Will new guidelines to reduce C-sections change maternity care?

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Women planning to deliver at some birth centers are being encouraged to stay at home when their labor begins. They are advised to rest, eat, walk around and not to time every contraction.

"We tell the mom not to spend all her labor energy in early labor. We don't expect a lot of progress," said Jessica Henman, a certified nurse midwife who directs the Birth and Wellness Center in O'Fallon, Mo. "We remind her things are going to go slowly."

Last month, national obstetrician organizations together released new guidelines aimed at reducing the spiraling cesarean rate in the U.S. A big change was allowing women much more time in labor, based on new research.

Other changes include: providing continuous labor support, letting women attempt to deliver twins, not using the fetus' weight as a reason for surgery and doing more to understand electronic fetal heart rate readings.

Women's health advocates said the guidelines developed jointly by the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine could completely change how women approach birthing options.

"The consensus statement has the potential to be a game-changer in ongoing efforts to improve the quality of maternal health care, and

maternal and child health outcomes," the National Partnership for Women and Families said in a statement.

But doctors acknowledge barriers. Changes are slow to take effect in massive hospital systems and in private practices where doctors have been doing things a certain way for decades.

The guidelines say that although national organizations can set the agenda to safely lower the cesarean rate: "... such an agenda will need to be prioritized at the level of practices, hospitals, health care systems, and, of course, patients. Changing the local culture and attitudes of obstetric care providers regarding the issues involved in cesarean delivery reduction also will be challenging."

Will hospitals need to have rooms available for longer? Will they urge women to stay home until they are in the later stage of labor? Will they bring back doula (labor coach) programs? Will they limit use of fetal heart rate monitoring?

"Those are great questions," said Dr. Alison Cahill, chief of the maternal-fetal medicine division at Washington University School of Medicine, who helped develop the guidelines. "Could these change obstetrics in the U.S.? We don't know yet."

Showing the way

But one can look to midwife-led birth centers at their homelike facilities to see how care can be done differently.

A study released in January of more than 15,500 women who received care at birth centers in 33 states showed that fewer than one in 16 (6 percent) required a C-section, compared with nearly one in four (24 percent) similar low-risk women planning a hospital birth.

While the C-section rate in the U.S. has climbed to one in three births - a 60 percent increase since 1996 - the rate at birth centers has stayed the same for more than 20 years.

Cesareans are associated with increased maternal mortality and morbidity, and those risks significantly increase with subsequent C-sections. Death and intensive-care stays also become more likely for babies.

Because most women who have C-sections end up having repeat C-sections in subsequent pregnancies, the new guidelines focused on practices that could prevent the surgery in healthy first-time mothers.

The two biggest reasons first-time mothers have cesareans are subjective: Doctors consider labor "stalled" or determine the electronic fetal heart rate readings are "nonreassuring." But the latest evidence shows that labor lasts much longer than long thought, and little information exists on how to interpret questionable but common heart rate patterns.

Electronic heart rate monitors - which are tied around the woman's belly and keep her immobile - are used in 85 percent of hospital births, but they aren't to be seen at the O'Fallon birth center. Henman said midwives use a hand-held doppler to occasionally monitor the baby's heart rate during the active phase of labor, when the woman's cervix dilates rapidly.

Though the active phase was considered to start when the cervix dilates to 4 centimeters, the new guidelines say 6 centimeters is more accurate. The active phase can also last twice as long, and women should be allowed to push for up to three hours. No time limit should be placed on a woman before she reaches the active phase.

Henman said that rather than watching the clock, she watches whether the cervix is thinning, contractions are strong and the baby is dropping down. "Our standard is to recognize early labor vs. active labor," she said. "Once she turns a corner, we expect progress."

Empowering women

Women are encouraged to seek comfort in a large tub in two of the center's birthing rooms and use whatever positions feel most comfortable. Women transfer to a hospital if more intervention is necessary, Henman said, such as an epidural anesthesia, medication to strengthen contractions or a cesarean section.

"Patience is really needed. That's where it's important for a woman to have support she needs, that this might be a really long process and that is totally normal," Henman said. "Nothing is wrong because you don't have your baby in an hour like you see on TV."

One of the two midwives, a birth assistant and whoever the woman wants with her provide support throughout the labor, which has been shown to help women avoid C-sections.

The new guidelines say cesareans should not be performed because of a big baby, unless the baby is estimated to weigh more than 11.2 pounds. Henman said the biggest baby she had delivered was 10 pounds 10 ounces. The mother pushed twice and didn't need stitches. "You can't make a judgment based on the size of the baby," she said.

Lamaze International, which studies and promotes healthy birth practices, said the new guidelines were an important step in closing gaps between evidence and day-to-day care that women receive in labor. But systemic change is hard, and women should not wait, said Lamaze president Michele Ondeck.

"This is why it's critical for women to have the education, resources and support they need to push for evidence-based care now," Ondeck said, "rather than waiting for providers to change their practice."

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