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By Sonya Charles

Once a cesarean, always a cesarean. Or so, at any rate, obstetricians long thought and practiced. Questions were raised about this belief as early as the 1960s, but it was not until after a National Institutes of Health consensus conference in 1980 that vaginal birth after cesarean rates began to significantly increase.[1] The trend toward VBAC peaked around 1996, when approximately 28.3 percent of women with a previous cesarean had a vaginal birth. Shortly after, however, obstetricians began to raise questions about the safety of VBAC. Specifically, they were concerned about professional liability in response to an increase in reports of uterine rupture and other complications resulting from a trial of labor after cesarean.[2] In 1998, the American College of Obstetricians and Gynecologists released new, more restrictive guidelines for attending any woman who attempts a trial of labor after cesarean. By 2004, the VBAC rate had fallen to 9.2 percent.[3]

The decline in providers and facilities that will allow a trial of labor after cesarean forces many women to choose a repeat cesarean. The choice is frequently not much of a choice, however, since the full range of options are often not on the table. This limited "choice" violates obstetricians' obligations both to respect patients' autonomy and to offer them good care.

There has been a vigorous but so far not very fruitful debate in the last few years about the lack of access to a trial of labor after cesarean. In March 2010, the NIH released another consensus statement on VBAC, expressing concern about the limited access women have to clinicians and facilities willing to offer a trial of labor after cesarean and calling for various stakeholders to work together to mitigate or eliminate these barriers.[4] In August 2010, ACOG released new practice VBAC guidelines that were more permissive than the previous guidelines, but failed to address what many (including ACOG) recognized as a major barrier to access—the requirement that anesthesia and surgery be "immediately available."[5] This means that any provider/hospital wishing to offer VBAC must be prepared to do emergency surgery. Due to a lack of resources, not all hospitals can meet this requirement. For example, the NIH report specifically mentions a lack of anesthesia staff resources to ensure "immediate" access.[6] As long as this requirement remains, it is unlikely that access to VBAC will significantly improve. In the new guidelines, ACOG reiterates its commitment to patient autonomy and reaffirms a woman's right to choose increased risks, but, in practice, liability issues will pressure physicians and facilities to comply with ACOG guidelines. The response to ACOG's 2010 guidelines by the American College of Nurse-Midwives nicely summarizes the problem: "It is unclear how these fully informed women will be at liberty to choose a TOLAC [trial of labor after cesarean] when facilities continue to refuse them this option, claiming compliance with the 2010 ACOG guidelines."[7] Therefore, access to VBAC is likely to remain a problem for the foreseeable future.

The Problem

Even though the number of providers and facilities that will allow a trial of labor after cesarean has declined, there are still many women who want this option. In fact, many women will go to great lengths to avoid a repeat cesarean. In her review of the current state of maternity care, Jennifer Block tells of women who labor in the hospital parking lot, refusing to be admitted until they are too far along to have surgery, and other women who fly in midwives who will attend a VBAC at home from another part of the country. She also describes a growing number of women who simply opt out of the medical system altogether and attempt an unassisted birth at home because they can find no skilled birth attendant willing to allow a trial of labor.[8]

But while some women go to great lengths to avoid a repeat cesarean, others are not willing to take what they see as unacceptable risks. When they are faced with a medical establishment that refuses to allow them a trial of labor, they reluctantly consent to surgery. These are the cases I will focus on.

There is some debate over which women are good candidates for a trial of labor after cesarean—which women have a reasonable chance of success, according to the medical evidence, and low overall risk of harm. For the purposes of this paper, my arguments apply only to those women deemed most eligible—namely, women who have had one previous cesarean using a low transverse uterine incision and who have no pregnancy complications that would otherwise indicate a need for surgical delivery.[9]

According to standard accounts of bioethics, informed consent consists of three components—competence, understanding, and voluntariness. We can assume the vast majority of these women are competent. It is also the case that many women who desperately want to attempt a VBAC have done their research. They have a good understanding of the potential risks and benefits for both VBAC and repeat cesarean.[10] But if there are no providers or facilities that will allow a trial of labor, how can we say their choice of a repeat cesarean is voluntary?

Consider the imaginary case of Susan, a well-educated, middle-class woman who is pregnant with her second child. Her first child was in breech presentation, so she delivered via cesarean section. For this pregnancy, she had hoped to attempt a VBAC. However, when she started looking for providers, she discovered that the closest hospital that would allow a trial of labor was two hundred miles away. It would be difficult to use this facility for labor and delivery under the best of circumstances, but having a toddler at home during the time she would go into labor makes it completely un-11 workable. Her state does not allow midwives who do home births to attend VBACs, but even if they did, she is not comfortable with this option. While she knows the absolute risk of a catastrophic event during a trial of labor is low, she still prefers to be in a medical facility. After reconciling herself to these facts, she signs on with a friendly obstetrician at the hospital nearest to her house and grudgingly consents to a repeat cesarean.

In a case such as this, I argue that Susan was forced by the circumstances into having another major surgery. Given the lack of providers and facilities willing to allow a trial of labor after cesarean, she cannot effectively choose what would be a reasonable medical option. For this reason, we should question the voluntariness of her consent. Unfortunately, there are many women in circumstances similar to Susan's, which is to say that there are many women whose autonomy is undermined by lack of access to a trial of labor after cesarean. This is a situation that should be of great concern to both obstetricians and the bioethics community.

Obstetrical Ethics

For a theory of obstetrical ethics, I draw on the work of Frank Chervenak and Laurence McCullough.[12] I use their theory for two reasons. First, theirs is the most thorough account I know of obstretrical ethics (versus general accounts of medical ethics or physician-patient relationships). Second, of obstetrician-patient conflict. When considering conflicts between an obstetrician and a patient, they focus on autonomy and beneficence. Like other ethicists, they put significant weight on respect for autonomy, but they recognize that it is not an absolute right. In cases where a patient's autonomy involves the help of the physician, we must also consider the role of beneficence.

Given our commitment to autonomy and a patient's right to refuse treatment, most bioethicists would agree that a patient has a near-absolute right to refuse treatment and leave the hospital. (For the sake of argument, we will assume the patient is competent and capable of leaving without assistance.) As Chervenak and McCullough explain, a patient who refuses treatment and withdraws from care is exercising a negative right to be left alone. This right is nearly absolute. However, if the patient refuses one treatment (for example, surgical delivery), but remains under the physician's care, then she is effectively requesting an alternative treatment (such as vaginal delivery)—which is a positive right. Whenever a patient invokes a positive right to an alternative form of medical management, the physician has some say in whether to participate. Thus, autonomous choices that invoke positive rights are more restricted.

When a patient requests an alternative form of medical management, the physician can refuse unless the requested treatment is in keeping with what Chervenak and McCullough call the beneficence model. Under the beneficence model, a physician cannot refuse a patient's request for alternative treatment as long as the treatment is reasonable, by which they mean that it has the potential to have some benefit to the patient. To lessen the creep of personal bias by the physician and to clarify the relationship between beneficence and reason, they define the beneficence model in this way:

> The beneficence model makes a peculiar claim: to interpret reliably the interests of any patient from medicine's perspective. This perspective is provided by accumulated scientific research, clinical experience, and reasoned responses to uncertainty. It is thus not a perspective peculiar or idiosyncratic to any particular physician.[13]

Based on this model, the physician cannot refuse to accommodate any request for alternative treatment that is supported by scientific research and clinical experience. This point is crucial because it shows that a significant number of women should have a right to request a trial of labor after cesarean. A last criterion about reasoned responses to uncertainty has to do with the nature of clinical judgments. Since many prognoses are based on statistical evidence, there is always room for error. However, when making these decisions, Chervenak and McCullough argue, we only need to be reasonably certain that the therapy will have some benefit (or not cause harm) based on scientific and clinical evidence.

Chervenak and McCullough pose the example of a woman who refuses a cesarean after being diagnosed with complete placenta previa. In this case, the potential for harm both to the woman and to the fetus is significant, and there appears to be no clinical benefit to attempting a vaginal delivery. The woman therefore does not have an autonomous right to request that a physician assist her in a vaginal delivery because doing so would violate the beneficence model.

They contrast this case to that of a patient who refuses surgery for a gangrenous toe. While research shows a better outcome with surgical treatment for gangrene, scientific and clinical experience show medical management can also work. Therefore, even though the physician may believe surgery is a better option, participating in medical management does not ask the physician to violate the beneficence model.

The question, then, is whether a trial of labor after cesarean violates the beneficence model. In March 2010, a multidisciplinary group convened by the NIH completed a consensus statement on VBAC, comprising a review and summary of the latest scientific evidence and recommendations for both practice and research. It concluded that, "Given the available evidence, trial of labor is a reasonable option for many pregnant women with one prior low transverse uterine incision."[14] A primary concern raised by obstetricians when considering a trial of labor after cesarean is the possibility of uterine rupture. According to ACOG's own statistics, however, when the woman has a low transverse uterine incision, the risk of uterine rupture is less than 1 percent,[15] and in the studies reviewed by the NIH group, there were no maternal deaths as a result of uterine rupture. The risk is slightly higher for the fetus. In the case of uterine rupture, there was a 3 percent risk of fetal death for term infants. While not insignificant, we can see that this is still a very low risk of fetal death.

Another complicating factor when deciding about a trial of labor after cesarean has to do with the hierarchy of potential outcomes. If we review the overall clinical outcomes for women who had a previous cesarean, VBAC has the best outcomes, elective repeat cesarean comes next, and failed trial of labor followed by emergency cesarean ranks last.[16] For this reason, obstetricians often believe that elective cesarean section is the most reasonable option. While it is true that the relative risk of complications and poor outcomes is higher with an emergency compared to a scheduled cesarean section, the absolute risk with both procedures is still statistically low.[17] Also, 60 to 80 percent of women who attempt a trial of labor after cesarean will have a successful vaginal delivery—the best outcome.[18]

Given the evidence, a woman who meets the general criteria and wishes a trial of labor is not making an unreasonable or irrational request. According to Chervenak and McCullough, the patient's decision does not have to coincide with what the physician believes is the best option. The requirement of the beneficence model is less cumbersome. The patient must only make a decision

that is reasonable—that is, a decision that has "a not-insignificant rate of success" and is consistent "with promoting the interests of the patient as construed in the beneficence model."[19] Current research shows that a trial of labor for women who had a low transverse uterine incision meets these criteria. Indeed, if the trial of labor is successful, then the woman will have achieved the best possible clinical outcome.

The Obstetrician's Role

A trial of labor after cesarean is a reasonable-enough option that women have an autonomous right to choose it, and physicians have no moral reason to refuse assistance. Not only does a trial of labor meet the beneficence model's criteria, but, based on the evidence, it appears to be a less harmful option than repeat cesarean. According to the NIH consensus report, "women who have a trial of labor, regardless of ultimate mode of delivery, are at decreased risk of maternal mortality compared to elective repeat cesarean delivery."[20] The benefits of VBAC are even more important for women who plan to continue having children. Allowing these women to have a vaginal birth instead of three, four, or five cesareans dramatically reduces their chances of further complications.[21] Given this evidence, structural barriers that limit access to VBAC are keeping obstetricians from providing optimal care.

In such a situation, obstetricians (along with professional organizations like ACOG) have a moral obligation to change these policies to allow a trial of labor after cesarean. VBAC supporters argue that the ACOG guidelines are largely responsible for limiting access. According to the NIH report, 30 percent of surveyed hospitals stopped offering a trial of labor after cesarean after ACOG first issued the requirement that emergency surgery be "immediately available." Some even referred to this as a "VBAC ban."[22] Given the significant role ACOG has played in reducing access to a trial of labor after cesarean, they have an even greater moral obligation to help eliminate these barriers. To do so not only supports patient autonomy, but also allows obstetricians to provide optimal care.

1. F.G. Cunningham et al., "National Institutes of Health Consensus Development Conference Statement: Vaginal Birth after Cesarean:
New Insights," *Obstetrics and Gynecology* 115, no. 6 (2010): 1279-95, at 1279.

2. American College of Obstetricians and Gynecologists, "Practice Bulletin 115: Vaginal Birth after Previous Cesarean Delivery," *Obstetricsand Gynecology* 116, 2 (2010): 450-63. While the reports of these increased risks are true, other commentators point out that the increase in risk for uterine rupture also coincided with an increase in off-label use of misoprostol (Cytotec) for labor induction—which is also associated with adverse outcomes when attempting VBAC. J. Block, *Pushed: The Painful Truth about Childbirth and Modern Maternity Care* (Cambridge, Mass.: DaCapo Press, 2007), 89.

3. Ibid., 87-88.

4. Cunningham et al., "National Institutes of Health Consensus Development Conference Statement," 1290.

5. American College of Obstetricians and Gynecologists, "Practice Bulletin 115." The NIH report calls on ACOG to remove this requirement since it is based on the lowest level of evidence—consensus—and opponents argue that it sets a higher standard for VBAC compared to other potential obstetrical complications; Cunningham et al., "National Institutes of Health Consensus Development Conference Statement," and American College of Nurse-Midwives, "American College of Nurse-Midwives Responds to ACOG's 2010 VBAC Recommendations," 2010, 1-5, http://www.midwife.org/documents/ACNMResponseACOGVBAC Recommendations_Aug10.pdf. The American College of Obstetrics and Gynecology admits that the requirement limits women's access to providers and facilities that are willing to allow a trial of labor after cesarean but reaffirms its commitment to keeping it; American College of Obstetricians and Gynecologists, "Practice Bulletin 115."

6. Cunningham et al., "National Institutes of Health Consensus Development Conference Statement," 1287-88.

7. American College of Nurse-Midwives, "American College of Nurse- Midwives Responds to ACOG's 2010 VBAC Recommendations," 3.

8. Block, *Pushed*, 94-97.

9. The current ACOG guidelines go further and would consider both women with two previous cesareans and women with unknown incision types as eligible for a trial of labor; American College of Obstetricians and Gynecologists, "Practice Bulletin 115." ACOG is right to be as inclusive as possible, but for the sake of simplicity, I will make a narrower argument here.

10. When we consider risks, we tend to focus only on mortality and morbidity statistics. To truly honor the informed consent process, we must also consider the potential psychological harm to the woman who feels she was coerced

into accepting an unwanted surgery without the opportunity to attempt a trial of labor after cesarean. However, I will not directly address this issue here.

11. See D. Brock, “Conscientious Refusal by Physicians and Pharmacists: Who Is Obligated to Do What, and Why?” *Theoretical Medicine and Bioethics* 29, no. 3 (2008): 187-200. Brock argues that asking someone to go one hundred miles to pick up a prescription is an “unreasonable burden” on a patient.
12. F.A. Chervenak and L.B. McCullough, “Justified Limits on Refusing Intervention,” *Hastings Center Report* 21, no. 2 (1991): 12-18. While this article is an older one, Chervenak and McCullough have continued to use this basic framework when considering conflicts between patients and physicians; see F.A. Chervenak, L.B. McCullough, and B. Arabin, “Obstetric Ethics: An Essential Dimension of Planned Home Birth,” *Obstetrics and Gynecology* 117, no. 5 (2011): 1183-87.
13. Chervenak and McCullough, “Justified Limits on Refusing Intervention,” 13.
14. Cunningham et al., “National Institutes of Health Consensus Development Conference Statement,” 1290.
15. American College of Obstetricians and Gynecologists, “Practice Bulletin 115.”
16. Cunningham et al., “National Institutes of Health Consensus Development Conference Statement”; American College of Obstetricians and Gynecologists, “Practice Bulletin 115.” Some have asked how my argument would affect women who would prefer an elective cesarean delivery over a trial of labor. Given this hierarchy of outcomes, I see no reasons elective cesarean should be ruled out. My focus is on expanding reasonable choices for women who want an alternative, not on restricting reasonable medical options.
17. Cunningham et al., “National Institutes of Health Consensus Development Conference Statement.”
18. Ibid.; American College of Obstetricians and Gynecologists, “Practice Bulletin 115.”
19. Chervenak and McCullough, “Justified Limits on Refusing Intervention,” 13.
20. Cunningham et al., “National Institutes of Health Consensus Development Conference Statement,” 1283.
21. Ibid.; American College of Obstetricians and Gynecologists, “Practice Bulletin 115.”
22. Cunningham et al., “National Institutes of Health Consensus Development Conference Statement,” 1287.