Big Valley Midwives
Informed Consent and Waiver of Medical Referral for Home VBAC

Every woman and her family have a right to decide, after weighing the risks and benefits, the course of their care during pregnancy. This right of informed refusal is recognized by the American College of Obstetricians & Gynecologists in their committee opinion number 237, published in June 2000, which states:

"Once a patient has been informed of the material risks and benefits involved with a treatment, test or procedure, 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. . . . Performing an operative procedure on a patient without the patient's permission can constitute 'battery' under common law. In most circumstances this is a criminal act. . . . Such a refusal [of consent] may be based on religious beliefs, personal preference or comfort."

That being said…you should also know that **your choice of having a vaginal birth after cesarean (VBAC) in your home is not supported by the American College of Obstetricians/Gynecologists (ACOG), AND is considered unsafe by the majority of physicians in your region**. The reason for their concern is that you do not have immediate access to a physician/surgery at home and time is lost in transporting to the hospital in case immediate surgery is needed. The best outcomes occur if a woman can have an emergency cesarean within 15-18 minutes of a problem developing.

Your chance of successfully having a VBAC ranges from 60-90+%. The rate varies widely in different studies. Factors that increase chances of success include prior vaginal birth, more than 18 months between pregnancies, giving birth to a normal birth weight baby (less than 9 lbs), giving birth by 40 weeks gestation, spontaneous onset of labor, and prior cesarean was performed without a clear reason--or was performed for a non-repeating factor such as a breech position. The rate of successful VBAC appears to be about the same for Women with more than one previous cesarean birth appear to have the same rate of successful VBAC as women with only one previous cesarean.

Recommended reading:

ACOG Practice Bulletin No. 115, "Vaginal Birth After Previous Cesarean Delivery", August 2010

NIH 2010 Consensus Conference Final Panel Statement on Vaginal Birth After Cesarean: New Insights

ACNM Responds to ACOG's 2010 VBAC Recommendations, August 2010

Childbirth Connections "What Every Pregnant Woman Should Know About Cesarean Section and "Vaginal Birth and Cesarean Birth: How do The Risks Compare", 2nd Edition, December 2006.

Childbirth Connections, "Comparison of ACOG VBAC Practice Bulletin 2010 with VBAC Practice Bulletin 2004 and Induction of Labor for VBAC Committee Opinion 2006", August 2010

These articles discuss the risks and benefits of having a vaginal birth after cesarean. If you have any questions or concerns, please write them down so we can go through them at our next visit.

ACOG (American College of Obstetricians and Gynecologists) 2010 guidelines regarding VBAC state that:

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1. The preponderance of evidence suggests that most women with one previous cesarean delivery with a low transverse incision are candidates for and should be counseled about VBAC and offered a TOLAC (trial of labor after cesarean section).
2. Women with two previous low transverse cesarean deliveries may be considered candidates for TOLAC.
3. TOLAC in women with low vertical uterine incisions have reported similar rates of successful vaginal delivery compared with women with low transverse uterine incision. Recognizing the limitations of available data, health care providers and patients may choose to proceed with TOLAC.
4. TOLAC is not contraindicated for women with previous cesarean delivery with an unknown uterine scar type unless there is a high clinical suspicion of a previous classical uterine incision.
5. There is nothing unique about the delivery of the fetus or placenta during VBAC.
6. For those considering larger families, VBAC may avoid potential future maternal consequences of multiple cesarean deliveries such as hysterectomy, bowel or bladder injury, transfusion, infection, and abnormal placentation, such as placenta previa or placenta accreta.
7. After counseling, the ultimate decision to undergo TOLAC or a repeat cesarean delivery should be made with the patient in consultation with her health care provider. The potential risks and benefits of both TOLAC and elective repeat cesarean delivery should be discussed. Documentation of counseling and the management plan should be included in the medical record.

In 2002, ACOG adopted new guidelines requiring physicians to be immediately available during a TOLAC, the revised 2010 guidelines essentially reaffirm this position. As a result, many community hospitals do not allow VBAC but recommend a scheduled cesarean as they are safer than an emergency cesarean. An alternate option is to plan a VBAC in a hospital with these resources.

In deciding to have a VBAC I have been informed of the following:

1. With a VBAC the major concern is rupture of the uterus during labor.

Risks to mother from a rupture include:

Rate is cited as 0.5% to 1.0% of all low-risk laboring women.

1. Blood loss necessitating transfusion
2. Severe damage to uterus necessitating a hysterectomy
3. Bladder damage
4. Infection
5. Blood clots
6. And rarely, death

Risks to the baby with a uterine rupture include:

Rate is cited as approx. 10% of uterine ruptures will cause harm to the baby.

1. Brain damage
2. Death

2. The normal risks of having a vaginal birth are also present for VBAC.

3. If you need a cesarean during a VBAC labor, you should be aware that the rate of infection doubles when the surgery is not planned.

4. Risks of your baby dying during a VBAC attempt are the same as a baby dying during a first labor. The risk of your baby dying with a VBAC compared to a planned repeat cesarean birth is slightly

increased as follows: Overall risk of death with VBAC is 6 out of 1,000 (0.6%), with a planned repeat cesarean the overall risk rate is 3 out of 1,000 (0.3%).

5. The scar on your uterus will always be at risk for rupturing. These tears often occur during labor but not always. Your chance of a uterine rupture before a planned cesarean birth is 2 in 1,000 (0.2%). If this happened, the risks to you and your baby are the same as if the uterus tore during a VBAC.

I understand these risks are minimized by not using drugs to stimulate or augment labor.

6. There are benefits of having a VBAC compared to a cesarean such as:

1. Shorter recovery time
2. Less chance of needing a blood transfusion
3. Less risk of infection
4. No risk of injury to the bowel or bladder
5. Less risk of breathing problems for the newborn
6. Greater chance of giving birth vaginally for subsequent pregnancies
7. Lower incidence of placenta accreta or third trimester uterine rupture in future pregnancies

The signs and symptoms of uterine rupture include the following: fetal bradycardia, increased uterine contractions, vaginal bleeding, loss of fetal station, and new onset of intense uterine pain. In more than 70% of cases, an abnormality in fetal heart rate is noted.

I understand that during labor monitoring of my blood pressure, pulse and baby's heart rate are necessary procedures and that my midwife will be regularly monitoring these vital signs.

I understand that in the event of a uterine rupture, prompt recognition and emergency management in a hospital can usually minimize serious results.

I understand that with previous surgical birth, there is an increase incidence of placenta accreta and that a third trimester ultrasound to determine the location of the placenta is advisable.

I understand that I must provide my midwife with a copy of the operative report of my surgeries.

I understand that because of emergency response time and the distance to a hospital this delay in necessary emergency care may result in serious harm, disability, or death, and I am assuming the risk that a life threatening complication may occur in my home.

I understand that current medical standard of care recommends that VBAC occur in a hospital setting.

I understand that in having a birth at home I can and will transfer to the hospital if I request it or if my midwife has concerns that anything outside of normal occurs during my labor and/or delivery.

I understand that Lucinda Chiszar and Brooke Myung are Licensed Midwives and that their education and experience includes attending successful VBAC in out of hospital settings. I am aware that collectively these midwives have attended over 300 births and approximately eight percent of these have been TOLAC in out of hospital settings with a successful rate of VBAC of over 75%.

I have had one or more cesarean births with a lower uterine segment incision and desire a homebirth with my current pregnancy. I voluntarily waive transfer of my care to a physician for a VBAC and choose to have my care with a licensed midwife and plan to give birth at home unless complications arise prenatally or during labor.

I have used the following materials and resources in making my decision and these are my questions/concerns:

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I have read the summary of the risks/benefits of having a VBAC and have had all of my questions and concerns addressed, and I have decided to proceed with my plans for having my baby at home with Big Valley Midwives.

Signed_____ DATE _____ (mother)

Signed _____ DATE _____ (partner)