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Toward an Ethically Responsible Approach to Vaginal Birth After Cesarean

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Determining approach to delivery after a previous cesarean is among the most contentious areas of obstetrics. We present a framework for ethically responsible guidelines and practice regarding vaginal birth after cesarean. We describe ethical complexities of 3 key issues that mark the debate: the cesarean delivery rate, safety, and patient autonomy. We then describe a taxonomy of considerations that should inform a responsible framework for guideline development and highlight critical distinctions between types of guidelines that have been blurred in the past. We then forward 2 central claims. First, in otherwise uncomplicated birth after a single previous cesarean, both vaginal birth after cesarean and repeat cesarean should be regarded as reasonable options; women, rather than policymakers, providers, insurance carriers, or hospitals, should determine delivery approach. Second, in complicated cases, providers and policymakers should carefully calibrate the strength of evidence to ensure differential risk and cost are adequate to justify directive guidelines given important variations in values women bring to childbirth.
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Determining approach to mode of delivery is central to obstetrical practice. It is also, all too often, a flashpoint for debates about ethics and reproductive medicine. A case in point is delivery after previous cesarean. For at least 3 decades, the appropriate approach to birth after previous cesarean has been characterized by dramatic shifts in practice patterns and considerable controversy.[1] Restrictive policies around vaginal birth after cesarean (VBAC) have taken hold, even in the context of serious consideration of expanded choice in other delivery scenarios, most notably around access to cesarean delivery in the absence of medical indication (CDMR).[2] Assessment of emerging data about the risk profiles of trial of labor (TOL) versus repeat cesarean (RCS) has been a subject of continued research and debate. In the meantime, patient experience has been marked by considerable variation in provider practice patterns, with significant differences according to region, insurance status,[3] even provider years in practice.[4]

Some providers strongly recommend RCS in all women with a previous cesarean, an increasing proportion of whom refuse to attend VBAC in any circumstance; a few indicate a strong presumption toward VBAC but a willingness to attend either mode of delivery; and others, especially in the midwifery community, counsel strongly toward a TOL. The result has been confusion about the respective roles that safety, cost, and patient preferences should play in crafting a patient-centered and evidence-based approach to childbirth and about how ethically to approach the decision between VBAC and RCS from the standpoint of clinical care and of public policy.

In what follows, we present a framework for guidelines and practice around VBAC. We begin by describing a trio of issues that tend to mark the debate about VBAC: the rate of cesarean delivery, maternal and fetal safety, and women's meaningful access to preferred delivery mode, indicating in each case why the issue is more ethically complex than it might first appear. We then describe a taxonomy of considerations that should inform an ethically, scientifically, and socially responsible framework for guideline development—4 criteria that form the scaffolding upon which accumulating data

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should be situated. We further highlight distinctions between types of guidelines that are critical to responsible guideline development and which have been blurred in the context of past VBAC debates.

On the basis of this framework, we forward 2 central claims. First, in otherwise-uncomplicated birth after a single previous cesarean, both VBAC and scheduled cesarean should be regarded as reasonable options, and women, rather than policymakers, providers, insurance carriers, or hospitals, should determine which approach to delivery to take. Second, with more complicated cases, providers and policymakers need to carefully calibrate the strength of evidence to ensure that differential risk and cost profiles are adequate to justify directive guidelines given the important variations in values that women themselves bring to decisions about mode of delivery.

Key Issues in VBAC Debates

Three issues have dominated headlines about VBAC. First and foremost are concerns about the high rate of cesarean delivery, most recently estimated at 31%. The decreasing use of VBAC (notably a 6% reduction between 2004 and 2007) has been cited as a contributing factor to record cesarean rates,[5] and proponents of VBAC have cited it as a means to "reduce the overall cesarean rate."[6] Concern about the dramatic number of cesareans has pressed practitioners and policymakers to decrease the cesarean rate, and raised questions about how best to achieve that goal.

Less univocal is the rationale for concern. Although the rate of cesarean delivery in the United States is alarmingly high, care must be taken to identify and disaggregate the different rationales for why it might be appropriately regarded as alarming.[7] Worries about resource allocation and cost containment and attendant questions about justice and responsible stewardship of limited resources for health care form the core concern for some. For others, and more controversially, concern about high rates of cesarean delivery reflects a value judgment about the "right" way to deliver, pressing whose notion of "right"—the obstetrician's, the midwife's, society's, or the childbearing woman's own view—should shape the goals of care.

Still another possible rationale pertains to access: as cesarean rates increase, they may influence practice patterns and provider expertise, limiting the availability of a preferred delivery mode or low intervention birth.[8] Disaggregating these rationales is critical to knowing how much weight lowering the cesarean rate should be given in guideline development; and whether those issues should translate into the clinical context as considerations physicians or women themselves should be concerned with.

The second topic that has dominated discussion of VBAC is assessment of safety. Ongoing efforts to refine the evidence base for assessing and comparing risks of VBAC versus scheduled cesarean have led to pendulum swings in the recommendations for clinical practice.[9,10] In the 1970s through the mid-1980s, emerging evidence established the relative safety of VBAC on the basis of findings of no maternal deaths and few fetal deaths in several thousand VBAC trials.[1] This led to enthusiasm about VBAC through the early 1990s on the part of the National Institutes of Health and the American College of Obstetricians and Gynecologists (ACOG) and counseling strongly in favor of a TOL. Events in the mid-1990s marked a dramatic change: renewed caution about VBAC determined from new data,[11] and media reports that raised concerns most centrally about the rare but potentially devastating risk of uterine rupture during labor. The 1999 guidelines from ACOG reflected and institutionalized such caution with promulgation of the standard advising "immediate availability"[12] of the physician in institutions equipped to respond to emergencies for women undergoing VBAC.[6] The VBAC rate began to plummet, landing most recently at a paltry 8.5%.

Important as safety considerations are, analyzing when data provide sufficient basis for directive guidelines is particularly challenging in the context of delivery mode. First, most of the concerning data have to do with very small probabilities of very bad outcomes, presenting well-known difficulties in reasoning around potential trade-offs between such probabilities and the benefits that may accrue to each approach. This has been particularly difficult with mode of delivery because many of the trade-offs have to do with extramedical, highly qualitative considerations about the process of birth, which are often poorly captured by traditional measures or risk-benefit analyses. The goal then is policy and practice in which consideration of the full profile of risks—both medical and extramedical—informs the risk-benefit calculus. To that end, a central challenge is finding agreement about how to reason about a very small probability of unlikely but tragic events (uterine rupture, for example) while giving full attention to the implications of efforts to avoid that outcome.

The third significant issue marking public discussions about VBAC focuses on women's autonomy. Concerns have been raised about the degree to which guidelines may have limited patient access to their preferred delivery mode, be it cesarean, as was the case in the 1990s, or vaginal, as is true currently.[13] The enthusiasm about the safety and feasibility of VBAC that characterized the early 1990s resulted, in some cases, in insurance mandates for a TOL and limited access to repeat cesarean for patients who desired it. Caution about VBAC reflected in current guidelines has again raised concerns about access, although now to vaginal delivery, with insurance companies, hospitals and physicians themselves declining to provide VBAC, even in the recommended setting.

These events have led some to emphasize expanded choice in delivery contexts, arguing against guidelines in favor of expanding options available to women. To the extent that increasing autonomy is primarily a matter of expanding choices, it may seem that simply allowing more delivery options should be the primary means to advance autonomy. Indeed, this is the presumption that guides discussions about ethics and autonomy in many recent discussions about VBAC.[14]

Once again, though, the issue is complicated. Although all can agree that respect for and promotion of autonomy is an important (if not universally trumping) ethical principle, un-