo major surgery again. I was confident that she could birth normally. Much to everyone’s surprise and sadness, she changed her mind and chose to go into the hospital and have an elective cesarean without labor. Her baby was 6.5 lb, and perhaps “chose” her entrance into the world in order to spare her mother—a nurse who spent most of her waking hours in a hospital—some anxiety, not knowing what a calm and wonderful experience traveling down “the girl parts” and “sliding out like a wet seal” could be. (Quoted from Stella, age-two-and-a-half, describing her brother’s homebirth, at which she was present.)

Several other nurses, a medical student, a radiologist and an anesthesiologist chose homebirth because, as one of them said to me, “Patient choice in an institution is, for the most part, an illusion.”

How do women choose VBAC in this climate? We all know that elective c-sections generally pose more risk than VBAC, and that many of the problems associated with VBAC result from induction of labor and the use of Pitocin. We know that waiting for a woman to go into spontaneous labor and undergo that labor takes more time than having her come into the hospital and get cut. Time is money; and cesareans are, among other things, convenient. Natural labor assumes the mother’s body is in control; cesareans put the docs at the steering wheel.

Women who become pregnant and choose to avoid a subsequent cesarean are hitting the same stone walls that caused the generation before them to band together and form organizations such as C/SEC, Inc., the CPM and ICAN. “Enough!” these groups chanted, as more and more pregnant women were being wheeled into operating rooms at record numbers. The term “cesarean epidemic” was coined. Do you remember when VBAC wasn’t considered safe?

And then it was.

And then it wasn’t again?

And then it was again?

And now it isn’t anymore?

Which factors made it safe and which now make it unsafe? Do you know that despite the fact that obstetrics

literature fails to mention it, VBAC was a grassroots movement? And that only when hospitals lost clients—i.e., revenue—did they then begin not only to accept VBACs, but to welcome them? Women were having VBACs all over the country—many at home—at which time doctors began to tout the idea as theirs; until that time, they had disregarded their own literature that deemed it safe.

“It seems we no sooner wind up one battle to save what we fought for and won years ago than we have to gear up and fight [again].” This quote was from a retired teachers’ newsletter, although these same words have been spoken by numerous childbirth activists over the years.

Another quote, “The master’s tools will never dismantle the master’s house,” by Audre Lourde, is germane to many in this society as well.

Do we have any idea what we are doing when we bring babies into the world before they go through labor? Apparently not. Why do we ignore the risks involved in major surgery for birth? Why do we continue to induce labors—for the doctors’ convenience and because we are tired of being pregnant? Why are the dangers of induction not s-p-e-l-l-e-d o-u-t just as the “dangers” of vaginal delivery are? Do we not understand that if a woman is not in labor her body is not ready to birth the baby and that our attempt to ripen a cervix and “get things going” are ways to control a process that is, most often, better off left to do its *own* thing?

Why don’t we rebel against having a particular “due date,” which is merely a guess and which is not sacrosanct? When did the normal 36–42 week range of normal become a few days around the “due date”?

Why do we hear such a fluff about “big babies”—don’t we know that a 9 lb or 10 lb baby with its head in a favorable position is easier to birth than a 6 lb baby whose head is not? And that a 6–7 lb baby can have the same head circumference as a 10 lb baby; the 10 lb baby just has thunky (thick and chunky) thighs and “chubs”!

Why, since twins and breeches are born naturally all over the rest of the world, are they cut out of women here in this country? Do we know that what is considered “medically necessary” is often not? We have so many examples of this—the most dramatic was the woman who left the hospital in labor and hid in a church and had her baby there, easily and naturally. She had been ordered to have a c-section by the courts in her state. So many women have contacted me who were pressured into having a c-section and who wished they’d had the courage to pull out their IVs and find the closest place of worship!

On a similar note, my doorbell rang one hot July evening a number of years ago. I answered it to find a very pregnant woman in tears, with her husband standing behind her. She explained that she had just been “risked out” of the birth center near my home. She had been told that because her water had released almost twelve hours before and she was not yet in active labor, she would have to go to the hospital. She knew what that meant—a cascade of interventions and “necessary” routines would be waiting for her, none of which would be her choice, and many of which would increase her chances of having another c-section. Her choice was to not go to a hospital. What happened to the “choices” that the birth center midwives should’ve been allowed to make? Their hands were tied because the obstetricians they worked for made the choices and rules at that center. The woman, by the way, went into active labor within an hour of arriving at my home and birthed a lovely daughter in my den five hours later with her two-and-a-half year old sleeping peacefully on the couch.

Whenever we make a choice, even one resulting from much thought and research, we have no guarantee that we’ll get the desired result. However, many doctors convince us that if we do things their way, we’ll have an almost 100% guarantee that everything will turn out exactly as they predict. We can increase our chances of things going well, but we cannot absolutely control outcomes. In *The Black Swan: The Impact of the Highly Improbable*, by Nassim Nicholas Taleb, we learn that we act as if we are able to predict events; however, our learning from observations or experience is severely limited.

Why do we act as if we can control birth and predict outcomes by measuring the amount of Pitocin we use (or don’t use) or by using continual—or intermittent—monitoring, for example? Why do we even use fetal monitors for most births, knowing that they’re fallible and were designed to be used only for high-risk situations?

Oh, we are all high risk, oops, I forgot.

Why did a particular “VBAC-hopeful” have a uterine rupture, but thousands of others, including several with four or five previous c-sections, didn’t? Why do we have trouble accepting that, as much as we know, there’s so much that we can’t know and, as a result, our “choices” are perhaps based on intuition and fluff as opposed to reason and research? Why do we think that true informed consent is even possible? If it’s not, then how does that affect the “choices” we make? How can we give information we don’t know? Or “information” that is influenced by money, power, legal matters and anxiety?

Why do a few doctors still champion VBAC and some use double-layer suturing and others do not, and no one knows for sure if this makes a difference, although everyone seems to have an opinion about it?

Why do we think doulas have made any difference at all in the general scheme of things? The c-section rate, as well as epidural rate, has risen dramatically despite the fact that doulas have become an accepted (though not necessarily welcome) part of births in the US. The doulas who write to me feel powerless (they are, for the most part) and frustrated. Doula/midwifery student Jessica Petrone remarks that going to births in the hospitals in her area is like watching the same bad movie over and over again. Sadly, doulas often spend their time helping women relax until they get their epidurals or c-sections. They can choose to speak up in a hospital, but if they do so one too many times, they may be asked to leave.

We are hearing in many arenas about the link between vaccines and autism. What about a link between epidurals and autism? Ultrasound and autism?

We hear all the time that a link exists between induction and cesareans, between epidurals and cesareans. We hear too, about the link between Pitocin and fetal distress, which leads to cesareans. Today, a woman told me that when she went into the hospital to have her first baby, she was 3 cm dilated. The nurse told her to have the epidural right then and there, “before the pain got too bad.” Surprise: Now she aspires to have a VBAC.

How many women do we know who chose to disregard their obstetrician’s advice and instead chose a VBAC—despite his/her insistence that they would suffer severe consequences—and had a wonderful, safe experience? How many of these women were told that they were “lucky” that nothing went wrong? How many women have been “lucky” enough to be in a hospital when something went wrong—something that would most likely not have occurred had they been laboring or having a VBAC at home? How many women have been unlucky in either setting?

Why do so many more American babies go into fetal distress than babies in other parts of the world? Why are our birth statistics so abominable? Why do women in the US seem less able to “do” their labors than women in other parts of the world? Why do they think pain is a four letter word? Are they willing to find ways to birth from a place of calm? Why haven’t programs like Gentle Birth and HypnoBirthing been adopted in their true form by hospitals? Why are most of the labor and delivery wards stocked with staff members who have never seen or had a true natural birth?

How do we know that the woman rather than the doctor is making the choice? Fact and fiction are insidiously interwoven, leaving the woman to *think* that *she* is making the decisions, when, in fact, a carefully selected word, placed in a strategic location, can set her mind reeling and cause her to doubt her ability and therefore to make a choice that she wouldn’t have made had she been on her own.

A medical student who worked with me last year noted that doctors, as deified authority figures, can influence women at any point in their lives, but most easily during pregnancy and labor, when the woman wants to have a healthy, live child (and also perhaps, as mentioned earlier, to have the pregnancy over and done with!). Why don’t we remember that most of our ancestresses gave birth successfully and that birth itself is what we “do” to “people the planet”?

Why doesn’t vaginal birth seem to “work” anymore? This failure causes women to have to recuperate from major surgery and then, if they are planning more children, to deal with VBAC issues of choice? Of course, the ability to

choose a VBAC is being threatened these days, forcing some women to choose a homebirth or an unassisted birth, which they may not have chosen if VBAC were still a viable option.

Are we all aware of the plethora of literature that tells us that VBAC is safe, as well as the reasons that VBAC seems to have fallen out of favor in the past few years? Are we willing to listen to Eugene Declerq or to get some information from Gloria Lemay, Sarah Buckley and Henci Goer? Is a pregnant woman who has had a VBAC really a VBAC mom any longer, or is she now simply a VBAVB—a vaginal birth after a vaginal birth mom? While some wonderful, vibrant, brilliant, enthusiastic and frustrated-with-birth women are certainly following in the footsteps of those who have been championing natural birth and VBAC for years, where are the other women of this generation who, instead of being hoodwinked, incised, debilitated and helped to feel as if cesarean section is a true “choice,” should be educating others about the dangers of major abdominal surgery and the absolute joy of natural birth? This kind of joy is totally different, and impossible (if for no other reason, than at least, for certain, hormonally) with an operative delivery.

While writing this article, I received an e-mail from a couple who told me that recently the medical board in their state had passed a law that makes attending a homebirth illegal in the case of VBACs, breeches and twins. Who gives the medical board the right to legislate over our bodies? Elizabeth Noble, prolific author of childbirth publications, tells me that birth is not the practice of medicine, but a physiological event.

Midwife Valerie El Halta agrees, noting in correspondence that midwifery is a healing art, not the practice of medicine—which is a science. If midwives are illegal, how can women “choose” midwives? Is it difficult to understand why some women choose unassisted births? Will these become illegal, too? What of the women who birth at home “accidentally” or those who birth in cars because they are unable to reach a hospital in time—will they be considered criminals and prosecuted, too?

I was at a VBAC less than 24 hours before writing this. After many hours, we transported the woman to a hospital. Once there, she had an epidural—much appreciated—and, even in my anti-epidural mindset, a necessary choice. The baby was born vaginally five hours after we left the couple’s home, largely because we chose a hospital that is still willing to do a VBAC. They made the choice to continue offering/attending VBACs even when the rest of the institutions in the area chose not to.

When a person makes a choice, he or she must, in some measure, take responsibility for that choice. Some women may find it easier to allow others to make their choices for them. When I made a choice to have a VBAC 33 years ago, it didn’t feel like a choice; it felt like a necessity. I could no sooner walk into the hospital and offer myself up as in some sacrificial ritual than allow my next newborn to be taken from me as my first baby had been (she was anyway). I knew of no one who had had a VBAC. I was told by eighteen doctors that I would die or that my baby would die (there’s that aforementioned card) if I dared to make this choice. I knew from my research that I was, instead, making a choice to live. (Do we have any guarantees in life? A few.) Was one incision, one scar, enough for me? You bet. Would I have been disappointed if I had had another cesarean? Yes. Would I have survived? I think so.

Lois Estner, co-author of *Silent Knife*, remarked in a February 2008 letter to the editor of the *Boston Globe* that for eons we females had been capable of giving birth with very little medical intervention. Then, childbirth moved to the hospital and the process became a medical—and increasingly a surgical—event. She reminds us that if the trend continues, the only women who will be able to “choose” a vaginal birth will be those who don’t arrive in time for their cesareans.

Recently, I had the pleasure of meeting with a dynamic midwife who has attended thousands of out-of-hospital births and who is a dedicated cesarean-preventer and a true VBAC advocate. She is deeply concerned about the lack of choice for women in her state. She suggested that we start educating young girls in nursery school about birth. She is deeply concerned about the constantly increasing number of cesareans and the fact that women are afraid of their own bodies’ “workings,” which alienates each woman from her self. She remarked that she’s thinking about starting a birth Web site for all women: mypusseyworks.com, and one for the men: mywifepussyworks.com, in order to reduce the number of cesareans and increase the number of VBACs. I think she should. *Why not?*

Carla Hartley, director of Ancient Art Midwifery and the Trust Birth Initiative, offers a map for confused obstetricians who don't seem to know the location from which the baby is supposed to emerge. She wonders why the motto in US hospitals today seems to be "No vagina required." Do you want to live in a culture where the women are deemed (or deem themselves) unable to give birth and babies are greeted in operating rooms with surgical masks and scalpels?


It's happening.

Oh, and one more question: Did you know that among the thousands of women I have worked with who had VBACs, not one has had postpartum depression? This includes women who had serious problems in this department after they had c-sections. They may be tired, perhaps, and a few may have tender bottoms, but this is mixed with joy, pride, awe, ecstasy and euphoria. Some say that the mode of delivery doesn't really make a difference and that women who are upset because they had a cesarean ought to get their heads examined. Hogwash. Women who have c-sections miss out on a huge event in their lives, something that, when the choices are right and love and caring are present, is nothing short of spectacular.

A VBAC mother asks, "Would I like to believe I got the wonderful birth I wanted because of the 'choices' I made? Absolutely. But that would be false, because even while I would argue our choices about our care *are* incredibly important, at the end of the day there is a mystery at the center of birth. I don't think that mystery can be understood by our rational minds, and it certainly can't be controlled or predicted by our choices. It (birth) just is. Even while our choices during pregnancy and labor do matter, birth is not, ultimately, a matter of choice."

To the women who choose to have a VBAC, may your births be all that you desire them to be. When a VBAC is not attainable, may each of you choose to feel strong and proud for having done what you could. For those who "choose" a c-section for reasons that aren't birth-necessary, may you "choose" not to get an infection, not to have to hobble to the bathroom, and not to have an unsightly scar on your belly. May you choose to get in touch with the real reasons you decided to be cut open, and may you choose to find someone who can tell your children about the *normalcy of birth*, so that when they become pregnant, they will be free to make their own body-loving choices.

Deal?

 **Nancy Wainer** is a midwife and has been a birth activist for more than a decade. She teaches childbirth classes, is a Hypnobirth instructor and attends birthing women in their homes. To read more about Nancy, see the interview, "Nancy Wainer: Supporting Birthing Women," by Julie Brill in *Midwifery Today*, [Issue 83](#), Autumn 2007.

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