SASHA GULISH.

a labor to love

I desperately wanted to experience natural childbirth, and I wasn't going to let my C-section scar—or my doctor's policy—stop me. by **AMY PATUREL**

WHEN MY twin boys were born in 2011 via emergency C-section, I didn't feel like I'd given birth. To protect me and my babies, a team of doctors had no choice but to strap me down and take that from me. All I could do was lie there clutching my husband's hand in a white-knuckled grip. The fluorescent lights were so bright that it was impossible to shut them out, even with my eyes closed. Afterward, I had to stay in a recovery room for four hours while my sons, who were six weeks premature, were whisked off to the NICU. I wasn't even among the first to hold them.

Friends and family kept telling me that it didn't matter how my boys came into the world as long as they were healthy, and I knew they were right. But I had always wanted to experience a natural, vaginal birth and I couldn't help feeling cheated. (I realize not all women who have had a C-section feel that way.) Because I had been on hospitalized bed rest for the last two months of my pregnancy, recovery was incredibly difficult: I couldn't walk or hold both my babies at the same time, and the separation from them interfered with my ability to nurse. So 18 months later, when

Having a VBAC can make holding a newborn more comfortable.

I saw two pink lines on a home pregnancy test, I was determined to try to have a vaginal delivery. I yearned to feel labor, even the painful parts.

I told my ob-gyn that I thought a VBAC (that's "vaginal birth after cesarean") would heal the emotional wounds from my previous labor and delivery, and that I felt it was best for both my health and my baby's.

"You're a great candidate," he said. "Your chance of delivering vaginally is as good as anyone going through labor for the first time." (Many women are not eligible for VBAC for medical reasons.) Then came the shock: He said, "But if you want this, I won't be able to deliver you."

A VBAC requires taking many precautions that add up to extra risk for physicians, my doctor explained. Malpractice lawsuits are more common with VBACs and, as a result, insurance premiums for doctors who perform VBACs are often higher. So his practice had a strict "no VBACs" policy—and it wasn't an anomaly. I couldn't find an ob-gyn within a 40-mile radius of my home in Temecula, California, who would support my attempt to labor naturally. It's a trend that goes directly against guidelines issued by the National Institutes of Health (NIH). "We would like for the patient to have a choice. We want doctors to tell the patient that it's a relatively safe procedure, to share the risks and the benefits, and then let the patient make the decision," says F. Gary Cunningham, M.D., chair of the panel that penned the NIH's 2010 consensus statement on VBAC. "But I don't believe that's happening, because if it were I think the VBAC rate would be higher."

> * The incidence of uterine rupture is extremely small when the prior cesarean scar is horizontal in the lower portion of the uterus.

In fact, such policies are even more common with hospitals than with doctors. "Just as many small hospitals are not set up to handle major traumas, they also lack the resources to perform the emergency surgery that might be needed during a VBAC," says Aaron Caughey, M.D., professor and chair of the department of obstetrics and gynecology at Oregon Health & Science University.

A Pregnancy Conundrum

According to The American College of Obstetricians and Gynecologists, VBAC is a safe and reasonable option for many women. In fact, its most recent VBAC guidelines, published in 2010, stated that "VBAC is associated with decreased maternal morbidity and with a decreased risk of complications in future pregnancies" as compared with C-sections. What's more, 60 to 80 percent of women who attempt a VBAC are successful. And yet most women who have a C-section the first time around opt for repeat C-sections. VBACs make up only 11 percent of births after a first C-section, per 2013 data, down from an all-time high of 28 percent in 1996, when a surge in malpractice lawsuits spurred the first hospital bans.

The most serious medical risk with a VBAC is uterine rupture, in which the scar from a previous C-section

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gives way under the pressure of contractions. The resulting tear, if it rips through all layers of the uterus, can be deadly for both the mother and the baby. But the incidence of uterine rupture is extremely small—between .5 and .9 percent, when the prior cesarean scar is horizontal in the lower part of the uterus, as it is for most women. That's about equal to the risk of having any serious birth emergency. And when rupture does happen, as long as you are in a hospital, "there are almost always warning signs that can be picked up through fetal monitoring," says Shannon Clark, M.D., associate professor of maternal-fetal medicine at The University of Texas Medical Branch at Galveston. These include a drop in the baby's heart rate, and the mom experiencing pain, bleeding, a rapid pulse, or sudden nausea and vomiting. In this case, a doctor will perform an emergency C-section.

Repeat C-sections have their own drawbacks. Each one increases the mother's risk for future pregnancy complications, including placenta accreta (when part or all of the placenta remains too firmly attached to the uterine wall). "There are some patients who have died from it. Approximately 14 percent of maternal deaths from hemorrhage are associated with this," says Dr. Cunningham. Placenta increta (when the placenta invades the uterine muscles) and placenta percreta (when the placenta grows through the uterine wall) are also big risks. In addition, C-sections have a higher incidence of infection and blood loss, as well as slower recovery and chronic pain, says Stuart Fischbein, M.D., an ob-gyn and VBAC advocate in Century City, California.

Although I wasn't planning to have a third pregnancy, I did worry that another C-section would interfere with breastfeeding and my ability to chase after my twins when I got home from the hospital.

My mind was made up: I decided to trade my longtime ob-gyn for a solo practitioner 50 miles away who was affiliated with a different hospital. I also hired a doula who had a high VBAC success rate. Together, we carefully crafted a detailed vaginal birth plan that involved meditation, massage, and a variety of labor positions. Then all I could do was wait.

The Big Moment

When my labor started early one morning midway through my 41st week of pregnancy, contractions came fast—first every 15 minutes and soon after, every five. I called my husband, Brandon, who was at work, as well as my doula, then lay down on my bed to try to relax and breathe. As if on cue, my water broke.

Minutes after Brandon came home, I was lying in the back of our Ford Fusion, gripping the front seat for support. After about 40 minutes, the car slowed to a standstill. We were in gridlock on one of San Diego's most jam-packed highways—and I suddenly had a tremendous urge to push. Channeling his inner race-car driver, Brandon hightailed it to the hospital on the shoulder of the highway.

There was no time for the usual trappings of a VBAC: no IV, no constant blood-pressure checks. Many pregnant women would have panicked, but for me the crunched schedule was actually good. I had to forgo the meditation and music I'd planned, but I also got to skip the medical monitoring I didn't want. The nurses were barely able to get a Doppler around my belly in order to assess the baby's heart rate. I was still intent on sticking to some elements of my birth plan: My ob hadn't arrived yet, so I told the doctor on call that I wanted to

could you be a good candidate for VBAC?

If you have had a cesarean and want a VBAC, Dr. Aaron Caughey suggests finding a doctor affiliated with a large medical center. "If you don't live near one, you may need to check into a hotel or stay with a friend near the hospital as your due date approaches," he says. Your doctor is most likely to green-light a VBAC if:

- **Your previous cesarean was the result of a factor that's unlikely to recur, such as fetal positioning (breech, for example) or fetal distress**
- **You've already had a successful vaginal delivery (before or after your cesarean)**
- **You go into spontaneous labor at or before 40 weeks with a baby expected to weigh less than 9 pounds**

stand up to coax the baby out with the help of gravity.

"You're having a VBAC. I don't know your history. You're not standing up," he said, and he forced my legs into a pair of stirrups. As nurses swarmed around me, I had a flashback to my C-section—to the feeling of being restrained, of medical professionals taking over, of losing my free will.

"I want my doctor," I said firmly. Then, as if he'd just heard me, my ob walked through the door.

"Amy, the baby is here," he said encouragingly. "You've got two big pushes and he's out."

Birth plan or no birth plan, stirrups or standing, I knew this VBAC was going to happen and that it would be a striking contrast to my first delivery. The lighting was soft and comforting. I wasn't medicated. And I was forming a memory that I would treasure for the rest of my life.

Jack was born just 19 minutes after we arrived at the hospital, and within half an hour he was nursing contentedly at my breast. That night, despite my exhaustion, I relived the wonderful, chaotic moments over and over again as I inhaled his newborn scent. The experience certainly wasn't what I'd expected, but as I now well know, sometimes real life is sweeter than the best-laid plans.