The National Institutes of Health Consensus Development Conference on Cesarean Childbirth in 1981 and the first official publication on vaginal birth after cesarean (VBAC) from the American College of Obstetricians and Gynecologists in 1982 concluded from the available evidence that carefully selected patients should be permitted a trial of labor after cesarean birth. Over the next decade, VBAC was embraced by physicians and patients. Some health maintenance organizations and insurance companies made trial of labor after cesarean mandatory. However, the original conservative criteria were extended, sometimes inappropriately, and reports of catastrophic outcomes from uterine rupture began to appear. Litigation and large medical–legal settlements became a reality when a newborn died or was neurologically impaired. In response, the American College of Obstetricians and Gynecologists’ Practice Bulletin in 1999 and those published subsequently have advised a more cautious approach. Specifically, they recommend that physicians providing VBAC should be “immediately available.” “Immediate availability” was not defined, but one study showed that there were no long-term neurological sequelae from uterine rupture when the fetus was delivered within 18 minutes.

Although all guidelines have been well intentioned, each new set resulted in unintended consequences. Today, the VBAC issue remains contentious and unresolved. Many hospitals no longer allow VBAC because they are unable to provide the level of response recommended, and some insurance carriers prohibit physicians from performing VBAC. Consequently, trial of labor after cesarean is now denied to many women who strongly desire this option and to physicians who want to provide it.

The March 2010 National Institutes of Health conference has focused attention again on VBAC, and the report is published on p. 1279. Several key points were presented by speakers during this conference. First, the overall risk for perinatal mortality and morbidity with trial of labor is similar to that for any nulligravid woman in labor. Second, trial of labor is held to a higher standard than other obstetric care. There is no “immediate availability” mandate for other acute obstetric emergencies with similar potential adverse neonatal outcomes such as severe abruption or umbilical cord prolapse. Third, it is clear from staffing studies that it is impossible now and in the future to provide 24/7 in-house obstetric and anesthesiology coverage to all hospitals in the United States (and around the world) that provide delivery services.

Where do we go from here? In my view, VBAC is essentially a uterine-rupture issue. What level of risk is acceptable, and who decides? Currently, hospitals, insurance companies, and plaintiff attorneys decide or strongly influence whether VBAC is an option. Instead, the patient should be allowed to make that choice after she has been informed of the facts and has
been counseled by her physician thoroughly. For that to happen, a number of conditions will be necessary:

- Physicians and patients need accurate information that compares neonatal outcome in all obstetric emergencies and specifically after uterine rupture.
- Standards of care should be based on medical evidence, not patterns of litigation. The medical-liability risk associated with VBAC must be solved with a different compensation system.
- We are obligated to make labor and delivery as safe as possible within the limits of what is practical and achievable.
- Despite the reality of disparate resources, we should “find a way” for those who want the option of VBAC. For example, hospitals and physicians without 24-hour in-house coverage may want to investigate the New England Perinatal Quality Improvement Network VBAC program (www.nepqin.org). It is a patient-oriented approach developed by a consortium of all involved in the VBAC issue. Other rural and suburban communities may find it to be a practical model.

Finally, attempts to increase the VBAC rate make little sense without addressing the reason for the problem in the first place. Reducing the number of primary cesareans deals with the problem where it originates. Unless measures are instituted to reverse the rapidly rising cesarean rate, catastrophic complications from placenta accreta and percreta associated with multiple repeat cesareans soon may be a greater problem than uterine rupture.

REFERENCES