Can a Vaginal Birth After Cesarean Delivery be a Normal Labor and Birth? Lessons from Midwifery Applied to Trial of Labor After a Previous Cesarean Delivery

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• Vaginal birth after cesarean • Informed consent
• Prenatal counseling • Intrapartum care

The cesarean delivery rate has dramatically increased in the United States over the last 15 years. In 1996, the overall cesarean delivery rate was 20.7%, and by 2008 it had increased 50% to a record high of 32.3% of all births.[1,2] As the number of cesarean births has increased, the adverse effects of this surgical procedure have also become apparent, which has recently reignited efforts to decrease the cesarean delivery rate.[3] Repeat cesareans account for 30.9% of the indications for cesarean delivery,[2] thus increasing the vaginal birth after cesarean delivery (VBAC) rate is one of the most important ways to reduce the overall cesarean delivery rate.

Pregnant women who had a cesarean delivery in a previous birth must choose between an elective repeat cesarean delivery (ERCD) or a trial of labor after cesarean (TOLAC). There are multiple considerations that affect this decision, including an individualized risk of uterine rupture and chance of VBAC success, access to intrapartum care if she wants a TOLAC, and her personal desires for how her labor and birth

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proceed. Although there are several recent publications that summarize recommended prenatal counseling,[4] most focus primarily on the risk of uterine rupture and the chance of VBAC success.[5,6] Antepartum and intrapartum care practices that might improve maternal satisfaction and/or vaginal delivery rates have not been given much attention in the context of VBAC. This article reviews evidence-based antepartum and intrapartum care practices that are known to improve maternal satisfaction and/or vaginal birth rates and explores how these care practices can be adapted for the woman undergoing a TOLAC. Although many of these techniques are frequently identified with midwifery care practices, they are found in many settings that focus on family-centered care.

Nationally, the proportion of women who attempt TOLAC after a previous cesarean delivery is approximately 17% to 28.8%, but there is wide regional and institutional variation.[2,7] Western states have the highest VBAC rate and southern states have the lowest, with the northeast and midwest statistically between the west and south. Tertiary academic hospitals, teaching hospitals, and public hospitals have higher rates of VBAC than do community settings. DeFranco and colleagues[8] conducted a retrospective cohort study of women who were offered VBAC in 17 hospitals in Pennsylvania between 1996 and 2000 (n = 25,065) and found the VBAC attempt rate was 61% in university hospitals and 50.4% in community hospitals.

VBAC rates seem to be higher when the provider is a family physician or certified nurse-midwife rather than an obstetrician.[9,10] Although the reason for these differences is not known, survey data from the American College of Obstetricians and Gynecologists (ACOG) has found that ACOG members are performing fewer VBACs secondary to concerns about medical liability and restricted access at their delivery settings.[11] In the 2005 Listening to Mothers Survey, 57% of the women interested in VBAC were denied the option of TOLAC.[12] The top 3 reasons for the denial were: caregiver unwillingness (45%), unwillingness of hospital (23%), and medical reason (11%).

VBAC success rates are not significantly affected by regional, institutional, or provider characteristics. Approximately 60% to 80% of women who undergo TOLAC have a successful VBAC.[3] Similarly, uterine rupture, which is arguably the most morbid complication of TOLAC, has remained stable at less than 1%.[3] Thus the variability in VBAC rates seems to be primarily related to a decrease in TOLAC rather than a decrease in VBAC success.

FACTORS THAT AFFECT DECISION MAKING ABOUT TOLAC VERSUS ERCD

Given a high VBAC success rate and low complication rates, factors that affect the choice a woman makes and factors that affect her experience deserve heightened scrutiny. Approximately half of women who have had a cesarean birth make their decision about future mode of birth before becoming pregnant again, and another 34% to 39% make their decision around the midpoint of the subsequent pregnancy.[13] Women attempt to balance risks to themselves versus risks to their fetus and factor in beliefs about their previous birth experience, family influences, and societal or cultural influences, a process that can engender a high degree of decisional conflict.[14,15] Therefore, it is worth reviewing what is known in general about how pregnant women assess risk and make health decisions.

First, most pregnant women are willing to tolerate a high degree of risk to themselves in exchange for no risk for their baby.[16–18] The health risks for the mother are higher with ERCD and the health risks to the fetus are higher with TOLAC.[3] This is the primary reason why the risks associated with ERCD and the risks associated with TOLAC are not comparable for the woman who is making this decision. Although