FOR IMMEDIATE RELEASE
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We, the International Cesarean Awareness Network (ICAN), would like to address the recent publication of Practice Bulletin 184 from the American College of Obstetricians and Gynecologists (ACOG), titled: “Vaginal Birth After Cesarean Delivery”. ICAN is a non-profit organization whose mission is to improve maternal-child health by reducing preventable cesareans through education, supporting cesarean recovery, and advocating for vaginal birth after cesarean (VBAC).

ICAN is hopeful that ACOG’s new VBAC guidelines will enable more maternity care consumers to find the support and evidence-based care that they need and deserve. Multiple statements throughout Practice Bulletin 184, such as “Coercion is not acceptable”, and “Global mandates for TOLAC are inappropriate because individual risk factors are not considered”, lead us to believe ACOG is working to decrease the widespread hospital VBAC bans that currently exist in the United States. As ACOG states, “respect for patient autonomy also dictates that even if a center does not offer TOLAC, such a policy cannot be used to force women to have cesarean delivery or to deny care to women in labor who decline to have a repeat cesarean delivery”. While ACOG also expresses understanding that some facilities may still choose to mandate surgery for patients with a history of prior cesarean(s), they made sure to add that “patients should be allowed to accept increased levels of risk” (eg, make their **own** choice), and stated that “none of the principles, options or processes outlined here should be used by centers, obstetricians or other obstetric care providers, or insurers to avoid appropriate efforts to provide the recommended resources to make TOLAC available and as safe as possible for those who choose this option”.

While we are encouraged by ACOG’s apparent stance that VBAC bans should not limit a patient’s right to informed consent and informed refusal, we are discouraged that they also chose to continue their hard stance against out-of-hospital VBAC. In their “Summary of Recommendations”, ACOG cited their recommendations regarding out-of-hospital VBAC as stemming from “consensus and expert opinion”, which is “Level C”. Maternity care consumers choose out-of-hospital birth for a variety of reasons. For example, if a local hospital mandates surgery for all patients with a prior cesarean, some may feel their only option is to birth out-of-hospital. ICAN supports a person’s right to choose their preferred birth location.

We greatly appreciate ACOG’s clarification regarding Level 1 facilities. ACOG, along with the Society for Maternal-Fetal Medicine, described Level 1 facilities as those that “can provide basic care”. They also stated that although there is reason to think rapidly available cesareans can

provide “small incremental benefit in safety”, there is no data available to compare “alternate systems and response times”. We are hopeful that this clarification may effect change among Level 1 hospitals with existing VBAC bans.

Possibly the most unexpected addition to this bulletin is the frequent mention of web-based VBAC calculators. In January of 2017, an article titled: “Validation of a Prediction Model for Vaginal Birth after Cesarean Delivery Reveals Unexpected Success in a Diverse American Population”, discussed the accuracy of the MFMU web-based VBAC calculator. The MFMU VBAC calculator appears to be the calculator that is most widely used among medical professionals. This study found that when using the MFMU VBAC calculator, predicted rates were “highly accurate” for those patients that received predicted “success” rates over 65%. However, for the patients that received predicted “success” rates of less than 35%, the study found the **actual** VBAC rates were nearly “twofold higher” than the predicted rate. In addition, ACOG clearly states that “no prediction model for VBAC has been shown to result in improved patient outcomes.” ACOG points to using individualized care several times in Practice Bulletin 184, but VBAC calculators do not take individual circumstances into consideration. For example, a previous diagnosis of ‘Failure to Progress’ can be attributed to many issues, one of which being simply a failure to wait. In ACOG’s Obstetric Care Consensus, titled: “Safe Prevention of the Primary Cesarean Delivery”, they stated that “studies that have evaluated the role of maternal characteristics, such as age, weight, and ethnicity, have consistently found these factors do not account fully for the temporal increase in the cesarean delivery rate or its regional variations”. We feel that by encouraging physicians to use web-based VBAC calculators, we may see a decrease in the rate of TOLAC, and subsequently a decrease in the rate of overall VBAC.

Multiple criteria are used in the development of web-based VBAC calculators, including maternal age, body mass index, prior vaginal delivery, and race, among others. The paragraph in Practice Bulletin 184 that discusses “obesity”, leaves a final sentence that states patients who have a BMI of “30 or greater may be candidates for TOLAC, depending on their other characteristics (eg, having had a prior vaginal delivery), and their care should be individualized”. If ACOG’s intention was **not** to limit options for people with a BMI over 30, we question why they chose to include the words “may be candidates” while adding an example of “having had a prior vaginal delivery”. We strongly feel this statement may lead some physicians and midwives to decrease access to TOLAC for those with a BMI over 30, that have not had a prior vaginal birth. According to ACOG, cesarean delivery poses a greater risk of “infection, bleeding, and other complications” for an “obese woman” than for someone with BMI in the normal range.

ICAN as an organization **strongly** disagrees with the use of a patient's race in VBAC calculators. There is a lack of scientific evidence that offers an explanation of why race is included in the calculations. Until peer-reviewed research examining correlations between race and mode of delivery provides something other than inconclusive results such as “possible physician bias”, or “cross-cultural differences”, race should not be part of the criteria used to determine the probability of any person’s ability to birth vaginally. It does not appear, to us, that race alone has been conclusively determined to be a causation versus correlation for higher risk of repeat cesarean, but instead appears to possibly be due to societal issues, including

systemic racism in the medical system. Our society is ethnically and racially diverse. We challenge ACOG to develop a culturally informed maternity care response to the rising cesarean rates among all people, but specifically among People of Color.

In December of 2016, ACOG clarified their stance on Vaginal Birth After Two Prior Cesareans (VBA2C), stating: "**Most women with two previous low-transverse cesarean deliveries are candidates for and should be offered TOLAC and counseled based on the combination of individual factors that affect their risk and probability of achieving a successful VBAC"**. With the amount of available data showing similar rates of attempted TOLAC turned VBAC between those with one prior cesarean, and those with two prior cesareans, and the studies showing similar, to a 1-2% increase in risk of uterine rupture, we are disappointed that Practice Bulletin 184 did not reflect the 2016 clarification wordage.

For maternity care consumers with Special Scars (classical, prior rupture, j-shaped, inverted T shaped, etc…), finding a care provider willing to accept the patient's right to bodily autonomy can be extremely difficult. We feel Practice Bulletin 184 will not help these patients regain their right to "accept increased levels of risk", or to exercise their right to give informed consent. As stated in "Safe Prevention of the Primary Cesarean", childbirth "by its very nature carries potential risks for the woman and her baby, regardless of the route of delivery". We agree with ACOG that pregnancy is "not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life. Therefore, a decisionally capable pregnant woman's decision to refuse recommended medical or surgical interventions should be respected". We feel ACOG's label of contraindication regarding people with special scars attempting TOLAC will limit the patient's ability to exercise their right to give informed consent and informed refusal. We do, however, thank ACOG for their continued support of TOLAC for people with a prior low-vertical incision.

The International Cesarean Awareness Network supports a person's right to choose their preferred birth location and mode, and to choose who will provide their prenatal and delivery care. We believe it is imperative that the public becomes educated on their rights and options in childbirth, and on the risks involved with each option. A person **cannot** give true informed consent without first being given unbiased counseling regarding the risks and benefits of all options. Patients should be their own best advocate, and that involves researching and studying childbirth, and human rights in the medical system. We greatly appreciate the time ACOG put into updating their VBAC guidelines, and we are extremely hopeful that this information will provide greater access to evidence based care for most people. We challenge ACOG to reconsider its endorsement of web-based VBAC calculators by evaluating the effect it will have on **all** people considering a TOLAC, especially People of Color and People of Size, to publicly restate their previous clarification on VBA2C- that "**most women with two previous low-transverse cesarean deliveries are candidates for and should be offered TOLAC and counseled based on the combination of individual factors that affect their risk and probability of achieving a successful VBAC",** and to reconsider their stance against planned VBAC for those with special scars.

International Cesarean Awareness Network

https://www.acog.org/Resources-And-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery

https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Refusal-of-Medically-Recommended-Treatment-During-Pregnancy

http://www.ican-online.org/huntsville/2016/12/15/should-mothers-be-denied-option-of-vba2c-acog-clarifies/

https://www.acog.org/Patients/FAQs/Vaginal-Birth-After-Cesarean-Delivery-Deciding-on-a-Trial-of-Labor-After-Cesarean-Delivery

American College of Obstetricians and Gynecologists' Committee on Practice Bulletins-Obstetrics, & Grobman, W., MD. (2017). Vaginal Birth After Cesarean Delivery. *Clinical Management Guidelines for Obstetrician-Gynecologists, 130*(5), practice bulletin 184.

Safe prevention of the primary cesarean delivery. Obstetric Care Consensus No. 1. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:693–711.

Refusal of medically recommended treatment during pregnancy. Committee Opinion No. 664. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;127:e175–82.

Vaginal Birth After Cesarean Delivery - Deciding on a Trial of Labor After Cesarean Delivery. Frequently asked questions. Labor, delivery, and postpartum care. FAQ070. American College of Obstetricians and Gynecologists. https://www.acog.org/Patients/FAQs/Vaginal-Birth-After-Cesarean-Delivery-Deciding-on-a-Trial-of-Labor-After-Cesarean-Delivery. 2011 August.

“ICAN of Huntsville » Should Mothers Be Denied Option of VBA2C? ACOG Clarifies.” ICAN of Huntsville, ICAN of Huntsville Leadership, 15 Dec. 2016, www.ican-online.org/huntsville/2016/12/15/should-mothers-be-denied-option-of-vba2c-acog-clarifies/.