Hospital Response Major Edit

Dear Dr. Soffici,

Thank you for your in depth reply to my letter requesting that Cottage Hospital re-examine its VBAC ban policy. I have spent some time over the last month researching more information about VBAC and some of the things you said. I still have several questions.

Several times in your letter you quoted the 1/200 uterine rupture rate that I used in my letter. However, on page 2, paragraph 2, you equated the risk of uterine rupture with the risk of fetal death. According to several studies I found, 1/200 is a high estimate of the risk of uterine rupture which depends upon the population studied and varies between 1/200 and 1/500. The Vermont/New Hampshire VBAC Project findings1 show that "not all tears in the uterus harm the baby. About 10% of the time the baby is harmed when the uterus tears. In other words, 5 to 10 babies out of every 10,000 VBAC tries will suffer brain damage or death (0.05% to 0.1%)" They found that the overall risk of infant death from a VBAC attempt is 6 per 10,000 compared to 3 per 10,000 planned cesarean births. Among thirty studies comprising 56,300 VBACs, the rate of stillbirths and newborn deaths attributable to uterine rupture was 1 in 3,3002. So again, the statistic depends on the population studied, but the risk of fetal death due to uterine rupture from a VBAC attempt is between 1/1660 and 1/3300, not 1/200. What is the fetal death rate for first time mothers? Other relevant rates for a comparison??

I was surprised to read that even in the absence of VBACs you still see the occasional uterine rupture. I did some reading and found that in a study conducted in California3 "only 34% of uterine ruptures were attributable to labor." In other words, 66% of the women experiencing a uterine rupture after having had a prior cesarean were not in labor when the rupture happened. So, elective repeat cesarean delivery did not prevent the ruptures. Since elective repeat cesarean doesn't necessarily prevent uterine rupture in the majority of cases, it seems even more important for Cottage Hospital to work to decrease the primary cesarean rate.

On page 4, paragraph 1 you mentioned the hospital's "decision to take the safest route and discourage these procedures." I would argue that VBAC is not a procedure, and cesarean section is not always the safest route. This will vary from woman to woman and pregnancy to pregnancy. That is why women should be allowed to make this choice for themselves with their care provider. If Cottage Hospital is really concerned about always taking the safest route, then medically unnecessary elective plastic surgery procedures such as liposuction would not be allowed.

In the last paragraph of your letter you mentioned that university hospitals still offer VBAC for patients and for the training of their residents. In the UK where I had my first baby, VBACs are considered the norm. According to 'A Guide to Effective Care in

Pregnancy and Childbirth'4, a famous text for obstetricians and midwives in the UK which assesses the 'gold standard' of evidence-based care:

"Overall, attempted vaginal birth for women with a single previous low transverse cesarean section is associated with a lower risk of complications for both mother and baby than routine repeat cesarean section."

"The morbidity (illness) associated with successful vaginal birth is about one-fifth that of elective cesarean. Failed trials of labour, with subsequent cesarean section, involve almost twice the morbidity of elective section, but the lower morbidity in the 80% of women who successfully give birth vaginally means that overall women who opt for a planned vaginal birth after cesarean suffer only half the morbidity of women who undergo an elective section."

The National Health Service's decision to offer VBACs is not to use women as guinea pigs for the training of new doctors as your letter seems to imply. It is a decision based on outcomes and research.

In my previous letter, I said I was concerned that if Cottage Hospital cannot meet the staffing standard for VBACs, that means the hospital does not have the ability to perform an emergency cesarean 24 hours a day, seven days per week. I was glad to read (page 2 paragraph 3) that Cottage hospital "is ready to perform emergency cesareans 24x7." and that "Cottage has the ability to mobilize and act quickly when needed." If this is the case, then I still do not understand why VBACs are not being allowed. If we use the uterine rupture rate of 1/200, and the previous figure that 4% of births at Cottage were VBACs before the ban, Cottage would still only expect to see a uterine rupture due to VBAC ever 2-3 years and a fetal death due to VBAC every 10 or so. This seems very low to me, and certainly less risky than many of the other births that take place at Cottage due to other complications.

I mentioned in my letter that I was concerned that Cottage Hospital is understating the risks of cesarean and exaggerating the risks of VBAC. Your response (page 3 paragraph 6) exemplifies my point. You mentioned only the risks of VBAC. The risks associated with cesareans are also very real and you did not respond to them.

Since writing my first letter, I learned that in 2005 The American Academy of Family Physicians Commission on Clinical Policies and Research convened a panel to systematically review the available evidence on trial of labor after cesarean delivery (TOLAC) using the Agency for Healthcare Research and Quality Evidence Report on Vaginal Birth After Cesarean (VBAC)5. Their recommendations include the following: Women with one previous cesarean delivery with a low transverse incision are candidates for and should be offered a trial of labor (TOL)

TOLAC should not be restricted only to facilities with available surgical teams present throughout labor since there is no evidence that these additional resources result in improved outcomes.
At the same time, it is clinically appropriate that a management plan for uterine rupture and other potential emergencies requiring rapid cesarean section should be documented for each woman undergoing TOLAC.

They also state that,

"Some have questioned the assumptions that seem to underpin the immediately available policy. For example, the policy assumes that having a surgical team immediately available will reduce morbidity or mortality from uterine rupture. The AAFP TOLAC Panel felt this was a debatable assumption. Similarly, the ACOG policy suggests that one rare obstetrical catastrophe (e.g., uterine rupture) merits a level of resource that has not been recommended for other rare obstetrical catastrophes (e.g., shoulder dystocia, abruptio placenta, cord prolapse) that may actually be more common. However, it may be argued that, while these other catastrophes are largely not predictable, permitting a TOL in a mother with a previous cesarean is a planned event that may demand a different degree of preparedness.
While adverse consequences of a TOLAC are distinctly uncommon and must be balanced against attendant risks associated with ERCD, current risk management policies across the United States restricting a TOL after previous cesarean section appear to be based on malpractice concerns rather than on available statistical and scientific evidence. The TOLAC Panel found no systematic evidence suggesting that improved outcomes for TOLAC patients resulted from restricting a woman's ability to undergo a TOLAC based on the availability of resources not usually present for other women in labor, the institutional setting, or the timeliness of operative delivery."

On page 3, paragraph 2 you said that the World Health Organization's recommended cesarean rate of 10-15% is not based on data and you mentioned "a very clear and elegant mathematical argument that the cesarean rate should be almost 100%, and that is not a statement that appeals to many, therefore the issue is left mute." Most people would agree with that the ideal cesarean rate depends on the goal desired and the population you are working with. However, the WHO recommended rate is widely accepted including by UNICEF and the Healthy People 2010 Initiative, and I have not been able to find any research recommending a 100% cesarean rate. My understanding is that the 10-15% cesarean rate recommendation was based on a series of conferences to examine the use of technology in childbirth. They involved over 30 member countries and specialists from all aspects of care including statisticians and epidemiologists. The result of these conferences was a paper published in the Lancet in 19856 and followed up by a piece by Chalmers7 which list recommendations by the WHO. The recommendations from the paper include:

Women must participate in decisions about their birth experiences.

There is no justification to have a cesarean section rate of higher than 10 - 15 %. Vaginal deliveries after a cesarean section should be encouraged.

Even if the mathematical argument based on optimized neonatal outcome is true, it is not very relevant in this situation because the health and safety of two people is inseparably linked. For this reason, what is best for both mother and baby may not be what would be optimal for one or the other.

According to your letter, the numbers I quoted for fetal injury during cesarean section are not accurate. I have done some more research and have found that I was, indeed, wrong about that. The rate of fetal injury due to cesarean section is approximately 1.1% according to one study.8 So the risk of fetal injury during cesarean section is greater than the risk of uterine rupture due to VBAC.

You also said I quoted other statistics in the third bullet point of my letter that were not accurate but you did not mention what these statistics were or how they were inaccurate. The only other statistic in that paragraph is that cesarean section carries a 2-4 times higher risk of maternal death than vaginal birth. This is documented by an article published on the American College of Obstetricians and Gynecologists website9. According to the article, "This study shows that cesarean delivery is associated with a three-fold increase in the risk of postpartum maternal death as compared with vaginal delivery."

You mentioned on page 3, paragraph 4 that "the complication rates for Cesarean sections in the last 20 years have dropped to levels that now are arguably safer than vaginal delivery." According to an American College of Obstetricians and Gynecologists news release from August 31, 2006, "Cesarean delivery is associated with a three-fold increased risk of postpartum maternal death when compared with vaginal delivery [...] Researchers emphasized that cesarean delivery is major abdominal surgery and that expectant women and physicians should carefully consider cesarean-related surgical complications and the increased risk of death when choosing the method of delivery." Cesarean section is not safer for mother or baby and carries the risks I mentioned before including the two to four times a greater chance of maternal death, as well as increased risk of emergency hysterectomy, injury to blood vessels and other organs, chronic pain due to internal scar tissue, increased chance of re-hospitalization and complications involving the placenta in subsequent pregnancies, and risks to the infant including an increased risk of respiratory distress syndrome, prematurity, and the development of childhood asthma and allergies. The recovery from a cesarean is much longer than for a vaginal birth, involving more pain, more difficulty establishing breastfeeding, and a longer hospital stay. You did not address these and they are important facts for women to be aware of when agreeing to a cesarean.

On page 4 paragraph 1, you said the national death rate from cesareans as less than 1 in 100,000 and unavoidable death due to pregnancy complications as 1 in 10,000. According to the news release I mentioned above, US women have a 1 in 3,500 chance of pregnancy-related death. According to a recent article in Mothering magazine10,

maternal deaths related to pregnancy are under-reported in the US and in 2004 were found to be between 13 and 37.4 or more maternal deaths per 100,000 live births. In either case, the numbers for maternal death seem to be higher than you quote, and they have risen since 1982 when the maternal death rate in the US was 7.5 per 100,000 live births.

According to the American College of Obstetricians and Gynecologists11:
"it has become clear that patients are entitled to participate with their physicians in a process of shared decision making with regard to medical procedures, tests, or treatments"; Once the patient has been informed of the material risks, and benefits involved; that patient has the right to exercise full autonomy in deciding whether to undergo the treatment, test, or procedure or whether to make a choice among a variety of treatments, tests, or procedures. In the exercise of that autonomy, the informed patient also has the right to refuse to undergo any of these treatments, tests, or procedures. This election by the patient to forgo a treatment, test, or procedure that has been offered or recommended by the physician constitutes informed refusal."

On page 4, paragraph 2 you said "the physicians at Cottage hospital are very much aware of the dichotomy between what is safest for the unborn fetus and maternal preferences and autonomy. These controversies are often complicated by lack of data, poorly understood data, and strong emotional components." You seem to be saying that autonomy and a patient's right to informed consent or refusal of surgery doesn't apply in the case of VBAC. You also seem to be saying that mothers desiring VBAC are prioritizing their own health above that of their unborn child. In light of the evidence of risks to the mother and fetus due to cesarean section, and the difficulty of bonding with an infant after major abdominal surgery, I would argue the opposite. Women desiring VBAC want the best possible experience for their unborn child.

You also mentioned that "The acceptance of women's autonomy and right to choose their mode of delivery has led to a significant number of women simply choosing Cesarean as the preferred mode of delivery" and that this is what has caused the greatest increase in cesarean deliveries at Cottage Hospital in recent years. I found this surprising because you seem to be saying that women have the right to choose a procedure that carries more risks, as long as they are choosing cesarean over vaginal delivery. In fact, repeat cesarean and VBAC carry very different risks, low in both cases, but women at Cottage Hospital do not really have the autonomy or the right to choose their mode of delivery if the option of VBAC is not open to them.

A concern I mentioned that you did not address with your letter was the following, "I understand that fear of litigation drives a decision to ban VBAC in many hospitals. However, many hospitals have women who want to attempt a VBAC sign a form stating that they understand the risks of VBAC. Could Cottage Hospital do this?"

The American Academy of Family Physicians has produced a document12 (attached) called a Trial of Labor after Cesarean Shared Patient-Physician Decision tool. It seems like it would be a very good tool for Cottage to implement to make sure that women

desiring a VBAC or an elective repeat cesarean section understand the implications and the risks of each.

You mentioned in paragraph 4 on page 4 that you have been pleasantly surprised to receive fewer than 2 complaints per year about the VBAC ban. I suspect you will find the hospital's complaint volume increasing once the public becomes aware of the policy, the reasons for it, and the attitude of the hospital towards vaginal birth and cesarean section.

I still feel strongly that giving birth is a life-changing event in the life of a woman and she needs to be able to work with her care provider to make decisions that are best for her so that she will feel good about the experience for the rest of her life. I still hope that you will re-examine this policy and give women who have had a previous cesarean and are candidates for VBAC the chance to choose between VBAC and repeat cesarean. Thank you for taking the time to consider my request again. I look forward to hearing from you.

Sincerely,

Jessica Barton

Notes:

1. Vermont/New Hampshire VBAC Project, Birth Choices After a Cesarean Section (3 October, 2002): www.vbac.com/pdfs/FinalEd.pdf

2. Henci Goer, BA, LCCE (2002) VBAC and the New England Journal of Medicine Birth 29 (2) , 150–151 doi:10.1046/j.1523-536X.2002.01782.x

3. Lisa M. Korst, Kimberly D. Gregory, Jeffrey A. Gornbein (2004) Elective primary caesarean delivery: accuracy of administrative data , Paediatric and Perinatal Epidemiology 18 (2) , 112–119 doi:10.1111/j.1365-3016.2003.00540.x

4. M. Enkin, M.J.N.C. Keirse, J. Nielson, C. Crowther, L. Duley, E. Hodnett, and J. Hofmeyr, A Guide to Effective Care in Pregnancy and Childbirth. Oxford University Press, 2000.: http://www.vbac.com/chapter38.html

5. www.aafp.org/PreBuilt/clinicalrec_tolac.pdf

6. WHO (1985) Appropriate technology for birth. Lancet ii, August 24, 436 - 437.

7. Chalmers I., Enkin M. & Kierse M.J.N.L. (eds) (1989) Effective Care during Pregnancy and Birth, Vol I & II, Oxford University Press, Oxford.

8. James M. Alexander, Kenneth J. Leveno, John Hauth (2006) Fetal Injury Associated With Cesarean Delivery, Obstetrics & Gynecology;108:885-890

9. Catherine Deneux-Tharaux, Elodie Carmona, Marie-Hélene Bouvier-Colle, Gérard Bréart (2006) Postpartum Maternal Mortality and Cesarean Delivery, Obstetrics & Gynecology 2006;108:541-548

10. Ina May Gaskin (2008) TITLE, March - April, PAGE

11. American College of Obstetricians and Gynecologists. Informed refusal. ACOG Committee Opinion 237. Washington, DC: ACOG, 2000.

12. www.aafp.org/online/en/home/clinical/patiented/counselingtools/tolac.html