All is not bleak on the VBAC front…

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As I consider the large pile of VBAC literature teetering on the edge of my desk, the words of Bruce Flamm are perhaps most apropos, "Once a cesarean, always a controversy." As midwives individually and collectively strive to provide the best care for women desiring vaginal birth after cesarean (VBAC), we find the process influenced by factors far beyond the scientific evidence: headlines, editorials, economics, and liability fears. At the national office, we hear most often of the problems, "we can no longer offer our clients the option of VBAC." Lest we despair that women will come to view operative birth as "normal" birth and that our future is in first assisting, I'd like to share with you a few items of good news on the VBAC front.

First, thanks to the tremendous efforts of the Division of Standards and Practice (particularly Ann Trudell), the ACNM VBAC Clinical Bulletin is about to go to press. The bulletin does an excellent job of briefly reviewing the history of VBAC in the U.S., presenting the facts we can glean from today's evidence. The last section, "implications for practice," provides guidelines that can be individualized to your setting. It is always a challenge to write a document that reflects both the science and the art of midwifery management through the presentation of evidence; this topic posed a special set of challenges and we owe a great debt of gratitude to the authors. Like all Clinical Bulletins, this one will be available on our Web site, from FOD, and will be published in the *Journal of Midwifery & Women's Health*.

Second, additional data of particular to concern to midwives is on the horizon. Ellice Lieberman, perinatal epidemiologist, Director of the Center for Perinatal Research at Brigham and Women's Hospital in Boston, and primary investigator of the National Associaton of Childbearing Centers (NACC) VBAC study, was on the program for our Annual Meeting. On Tuesday, June 3, 2003, she reported on the findings of over 1,800 women during a ten-year period who chose VBAC in NACC accredited birth centers. This yet unpublished data on women who received care primarily from CNMs, reports on VBACs in births that were neither induced nor augmented in the birth center. Outcomes for all women transferred intrapartum are included in the analysis.

And finally, some regional good news from Vermont (VT) and New Hampshire -- and they're happy to share! A collaboration of hospitals in those two states has produced a set of collective recommendations for VBAC care, including a regional definition of provider's "immediate availability" based upon patient risk status that has allowed many women to continue to safely choose VBAC.

This project is an outgrowth of a larger project underway since 1995. Teams from the 13 hospitals in VT that deliver babies initiated a benchmarking program to learn from each other the best ways to reduce c-section rates. They have collected and reviewed data, developed individual action plans and produced reports. From 1994 to 1997, the hospital with the highest c-section rate in VT fell from 28 percent to 23 percent. When the VBAC issue heated up, this group was concerned and ready to respond. [Two consensus conferences were held in the past year, and three documents were produced: 1) *Birth Choices After a Cesarean Section*, is written for clients and addresses the benefits and risks of VBAC and planned cesarean birth; 2) *Consent for Birth After Cesarean Birth*, is a specific consent form; and 3) *VBAC Guidelines* provides specific definitions to help providers assign risk and determine appropriate individualized intervention. The guidelines incorporate ACOG guidelines, but the [team/authors] have tackled the difficult issue of defining cesarean section "availability." Their approach emphasizes the fact that not all VBAC candidates face the same risk: the woman who underwent her second LCTS 14 months ago who now requires induction of labor merits a different approach than the woman with one prior LTCS three years ago in spontaneous active labor. Though this project has been led by perinatologist in the tertiary care centers at Dartmouth-Hitchcock Medical Center and the University of Vermont, it is clear that they understand and speak to the practical needs and concerns of women and providers in small community hospitals across the states.

This project is a model for the use of a collaborative, multidisciplinary team, driven by data, developing standards that can be individualized to specific settings and the needs of individual women. Access the documents at *www.nneob.org*.

I expect that you have at least one memory like mine: that woman who carried the scar of an operative birth on her heart as well as on her uterus, who sought out a model of care that would maximize her opportunity for a VBAC. Witnessing her elation as she reached between her legs for her baby, watching her walk triumphant and upright to the shower six hours later, enjoying the relaxation so evident as she put her baby to breast unconcerned by incisional pain; it is for her that we advocate. Q

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