

Patient-Choice Vaginal Delivery?

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ABSTRACT

Patient-choice cesarean delivery is increasing in the United States. The American College of Obstetricians and Gynecologists supports this option, citing ethical premises of autonomy and informed consent, despite a lack of evidence for its safety. This increase in patient-choice cesarean delivery occurs during a time when women with a breech-presenting fetus or a previous cesarean section have fewer choices as to vaginal birth. Patient-choice cesarean delivery may become widely disseminated before the potential risks to women and their children have been well analyzed. The growing pressure for cesarean delivery in the absence of a medical indication may ultimately result in a decrease of women's childbirth options. Advocacy of patient-choice requires preserving vaginal birth options as well as cesarean delivery.

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INTRODUCTION

Patient-choice cesarean delivery, a primary elective cesarean delivery performed without a medical indication, is increasing among pregnant women.^{1,2} The American College of Obstetricians and Gynecologists (ACOG) has released a formal opinion supporting obstetricians who perform elective primary cesarean delivery, citing the ethical premise of patient autonomy and informed consent.³ As physicians who advocate for women's right to choose among a variety of medical options, we are pleased at the emphasis on preserving women's medical choices. We are, however, perplexed at the narrowness of the choice. In recent years we have seen a decline in women's choices for vaginal birth as vaginal birth after cesarean (VBAC) becomes less available and vaginal breech birth is rarely performed.^{4,5} The question of patient-choice cesarean delivery asks only whether a woman should have the right to choose a cesarean delivery in the absence of a medical indication. A woman's right to choose a vaginal delivery is not addressed.

Why is cesarean delivery and not vaginal delivery framed in the language of choice? We contrast professional attitudes toward patient choice for vaginal and cesarean birth, explain the importance of considering the effects of a primary elective cesarean delivery on maternal and neonatal outcomes of subsequent pregnancies, and describe the potential long-term implications of the growing acceptance of patient-choice cesarean delivery.

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IS PATIENT CHOICE AVAILABLE FOR VAGINAL BREECH OR VBAC DELIVERIES?

Before 1970 vaginal breech birth was the expectation for most of the approximately 3% of women with a term breech presentation. Cesarean delivery gradually replaced vaginal breech delivery during the last 30 years because of concerns about a potential difficult vaginal delivery. The

Term Breech Trial (TBT) in 2000 found increased perinatal mortality or severe morbidity within the first 3 months of birth when breech infants are delivered vaginally rather than by cesarean section.⁶ After the publication of this study of short-term outcomes, obstetric practice swung definitively away from vaginal delivery of the term breech infant. ACOG published an opinion supporting planned cesarean delivery in patients with breech presentation at term if an external cephalic version is not successful. Yet recent studies have shown that planned vaginal breech in selected populations may be relatively safe.⁷ The clinical relevance of the short-term benefits of elective cesarean delivery has also been called into question by the 2-year follow-up results of the TBT, which failed to show a reduction in the outcomes of neonatal mortality or developmental delay in the elective cesarean delivery group.⁸ Despite the finding of equivalent long-term outcomes, ACOG has not revisited its recommendation against planned vaginal breech delivery.

The primary investigator of the TBT has stated that a woman's choice for vaginal breech delivery should be respected,⁹ and opinions from professional societies in Australia and the United Kingdom acknowledge a woman's right to choose vaginal breech delivery.^{10,11} In the United States, however, vaginal breech delivery is not described as an optional choice for women. The obstetrician is simply instructed to document well when a woman refuses cesarean delivery for a known breech presentation.³ Faced with ACOG's recommendation against vaginal breech delivery, few physicians now offer women that choice. In our experience, few physicians unwilling to perform vaginal breech delivery offer the alternative of referral to another physician to facilitate a woman's choice, an alternative that ACOG does recommend when a physician declines to perform a patient-choice cesarean delivery.

As the number of vaginal breech deliveries continues to decline, so does the VBAC rate. The VBAC rate is falling precipitously because of concerns about the risk of uterine rupture and the decreased availability of physicians and hospitals offering VBAC services. The number of women with a previous cesarean delivery who have a subsequent vaginal birth has dropped from 28.3 in 1996 to 9.2% in 2004.¹² The risk of uterine rupture during a trial of labor imposes a small increase in neonatal risk compared with repeat cesarean delivery, although for an appropriate candidate the absolute risk of adverse neonatal outcome remains quite small. The risk of uterine rupture in a woman in spontaneous labor who has had a single previous cesarean delivery, with the commonly used lower segment transverse incision, is about 1 in 200. A recent large multicenter prospective study¹³ found a risk of only 1 in 2,000 for an adverse

perinatal outcome with attempted VBAC, as most fetuses will tolerate the rupture of the uterine scar until an emergency cesarean delivery. These real risks, however small, must be discussed with women, who should retain the right to choose either VBAC or elective repeat cesarean delivery in a subsequent pregnancy.

ACOG has recommended that hospitals offering VBAC services should have surgeons "immediately available" for rapid operative intervention, if necessary.⁴ Women in many communities no longer have the opportunity for a trial of labor after cesarean delivery because the surgical intrapartum emergency capability at their hospitals is deemed to take too long to mobilize. Thus, in rural areas women wanting a VBAC must either travel, in labor, to a facility offering that service or move to an urban area some weeks before the estimated date of delivery. For a woman who has had a previous cesarean section, travel in labor is certainly no safer than laboring in the rural hospital. Recent evidence-based American Academy of Family Physicians clinical guidelines on Trial of Labor after Cesarean (TOLAC) concluded there is no evidence to support restricting TOLAC to facilities with onsite surgeons.¹⁴

OUTCOMES OF PRIMARY ELECTIVE CESAREAN DELIVERY

When counseling women about cesarean delivery, we must remember that it carries risks of its own. Extrapolating from studies of repeated cesarean delivery compared with VBAC, we anticipate that women choosing primary elective cesarean delivery will have a higher incidence of maternal morbidity, including hemorrhage, infection, and venous thromboembolism. Maternal mortality, while a rare event in developed nations, is 2 to 3 times higher in elective cesarean delivery than in vaginal delivery, although there are no large studies of maternal mortality risk for primary elective cesarean delivery.^{15,16} Future pregnancies are at increased risk for placenta previa, placenta accreta, uterine rupture, and peripartum hysterectomy. Respiratory compromise and admission to a neonatal intensive care unit are more likely in infants born by elective cesarean section than by spontaneous vaginal delivery.^{17,18} Neonatal outcomes in subsequent pregnancies are worse in women who had a cesarean delivery in their first pregnancy.¹⁹ The choice of a cesarean section does affect a woman's reproductive future.

As with the introduction of many obstetric procedures, primary elective cesarean delivery may become widely disseminated before the potential risks to women have been determined. The history of obstetrics includes many interventions that have entered clinical practice without evidence of benefit to women

or their infants: continuous electronic fetal monitoring,²⁰ episiotomy,²¹ prophylactic forceps,^{22,23} and diethylstilbestrol for the prevention of miscarriage.²⁴ Once introduced into practice, interventions tend to persist. Despite clear evidence that routine episiotomy is harmful and continuous electronic monitoring of low-risk pregnancies is of no benefit, the overwhelming majority of laboring women undergo continuous fetal monitoring, and the United States episiotomy rate is still 29%.²⁵ Advocates of patient-choice cesarean delivery have taken the position that, although safety data are inconclusive, we should support the decision of a well-informed patient to choose cesarean delivery. This standard is not applied in most areas of medicine; we prefer to compare safety data on the new intervention with those of the old. It is premature to accept patient-choice cesarean delivery without studies comparing risks with those of vaginal delivery.

FUTURE IMPLICATIONS FOR CHILDBIRTH OPTIONS

Currently there is silence on the right of a well-informed patient to choose vaginal breech delivery or VBAC in a rural community hospital. If we cannot find her a hospital or a physician for the type of birth she desires, she may be left with no choice but to consent to a cesarean delivery. Whereas the legal right of a woman to refuse a cesarean section in almost all situations is well established, so choosing leaves the woman in the difficult position of having her delivery attended by a physician with whom she is in conflict.²⁶ As we push VBAC and vaginal breech delivery out of our hospitals, we may actually make outcomes worse: women who believe their choices will not be respected in such situations may prefer to stay home, and surely VBAC is less safe at home than in the hospital.²⁷

As patients have no established right to choose vaginal birth in the above scenarios, the future may find all vaginal deliveries threatened. Let us speculate for a moment: would a randomized controlled trial of vaginal delivery vs primary elective cesarean delivery at term show a difference in neonatal outcome? The neonatal morbidity and mortality occurring from intrauterine fetal demise from 39 to 41 weeks would be eliminated, as well as the inevitable placental abruptions, prolapsed umbilical cords, shoulder dystocias, and fetuses "unable to tolerate labor." If a sufficiently large population can be gathered and if the outcomes of future pregnancies are not considered, one might show a statistically significant decrease in perinatal mortality based on the intrauterine fetal death rate alone. Could women then lose the choice of vaginal birth altogether? The choice of outcome measures will

be of critical importance for a study of patient-choice cesarean delivery. If the primary maternal and neonatal morbidity occurs in the women experiencing repeat cesareans in future pregnancies, then a study of the short-term results will underestimate total morbidity.

What are the potential medical consequences of a widespread policy of patient-choice cesarean delivery, which already accounts for more than 2% of all births?² As the national cesarean section rate increases from the 29.1% peak reached in 2004,¹² expectations will shift away from any concept of normal as it pertains to birth. The heart of our labor and delivery units will be the surgical suite. Nurse-midwives and family physicians who do not perform cesarean deliveries will have diminished roles in childbirth, perhaps limited to prenatal care. Instead, births will require an anesthesiologist and an obstetric surgeon, as well as a scrub technologist and a circulating nurse. Births will occur predominantly in centralized facilities, with the proper surgical and transfusion support. Staff scheduling will certainly be simplified, as few births will occur inconveniently at night or on the weekends. Patients may be able to book their own physicians to attend these operative births. Or maybe not—perhaps all these cesarean deliveries will be done instead by laborists, the obstetric version of hospitalists.²⁸

Why advocate for patient choice only when that choice is a cesarean delivery? If time is money, then compared with VBAC, cesarean delivery has economic advantages. Although hospital charges for uncomplicated cesarean delivery are substantially greater than for uncomplicated vaginal delivery (\$11,524 vs \$6,239 in 2003),²⁹ the increased use of labor induction and regional analgesia has resulted in the actual cost of the average vaginal delivery approaching that of elective cesarean delivery.³⁰ Hospitals can profit from the higher charges for elective cesarean delivery as long as third party payers will pay for these expenses; if insurers decline to cover elective cesarean delivery, then patient-choice cesarean delivery becomes the privilege of the affluent alone.³¹ Hospital staffing is less complicated as well. Elective cesarean delivery allows everybody from the patient's family to the delivering physician's office staff to schedule their busy lives more efficiently. The economic and staffing efficiencies have been described as advantages of a policy of elective cesarean delivery in a commentary in the *New England Journal of Medicine*.¹ Whereas some physicians express concern about medicolegal liability, even in circumstances in which a well-informed patient requests VBAC, vaginal breech birth, or support for home birth, we should remember that the patient-choice cesarean delivery may engender its own legal liability when patients develop surgical complications.

Before we enthusiastically adopt the universal right of women to choose elective primary cesarean delivery, we must ask ourselves whether this issue is really about patient choice. If we agree that it is, then we ought also to support patient choice in situations that allow them to choose vaginal birth.

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Key words: Cesarean section; surgical procedures, elective; patient choice; vaginal birth after cesarean; breech presentation; pregnancy; childbirth

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