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VBAC - On Whose terms?

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Gina Lowdon and Debbie Chippington Derrick explore the reasons for the currently low rates for VBACs and what women can do to make sure the odds are in their favour.

The highly respected Guide to Effective Care in Pregnancy and Childbirth states: "The care of a woman in labour after a previous lower-segment caesarean section should be little different from that of any woman in labour."[1]

Despite evidence supporting the safety and desirability of VBAC (vaginal birth after caesarean), mothers who have undergone one or more caesarean sections are frequently led to believe that VBAC is a risky choice that may well turn out to be hazardous, especially for the baby. This impression is further emphasized by 'hospital policies,' which dictate the 'management' of women who are in labour following a previous caesarean section.

Such policies vary in their content and flexibility from hospital to hospital and from consultant to consultant. Individual midwives will also vary a very great deal in how strictly their practice adheres to the policies laid down in their unit.

Policies for the management of VBAC labours, or 'trials of scar' or 'trials of labour' (phrases some hospitals persist in using), often include some or all of the following:

- No induction. It is common not to induce VBAC mothers who go overdue.
- Early admission. Mothers are often told they should attend the hospital as soon as labour starts.
- Continuous electronic fetal monitoring.
- Siting of an IV (intravenous) drip or at least a canula (a needle that could take an IV) so an IV can be set up quickly if needed.
- Restriction on the length of the first stage of labour.
- Restriction on the length of the second stage of labour.

With the exception of 'no induction', there doesn't seem to be any research evidence to show that the use of such measures are beneficial to either mothers or their babies, and there are strong arguments that for the majority of healthy mothers and babies such restrictions on the natural course of labour can be detrimental.

Few women realise that such policies, which are in place to guide the practice of maternity professionals, are not legally binding on pregnant women, who are under no obligation to abide by them. In addition

most women are led to believe that failure to submit and comply with the 'rules' will put the baby at risk. Many women are also under the impression that if they do not comply then they may no longer be eligible for care, if or when the need arises.

In reality women are left with no real choice and little control. VBAC mothers are usually faced with the prospect of a highly medicalised labour, conducted on terms and to a time scale laid down for them by the hospital with no consultation or consideration of their needs as individuals. These are often precisely the conditions that caused a previously avoidable section to become necessary and also the conditions that some mothers now realise need to be avoided if the chances of achieving a vaginal birth are to be maximised.

The message that VBAC mothers are 'high risk' is coming across strongly. According to the National Sentinel Caesarean Section Report, in some units as few as 8% of caesarean mothers are even offered a 'trial of labour'. The national VBAC rate is shown to be only 33% and the range between units is wide; from 6% to 64%.2

Those that are offered a VBAC have often experienced a previous difficult and highly medicalised labour, which they have no desire to repeat. Many women find the additional restrictions laid down by hospital policies for the management of VBAC labours daunting and very worrying. Mothers wonder how they will find the strength of mind and body to submit to such a catalogue of events, but lack the information and courage to take the perceived risk of going against the 'advice' of health professionals.

The majority of women would prefer to experience a straightforward, intervention-free, properly supported vaginal birth. However, women want what is best for the baby and it would be extremely rare to find a woman who would be prepared to go through vaginal birth at any cost. It is a demonstration of the strength of the desire for a vaginal birth that so many women will go ahead with labour despite the conditions imposed upon them.

If a woman perceives she will not be able to maintain control during labour, she may prefer instead to opt for a surgical procedure that would be more predictable. In today's modern world the events of surgical procedures are often more familiar than the processes of natural vaginal birth. Many people know someone who has coped with surgery without finding it traumatic, even if they have not done so themselves. Mothers may therefore view surgery as an ordeal with which they feel they should be able to cope.

Also, mothers have no reason to believe that health professionals would be giving them anything other than the best of information and care. Few women are aware that given sufficient information they would be quite capable of making their own decisions about which measures are appropriate and acceptable, and which are neither helpful nor beneficial, and would thus be able to maintain a degree of control with which they are comfortable.

Informed women are often able to labour confidently if they are free to do so on their own terms, and will either achieve a good positive vaginal birth, or switch to a caesarean delivery before labour has

degenerated into an horrendously unpleasant endurance test.

Induction

Some consultants continue to induce mothers with a scarred uterus routinely despite the additional risks. Prostaglandin gel pessaries came into widespread use in the late 1980s and concerns have been growing over the effect they could be having on the uterine scar tissue of susceptible women. Previous articles in this Journal (see AIMS Journal, Autumn 2001) have dealt with the serious concerns relating to the use of misoprostol in particular and prostaglandin gel pessaries in general. There is certainly enough evidence now to suggest that routine induction of VBAC mothers should be avoided and when it is necessary it should be conducted with great care.

Mothers who go overdue are therefore in a difficult position and often under pressure to accept an elective caesarean section. They are fed scare stories of placentas that begin to fail at 42 weeks, and of babies that grow so large that the strain on the scar is sure to result in a rupture.

Although there is evidence that reducing the numbers of women going over 42 weeks gestation does improve outcomes, the risks involved in post term pregnancy are very small. Due dates can also vary by several days depending upon which method of calculation was used.

There is no evidence to support the fear that larger babies are more likely to result in caesarean scar rupture, and indeed many twin pregnancies also result in successful VBACs. VBAC mothers have given birth to some very large and healthy babies, some of which followed caesarean deliveries of much smaller siblings. Failure to progress and fetal distress are rarely evidence of a small pelvis or a mother's inability to labour effectively - they are much more likely to be caused by poor support and over-medicalisation of labour.

Little, if any, consideration is generally given to the case of the mother who has passed a healthy pregnancy, who perhaps has a long menstrual cycle, who many have conceived later in her cycle, whose family history tends toward longer pregnancies, who may well naturally be destined to have a longer pregnancy, and whose baby is active and healthy and simply not quite ready to be born yet.

Providing a mother is confident that her baby is doing just fine, she may prefer to avoid the risks of induction or an elective caesarean, preferring instead to let nature take its course unhampered. The onus should not be on the mother to refuse routine medical intervention, it should be on the health professionals to convince an individual mother that any intervention is necessary or advantageous in her particular case.

Early Admission

VBAC mothers are often advised to attend the hospital as soon as labour starts. The rationale for such advice being that the uterine scar could rupture - leaving some mothers terrified of the first contraction!

The most commonly quoted rate of caesarean scar rupture is 0.5% or one in 200 VBAC labours, the vast majority of which are benign (causing no problems for either mother or baby). Serious complications of caesarean scar rupture are very rare.

All pregnancies carry risks and serious, potentially life-threatening problems could arise during the labour of any woman. For instance umbilical cord prolapse has been estimated to have a 1% incidence[3], double that of caesarean scar rupture, yet this potential danger is not continually picked out with the same degree of emphasis that is given to the lesser risk of serious caesarean scar rupture. Indeed many pregnant women pass an entire pregnancy without it once being mentioned. It seems invidious to single out the very small additional risk of the uterine scar for special scare tactics and one has to question the reasons for this.

A mother who has no concerns over the immediate well-being of her baby may prefer to spend the early part of labour at home, waiting until her labour is well-established and she feels the time is right to transfer in to the hospital.

Contrary to common belief home birth is an option for VBAC mothers and there are many women who have exercised this right even after two or more caesareans. Indeed there is a strong argument that giving birth at home can be safer than a hospital delivery as labour is much more likely to be left to take its natural course and the risks associated with various routine interventions in childbirth are avoided.

Continuous EFM

Women are commonly informed that continuous electronic fetal monitoring will be necessary if there is a history of caesarean section. Numerous studies have shown that electronic fetal monitoring, whilst increasing the caesarean section rate, does not improve outcomes for mothers or babies. Providing there are no signs of anything untoward VBAC mothers should not require any additional monitoring over and above that which is normally appropriate for all mothers.

Caesarean scar separation that has serious consequences is a rare occurrence and consequently little is known about the possible warning signs. Some practitioners are of the opinion that maternal pulse monitoring would provide the earliest indication of potential problems.

Medical practitioners are required by law to seek the consent of a patient before any form of treatment or care is administered. Often, particularly when 'routine' procedures are used during labour and birth, consent tends to be assumed rather than sought, leaving the onus on the mother to refuse.

Difficult though it may be to do, mothers have a right to refuse treatment when it is offered. In fact the onus should be on the health professional to make sure that the mother's informed consent has been obtained, which should mean that possible side effects and/or risks of any treatment should have been made clear. Appropriate treatment cannot be withheld or withdrawn, so if a few minutes or some time later a mother changes her mind or decides her circumstances now merit the intervention proposed, then

treatment can proceed at that time.

This applies to all forms of treatment and care, including all the common interventions in childbirth such as induction, electronic fetal monitoring, vaginal examinations, augmentation of labour, or use of forceps or ventouse. Mothers have a right to say "no thank you".

Any treatment or care given following a mother's clear refusal or in fact given without the mother's consent, would constitute assault and the health practitioner concerned would be laying themselves open to legal action by the mother.

Siting of IV Drip

Some hospital policies for the management of VBAC labours include the siting of an IV drip or canula, in case of sudden emergency. The risk of such an emergency is very low - little higher than that for any labouring woman. In the vast majority of cases it would not be difficult to site an IV quickly if required. Mothers may therefore wish to come to their own conclusions as to whether this would be helpful in their case.

Restriction of the Length of First Stage of Labour

It is common for restrictions to be placed on the length of the first stage of labour. The fear is that prolonged labour would place an undue strain on the uterine scar and would increase the risk of caesarean scar rupture. There is no research evidence to support this theory. The length of time hospitals 'allow' mothers to labour varies greatly, demonstrating that opinion is far from universal on this issue.

When combined with a policy of early admission VBAC mothers are thus set up to fail, since the length of the labour is often confused with the time spent on the labour ward.

Providing labour is spontaneous and proceeding at its own pace there is no reason to suppose that modern surgical scars will not stand up to normal labour. Indeed there are cases where labour has continued for several days, followed by the successful vaginal birth of a healthy baby from an intact uterus. If nature is allowed to take its course longer labours tend to proceed more gently and present no problems per se.

When a mother is labouring well and the baby is showing no signs of distress it seems nonsensical to transfer a mother to theatre for an emergency operation, simply because an arbitrary time limit has expired. The condition of the mother and baby should be the primary indicators of whether a labour can be safely allowed to continue, not the number of hours ticking on the clock.

As explained, no form of treatment or care can be carried out without the mother's consent, including caesarean section. However it takes courage to refuse when the fear has been planted in a mother's mind that her uterus could rupture and her baby could die at any moment, remote though this catastrophe may be in reality. She needs to know that the research evidence backs up her own gut feeling that she is

not really at risk at that time.

Restriction of the Length of the Second Stage of Labour

Restrictions are also commonly placed on the duration of the second stage of labour. Again there is no consensus of opinion and limits vary from hospital to hospital. Some are so short that very few mothers are likely to be able to 'perform adequately'.

A very high proportion of VBAC labours which result in a vaginal delivery are forceps or ventouse 'assisted'. Medical practitioners are often so stressed by what they see as the potential dangers of VBAC that many do not have the confidence to allow the mother to labour in her own time. They want the birth concluded as quickly as possible, to get to the point where the perceived spectre has passed.

Often the stage of transition, which can precede the active 'pushing' second stage and may last some time, is totally forgotten and it is assumed that there has been active expulsion of the baby since reaching 10cm dilation, when in fact no active expulsion has begun. This can lead to concern about the duration of, and the lack of progress in, second stage.

Short time restrictions on the length of the second stage also increase the risk that a mother and her baby will be subjected to an 'assisted' delivery, or that she will be bullied into pushing without the aid of uterine contractions, usually in a position where gravity is not assisting.

To many women the prospect of a forceps or ventouse delivery, together with the often accompanying large episiotomy, is terrifying. Another caesarean delivery can be seen as the lesser of two evils.

Of course a woman does have the right to refuse. She might wish to push for a while longer, or she might prefer to turn down the offer of forceps or ventouse in favour of a caesarean. She does not have to accept what is offered. If a mother refuses forceps and/or ventouse and a speedy delivery is considered necessary then a caesarean will have to be offered - and the decision and control will remain with the mother, rather than the medical staff.

If, however, the only reason a speedy delivery is being considered is that the sand in the egg timer has run out, and mother and baby are coping just fine, there is little justification for mending what is not broken.

Too often women's needs are ignored and control denied. Options remain hidden, or are made to appear unsafe or unacceptable. Women are frequently forced to agree to the advice of health professionals against their better judgement, in the often mistaken belief that it is the only safe or reasonable course open.

Armed with good, research-based information VBAC mothers are frequently able to take control of birthing their own babies. Even when the events do not progress in quite the way that was hoped for, providing a mother is able to remain in control of the situation, and is involved in all the decisions taken, she will usually be left feeling strong and confident. This is in great contrast to the often traumatised women who emerge from the processes inflicted upon them by a rigid policy driven system.

To give birth free of interventions takes courage and sufficient information to enable a mother to believe in herself and her instincts. VBAC mothers can and do give birth safely to healthy babies without undue difficulty and without trauma - and the chance of doing so is much higher if a woman can labour on her own terms and not on those laid down by the hospital.

References

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2. The National Sentinel Caesarean Section Audit Report, RCOG Clinical Effectiveness Support Unit, October 2001, p45
3. Birth After Cesarean, The Medical Facts, Bruce L Flamm, MD, Simon & Schuster, 1990, p105