Risk Management: Vaginal Birth after Cesarean

The following information is provided by Preferred Physicians Medical as an outline for discussions regarding the role of anesthesia in developing policies related to Vaginal Birth after Cesarean (VBAC). It should be noted that current guidelines developed by the American College of Obstetrics and Gynecology (ACOG) and the American Society of Anesthesiology (ASA) for offering VBAC delivery do not adequately address some key concerns from a medical professional liability standpoint. Specifically, neither organization has explicitly defined the term "immediate availability" as it pertains to the requirement that facilities offering VBAC have appropriate staff "immediately available" to perform an emergency cesarean in the event of uterine rupture. In addition, neither organization has adequately addressed the issue of informed consent, especially as it relates to this staffing issue. While the most recent ACOG Bulletin (Practice Bulletin #115, August 2010) places greater emphasis on allowing patients to accept increased levels of risk with proper informed consent, there is no assurance that such an approach will ultimately insulate health care providers from legal liability in the event of a catastrophic outcome.

Preferred Physicians Medical does not endorse offering VBAC in facilities that are unable to have an obstetrician, an anesthesiologist and surgical team specifically trained and prepared to perform an emergency cesarean delivery physically present and available throughout the course of the attempted labor. In this regard, the information provided here is intended to illustrate the liability issues created when facilities offer VBAC without optimal staffing or other resources.

Resources

The information listed below is provided as a resource for developing policies and procedures related to Vaginal Birth after Cesarean. Additional relevant information is attached, as it becomes available.

1. ACOG, "Vaginal Birth After Previous Cesarean Delivery", Number 115, August 2010.
2. ACOG, “Patient Safety Checklist. Appropriateness of Trial of Labor After Previous Cesarean Deliver (Antepartum Period)” Number 8, November 2012.
3. Dailey, P.A., Vaginal Birth after Cesarean Delivery (VBAC). Summarizes 1999 Practice Bulletin on VBAC along with the Joint Commission's 2001 Anesthesia Care Standards.
4. Crowley, M.P., Obstetric Anesthesia: Recent Guidelines for Our Availability to the Labor Floor, ASA Newsletter, October 2000.
5. Optimal Goals for Anesthesia Care in Obstetrics, a joint statement from the American Society of Anesthesiologists (ASA) and the American College of Obstetricians and Gynecologists, Approved by the ASA House of Delegates October 17, 2007 and last amended on October 20, 2010.

Other information on VBAC is available over the Internet. We recommend using Google as a search engine and using a combination of terms such as VBAC, informed consent, and staffing. Additional information is available through the search functions provided by sites maintained by the ASA (www.asahq.org), ACOG (www.acog.org) and the Joint Commission (www.jointcommission.org).

Staffing

One of the principal concerns raised by the decision to offer VBAC delivery, is the availability of staff necessary to respond in the event of a uterine rupture. Credible organizations that have addressed this issue, including the ASA, ACOG, and the Joint Commission, all recognize that the risk of uterine rupture in VBAC procedures requires a more immediate response than typically contemplated by ACOG's normal 30-minute rule. (A complete discussion of the development of the 30-minute ACOG standard and its relevance to VBAC is contained in Dr. Crowley's article cited above). Given the catastrophic injuries that may result from uterine rupture, physicians should anticipate that credible and well-respected members of both the Anesthesia and Obstetric communities will be prepared to testify in court that an appropriate response time may be less than 5 minutes. Our experience in handling brain damaged infant litigation suggests in the event of a catastrophic outcome, plaintiff attorneys will have little difficulty securing testimony that any delay caused by the failure to have

appropriate personnel in-house and available to perform an emergency cesarean delivery is below the standard of care.

For these reasons, Preferred Physicians Medical recommends that facilities offering VBAC require the physical presence of an obstetrician, along with an anesthesiologist and a trained surgical team available to perform an immediate emergency cesarean delivery.

1. While the ASA, ACOG and Joint Commission guidelines have each suggested that staffing decisions related to offering VBAC procedures should remain a local decision based on each institution's available resources and geographic location, this approach ignores an important litigation reality. Local decisions are ultimately measured by experts retained from outside the local community, especially in the case of experts retained by the injured patient or family. These experts almost always insist that a national standard exists; one that doesn't recognize the flexibility suggested by the ASA, ACOG, or the Joint Commission. In fact, such experts will typically opine that patients in every American community are entitled to the same standard of medical services. While this may not be a practical reality, it is the reality that prevails in the courtroom. This is especially true in cases in which a patient has not been specifically advised that a higher level of care and treatment may be available at another facility. For this same reason, Preferred Physicians Medical is not convinced that attempts to create regional standards will be legally effective, e.g., Northern New England Perinatal Quality Improvement Network (NNEPQIN) VBAC Guidelines.

Informed Consent

A second major concern from a liability standpoint relates to the informed consent process. Our review of litigation suggests that informed consent tends to be a central focus in VBAC cases. Given the potential for catastrophic injury, Preferred Physicians Medical recommends that facilities utilize a specific informed consent for VBAC procedures.

Please note that documentation is only one part of the informed consent process. Physicians, primarily the obstetrician in this case, must thoroughly discuss the risks and benefits of VBAC with the patient. Any issues surrounding whether the patient is an appropriate candidate for an attempted VBAC delivery should also be addressed. Ideally, these discussions should occur well in advance of labor and delivery. Many obstetricians and hospitals include these discussions in a birthing plan or questionnaire that is completed in the later stages of pregnancy. The patient, once determined to be an appropriate candidate for VBAC, should be specifically advised regarding the benefits and risks of both VBAC and repeat cesarean delivery and should understand that both options are available. Specific information regarding the risk of uterine rupture and the potential for catastrophic injury to both mother and child should be discussed. Many facilities include a summary of information available from ACOG.

To the extent this procedure is offered at a facility without optimal staffing, Preferred Physicians Medical recommends that patients be informed that the risk of injury is directly related to the facility's ability to timely perform an emergency cesarean delivery. Patients should be further informed that the availability of emergency services may vary depending on location; therefore, patients desiring VBAC may want to investigate whether other facilities in their area provide a higher level of staffing. From a professional liability standpoint, Preferred Physicians Medical believes a failure to specifically address this issue with the patient compromises the effectiveness of the informed consent process in the event of litigation.

In this regard, we have included draft informed consent language reflecting our recommendations. Obstetricians may wish to add more specific information regarding the risks and benefits of VBAC.

The attached sample form is provided for guidance in developing an appropriate informed consent for patients undergoing VBAC deliveries. This form has been compiled following a review of medical literature, informed consent documents and guidelines developed by ACOG, ASA and the Joint Commission. Such forms should be reviewed periodically and updated to reflect current medical literature and policy statements from ACOG, ASA and Joint Commission.

As with any sample form, the suggestions here must be tailored to reflect individual jurisdictional requirements and any unique practice issues that may exist at your facility. Preferred Physicians Medical encourages the involvement of legal counsel in developing these important documents.

In this example, Preferred Physicians Medical has included specific language regarding the immediate availability of personnel necessary to perform an emergency cesarean delivery. To the extent such personnel is physically present and available throughout the attempted vaginal delivery, this language can be omitted. Please note that Preferred Physicians Medical does not endorse the practice of providing VBAC delivery at facilities that do not require all necessary medical personnel to be physically present and available throughout the attempted vaginal delivery.

Facilities may also elect to include more detailed medical information if such information is not routinely provided in another format, e.g., patient brochures provided by the facility. In such situations, the facility should be able to document that the patient actually received the literature.

Recommendations

Based on the above discussions, Preferred Physicians Medical recommends that anesthesiologists participate in hospital discussions related to offering VBAC. To the extent facilities elect to provide this procedure, anesthesiologists should encourage the hospital to adopt a policy that reflects both the latest medical information, and also considers the impact of an adverse outcome from a professional liability standpoint. It should be noted that given the significant losses that can arise from a failed VBAC, many insurance companies consider these issues in both providing and pricing insurance coverage. Accordingly, we encourage each involved health care professional as well as the hospital to obtain input from their respective carriers. The magnitude of losses associated with permanent brain damaged infants has become a significant issue. Verdicts ranging from a few million dollars to over $100 million are not unusual in the current legal environment, depending on jurisdiction.

Anesthesiologists asked to participate in VBAC procedures in facilities without optimal staffing, resources or appropriate informed consent documents may wish to explore obtaining an indemnification agreement from the hospital that will protect the anesthesiologist and the anesthesia group from liability in the event of a claim.

Informed Consent: Vaginal Birth after Cesarean Section

Patient's Name: _____

I understand that having had one or more prior cesarean deliveries, I have the option of undergoing an elective repeat cesarean or attempting vaginal birth after cesarean (VBAC). In making a decision in this regard, I have had the opportunity to discuss these options with my health care provider(s) and discussed the risk and benefits of both procedures.

I understand that my physician has evaluated me as a suitable candidate for VBAC delivery based on standards developed by the American College of Obstetricians and Gynecologists (ACOG).

I understand that approximately 70% of women undergoing a VBAC will successfully deliver vaginally.

I understand that there is a risk of uterine rupture during a VBAC of approximately 1%, which may result in serious injury to both my baby and me, including the possibility of death or permanent brain damage. I further understand that the risk of uterine rupture may also result in severe bleeding that requires a hysterectomy.

I understand that if my uterus ruptures during my VBAC, there may not be sufficient time to operate in order to prevent either permanent brain damage or death to either me or my baby, or both. In this regard, I am aware that the risk of harm depends in part on the availability of physicians and other health care providers to respond immediately. At [insert facility name], physicians and other health care providers necessary to respond to an emergency may not be required to be physically present during my attempted VBAC delivery, and therefore emergency procedures may be delayed resulting in significant permanent damage and/or death. Other hospitals in the area may require physicians and other health care providers to be physically present throughout the trial labor in order to immediately respond in the event of a uterine rupture. I have considered this information in making my decision to attempt VBAC delivery at [insert facility name], and understand that I am voluntarily accepting the additional risk described.

I have read the above information and have had an opportunity to discuss this with my doctor. Based on this discussion:

- ☐ I want to attempt a VBAC
- ☐ I want a repeat cesarean

_____ _____

Patient's Signature Date

_____ _____

Physician's Signature Date