

Vaginal Birth After Caesarean (VBAC)

Website Resource:

Mayo Clinic Information <http://www.mayoclinic.com/health/vbac/MY01143>

Vaginal Birth After Cesarean (VBAC)

http://www.obgyn.net/women/women.asp?page=/women/articles/vbac_dah

by D. Ashley Hill, MD, OBGYN.net

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About 25% of all babies in the United States are born by cesarean delivery, creating a situation where many women have to choose whether or not to have a repeat c/section, or to undergo an attempt at vaginal delivery for their next pregnancy. In medical terminology this is called a "vaginal birth after cesarean," or VBAC, and is pronounced "V-BACK." Scientific investigation has led to considerable information about this process, and by reviewing this information, and discussing this issue with a physician or midwife, patients can determine if they wish to have another c/section or to try for a vaginal delivery. VBAC's are successful on average 60-80% of the time and are considered by most to be a valid way to reduce the overall c/section rate.

Before discussing the pros and cons of either a repeat c/section or an attempt at vaginal delivery, it is helpful to discuss what occurs during a c/section. Basically, an Ob/Gyn doctor makes an incision into the skin of the abdomen, usually via a "bikini cut" but sometimes via an up-and-down cut called a vertical skin incision. He or she then cuts through each layer of tissue until reaching the uterus, which is essentially a large muscle. The area closest to the bladder, called the "lower uterine segment," heals better than the upper part of the uterus, so doctors make an incision in this lower area 90% of the time. The doctor makes a sideways cut, (going the same direction as the bikini cut), into this area, then reaches in, cups the baby in her or his hand, and delivers the baby through the incision. This sideways cut on the uterus is called a low transverse c/section, or LTCS for short. The uterine incision is sutured closed and heals over the next 2-6 weeks.

In unusual cases the doctor may need to make an up-and-down (vertical) cut into the muscle of the uterus, which is called a "classical c/section" to deliver the baby. Since this cut is through muscle, it may not heal well, and can come apart during the next pregnancy or delivery. This is called a scar breakdown, scar dehiscence, or a uterine rupture, depending on the extent of breakdown. When this happens the baby, umbilical cord, or placenta (afterbirth) may pop through the opening in the uterine muscle and into the abdominal cavity, causing bleeding, fetal distress, and, in some cases, even brain damage or death. If the uterus actually ruptures (which is thankfully rare), the mother can hemorrhage, leading to an emergency hysterectomy. This is much more common with classical c/sections than low transverse c/sections. As frightening as this sounds, we know through medical research that uterine scar breakdowns (and especially uterine ruptures) are relatively uncommon events, occurring in 5-12% of classical incisions and 1/2 of 1% of low-transverse incisions.

There are pros and cons to both repeat c/sections and an attempt at vaginal delivery, so patients should be well-versed on both so that they can make an informed decision regarding their health care. While an attempt at vaginal deliver after a low-transverse c/section is usually quite safe, current medical standards clearly show that women who have had a classical c/section should *not* undergo an attempt at vaginal delivery, since the chance of uterine rupture is too high to

risk. These women should undergo a repeat c/section for every subsequent pregnancy. Therefore, this paper will focus on women who have had a low transverse c/section, since they may safely undergo an attempt at vaginal delivery if they wish. Please note that the important incision is on the uterus, and that the type of *skin* incision is irrelevant. There are many benefits of vaginal delivery, for both mother and baby. During a vaginal delivery the amniotic fluid is squeezed from the baby's lungs, making it easier for him or her to breathe. This does not happen as much during c/section. Furthermore, it is a misconception that c/section is always safer for babies than vaginal delivery. Scalpel injuries and trauma to babies during c/section, although rare, can certainly occur. In most cases vaginal deliveries are safer for mothers than c/sections, with some medical studies indicating that the chance of death for a mother is 7 times higher when delivered by c/section versus vaginally. Contrary to popular belief, a c/section is a *major* operation, not unlike a hysterectomy in its complexity and potential complications! These complications may include infection, hemorrhage, scar tissue formation (which may produce lifelong abdominal or pelvic pain), anesthesia complications, opening of the skin incision leading to a very large scar, damage to the bladder or intestines, and the formation of blood clots within blood vessels or the lungs. These complications are usually much more common with c/sections than vaginal deliveries, although as with all medical issues the patient's individual situation will dictate which complications are more, or less, likely. An unfortunate side effect of our legal system is that many women are led to believe by malpractice lawyers that a c/section will prevent any and all problems for their baby. This is simply untrue and is a very unsophisticated way of looking at this major operation and pregnancy in general.

There are certain risks that are more likely when a patient has had a prior c/section. These include scar tissue formation around the uterus that may make another c/section technically difficult, and the development of placenta accreta, where the placenta grows into the prior uterine scar, sometimes leading to hemorrhage and emergency hysterectomy. The most uncommon, but most significant, risk is uterine rupture. This occurs in about 1/2 of 1 percent (about 0.5%) of patients who have had a prior low-transverse c/section. As discussed, this may result in hemorrhage or harm to the baby, but both of these are actually uncommon. Uterine ruptures usually cause significant pain, so close observation by a patient's doctor and nurse, and perhaps the use of fetal monitoring, will often diagnose this condition.

Since we know that vaginal deliveries are almost always safer for the mother, and usually as safe for the baby, and that VBAC attempts are successful in about 80% of cases, why do some women still choose to have a repeat c/section rather than try for a vaginal delivery? In some cases it is fear of pain during labor (although many patients report that the pain from recuperation from a c/section is worse than labor pain), in others it is a "fear of the unknown," while for some women there is a convenience in scheduling the exact date of their baby's birth. Some patients desire a tubal ligation and believe that it is safer to undergo a c/section and tubal ligation rather than a vaginal delivery with subsequent tubal ligation, although medical research has shown this to be untrue. Finally, a number of women do not wish to take the risk, no matter how rare, of uterine rupture. No matter what the reason, since there is a small risk with an attempt at vaginal delivery and a risk with repeat c/section, patients should make the best choice for themselves, based on their specific medical history, doctor's advice, and individual situation.

Discussion Group

Resources:

"How can a hospital say it can handle an emergency C-section due to fetal distress yet not be able to do a VBAC?" asks Dr. Mark Landon, a maternal-fetal-medicine specialist at the Ohio State University

Medical Center and lead investigator of the NIH's largest prospective VBAC study.

This doctor is amazing in his research into VBAC. If you are interested you can find more information about him on the internet. He has a facebook page http://www.facebook.com/profile.php?id=570392567&v=feed&story_fbid=131501110175#/pages/Dr-Mark-Landon/130023390436?ref=nf.

There are really some doctors who want this to work out for moms. Birth story listed at <http://www.fourtrimesters.com/birthstories.htm>

www.mothering.com has VBAC birth stories as well

Check out www.ican-online.org for book and links for further reading regarding VBAC.

Testimonials:

I myself had a successful VBAC with a 9lb 4oz boy. No problems, even though I was considered high risk because of the death of my first and consequent c-section for my second.

For me, this VBAC is redemption. I feel like I have reclaimed my body. Just three weeks before Estella's birth, I cried about having a c-section with my son. Now I am at peace with it. We feel that the c-section made this birth even more triumphant. We like to believe it will help other moms have more choices about their births and more providers willing to accommodate them.

As a 3 time VBAC mom myself, I can tell you that hypnotherapy and Childbirth Education classes really helped me to give birth without fear or intervention of any kind. I have talked to many other VBAC moms who did not use hypnotherapy or CE and had a much more difficult time trusting in their bodies.

This mom had 3 prior surgical births, plus 10 days of released membranes!
<http://rixarixa.blogspot.com/2007/05/home-birth-after-3-cesareans.html>

Topic: Negotiating a VBAC

The first thing that needs to happen for these moms is that they need to switch doctors. Taking CE is not going to allow them a VBAC if they are with a doctor who simply will not do one. The mother will not be able to convince the doctor, he may pay her some lip service and say that they can "try" but in the end, the doctor will find a reason to perform the cesarean. The mother needs to educate herself on the safety of VBAC and potential risks and non-necessity of ERCS and to change doctors. If she's not comfortable switching now, she is likely going to be less comfortable switching as she gets further along in her pregnancy.

Topic: Encouraging VBAC

YES!! She can most certainly do it, if she believes that she can. She should approach her birth as any other and expect a calm, confident experience. She should practice diligently, as she will be working to overcome more programming than your average mom due to her prior experience, but it will be infinitely powerful for her.

One of our favorite moms had a homebirth VBAC and when she first called me she was terrified. She was seeing an OB and said "I'm trying to do a VBAC" and we had a long talk about it and she came to class, and had such a fabulous birth...in fact her midwife almost missed the birth because she went so fast!

Re: Words of Wisdom for a VBAC

One thing I can think of right off the top of my head is that you'll need to read "The Silent Knife" by Nancy Wainer Cohen & Lois J. Estner. See if your local library can get it for you. It was written in 1983 and except for a few minor things (like shaving moms for delivery) it is still relevant. I worked as an OB RN for many years & I know from first-hand experience that most of the things they talk about in the book are true.

One of the most important things your "mom" needs to do is discover what level of commitment to VBAC her doctor/healthcare provider really has; will he/she allow her to labor and give birth to her baby without technological interference? Is he/she just giving "lip service" to the mom's wish to have a VBAC and has he/she really decided that a c-section will probably be inevitable? Or is he/she committed to seeing to it that the mom has the best VBAC experience possible? Will he/she be supportive of a specific set of childbirth education tools? These are all very important questions. The mom has to let her healthcare provider know what her plans are well ahead of her birthing and then she has to keep reminding him/her of her wishes. She has to do this when she gets to the hospital too (if that is where she is going to give birth to her baby).

I would recommend that your mom engage the services of a Doula and take the Childbirth Education Classes too.

OPPOSING BANS ON VAGINAL BIRTH AFTER CESAREAN (VBAC)

by the National Organization for Women (NOW)

WHEREAS, the National Organization for Women (NOW) has a long history of supporting a woman's right to make reproductive choices; and WHEREAS, Vaginal Birth After Cesarean (VBAC) has repeatedly been shown to be a safe and reasonable choice for women; and

WHEREAS, VBAC labors that are not induced or augmented with drugs proceed without the need for emergency surgical intervention 99.6% of the time; and

WHEREAS, unnecessary cesareans pose serious risks to mothers, including two to four times a greater chance of maternal death; increased risk of emergency hysterectomy; injury to blood vessels and other organs; chronic pain due to internal scar tissue; increased chance of re-hospitalization; complications involving the placenta in subsequent pregnancies; and

WHEREAS, unnecessary cesareans pose risks to the infant, including an increased risk of respiratory distress syndrome; prematurity; the development of childhood asthma; and a 1-9% chance the baby will be cut during surgery; and

WHEREAS, over 300 hospitals within the United States have banned VBAC, including at least one hospital in every state; and

WHEREAS, it has been reported that some women seeking care in hospitals that ban VBAC have been forcibly anesthetized and C-sectioned when they try to withhold consent to surgery; and

WHEREAS, the right to refuse unwanted and unnecessary medical treatment is a fundamental right; and

WHEREAS, the right to bodily integrity is a fundamental right,

THEREFORE BE IT RESOLVED, that NOW oppose institutional and healthcare policies that deny women's access to VBAC; and

BE IT FURTHER RESOLVED, that NOW's policy statements, brochures, and fact sheets concerning reproductive freedom include information on VBAC; an

BE IT FINALLY RESOLVED, that NOW and its chapters work with national and state health care organizations and providers to oppose legislation and public policy that would restrict women's access to VBAC and to medically accurate and comprehensive information on childbirth and the right to choose VBAC.

Study backs natural birth after C-section

Posted 6/29/2006 9:28 PM ET

By Rita Rubin, USA TODAY

A study out today could lead to an increase in the number of pregnant women who try for a vaginal birth after a cesarean section, a type of delivery called a VBAC.

The study, published in *Obstetrics & Gynecology*, involved 17,890 women with a prior C-section who delivered at one of 19 academic U.S. medical centers from 1999 through 2002.

It found that those who'd had multiple C-sections were no more likely to have a uterine tear, or rupture, than those who'd had only one C-section. Ruptures occurred in nine of 975 women with multiple previous C-sections, or 0.9%, and 115 of 16,915 women with just one prior C-section, or 0.7%. Women with multiple C-sections were more likely to need a blood transfusion or a hysterectomy if they tried for a VBAC, but their actual risk was just 3.2% and 0.6% respectively.

"I think most practitioners have with time shied away from offering VBAC to women with multiple prior cesareans because of a perceived risk of uterine rupture," says lead author Mark Landon, a professor of obstetrics and gynecology at The Ohio State University in Columbus. If such women have an increased risk of rupture, it must be quite small, Landon said.

Gary Hankins, chairman of the American College of Obstetricians and Gynecologists' obstetrics practice committee, said he expects his group will now revise its VBAC advice for women who've had multiple C-sections.

In 2004, Hankins' committee said that the only women with multiple C-sections who are candidates for a VBAC are those with a prior vaginal delivery. The new study found that having a prior vaginal delivery made no difference.

VBAC has become one of the most hotly debated topics in obstetrics. In 1999, the obstetricians and gynecologists group advised that it only be allowed in hospitals with an "immediately available" surgical team. That guideline stemmed from concerns about the risk of a potentially catastrophic rupture in laboring women with a C-section scar on their uterus.

By 2004, the VBAC rate had dropped to 9.2%. Many hospitals and doctors would not allow any woman to attempt one.

"I think the important message from Landon's paper, and from our work, is that VBAC in women with multiple prior C-sections is very reasonable," says George Macones, chairman of the Department of Obstetrics and Gynecology at Washington University in St. Louis and author of a study last year that found only a small increased rupture risk in such women.

Find this article at: http://www.usatoday.com/news/health/2006-06-29-vbac_x.htm

Discussion Group

When considering a VBAC, moms can feel disappointment and lack of support after a prior c-section. For this, she can contact ICAN. <http://www.ican-online.org/> There she will find accurate information and lots of support for herself and her husband. She will also be able to get the lay of the land re: VBAC friendly providers in her area, and so will have a much better chance of getting a doc or midwife who gives more than lip service to supporting VBAC.

Having a (VBAC) isn't a problem. At least 60 % of women who've had a cesarean can have a vaginal birth. Of course, it depends upon why the first one was done, but size isn't necessarily an exemption. The problem right now is a VERY CONSERVATIVE medical model around this issue.

Topic: Advise on minimizing fear of VBAC

I have a mother pregnant with her 3rd child. 1st was natural, 2nd c/s due to Breech position and now is planning a VBAC. Her Dr has pulled the fear card in a big way, talking about scar rupture etc, in particular if the scar is vertical. Is it possible to have a transverse scar externally but vertical internally? This seems to be what the Dr is inferring, leading onto the concern of scar/uterine rupture. Can anyone help out with some more details for us in order for her to feel more comfortable?

*Lots of good links here, including birth stories:
<http://www.homebirth.org.uk/vbac.htm>*

Vaginal Delivery of Breech Baby Safe Under Specific Circumstances

<http://www.mail-archive.com/ozmidwifery@acegraphics.com.au/msg22223.html>

Reuters Health

By Martha Kerr

NEW YORK (Reuters Health) May 12 - Neonatal outcome of planned vaginal deliveries of breech presentations is virtually the same as the outcome of planned cesarean delivery if strict criteria are met, including pelvimetry and management of labor.

Investigators with the PREsentation et MODE d'Accouchment (PREMODA, presentation and mode of delivery) study, led by Dr. Francois Goffinet of the Universite Pierre et Marie Curie in Paris, conducted a prospective study with intent to treat analysis with 2526 women with planned vaginal delivery and 5579 planned cesarean delivery of breech presentations. The main outcome measure was fetal and neonatal mortality combined with severe neonatal morbidity.

Of the women planning vaginal deliveries, 71.0% were successful. The rate of the combined adverse outcome was 1.59%. Of the 5,579 planned cesarean deliveries, the combined adverse outcome was about the same, at 1.60%.

Strict criteria had to be met to follow through with a planned delivery, Dr. Goffinet pointed out. Pelvimetry was used by 82.4% of physicians in the PREMODA study compared with 9.8% of physicians in comparable settings in national registries. Continuous fetal heart rate monitoring was also performed in the planned vaginal delivery group.

A second stage of labor longer than 60 minutes, a significant cause of neonatal complications,

occurred in only 0.2% of the planned vaginal delivery group, Dr. Goffinet noted. Active pushing before the presenting part reached the pelvic outlet was used by the PREMODA physicians, which is earlier than recommended in French practice guidelines.

Four of infants of planned vaginal deliveries had Apgar scores below four at 5 minutes compared with 1 in the planned cesarean section group.

Dr. Goffinet told Reuters Health that complications to the infant and the mother are higher if a rescue cesarean delivery is needed after the baby is engaged, but that the risks are about the same as an infant engaged in a women with a planned cesarean section.

These results are published in the April issue of the American Journal of Obstetrics and Gynecology.

Am J Obstet Gynecol 2006;194:1002-1011.

Battle lines drawn over C-sections

By Rita Rubin, USA TODAY

http://www.usatoday.com/news/health/2005-08-23-csection-battle_x.htm

For some women, birth has become the latest battleground for reproductive rights.

At a growing number of hospitals, women are being forced to schedule a repeat cesarean section just because they already had one. Doctors and hospitals say they fear lawsuits if they allow a patient to attempt a vaginal birth after a C-section — called a VBAC — and something goes awry.

"We think the risk is more of a legal risk than a medical risk," acknowledges Bob Wentz, CEO of California's Oroville Hospital, which banned VBACs two years ago.

As the overall C-section rate in the USA continues to climb, so will the proportion of pregnant women who have already had one. C-sections hit an all-time high of 27.6% in 2003, the most recent year for which information is available.

Though VBACs practically were unheard of before the 1980s, the overall C-section rate was so low that relatively few women cared. But today, some pregnant women regard VBAC bans as an intolerable attack on personal autonomy. They view VBACs' risks — mainly, the chance that the uterine scar from their previous C-section will tear — as a reasonable trade-off for the chance to experience a vaginal birth and avoid abdominal surgery, which carries its own risks.

"My uterus, my choice," read one placard at a rally in late July at St. Joseph Medical Center in Tacoma, Wash. On Aug. 1, the hospital began requiring that all pregnant women who had had a C-section schedule a repeat cesarean for their next delivery.

In large chunks of the USA, no hospital or doctor will allow women to attempt a VBAC:

- In Flagstaff, Ariz., an obstetrician/gynecologist says she was reprimanded by her colleagues for arranging to do what her own patients could not: have a VBAC at her own hospital.
- In North Platte, Neb., a mother of five delivered baby No. 6 at home after the local hospital suggested that because she had had one C-section, she temporarily relocate to Denver or Omaha

— each nearly 300 miles away — if she wanted to deliver vaginally.

- In Oklahoma, most OB/GYNs won't allow patients to attempt a VBAC because their malpractice insurance no longer will cover claims resulting from such births.

The VBAC rate peaked at 28.3% in 1996. By 2003, it had dropped to 10.6%, less than a third of the 37% goal set by the U.S. Department of Health and Human Services' Healthy People 2010 report. The report viewed unnecessary C-sections as a heavy toll on pregnant women and health care resources.

More recent data are not yet available, but all signs indicate that the VBAC rate has slid into the single digits. In other words, more than 90% of pregnant women who have had a C-section will have another. "I think VBAC is dead," says Gary Hankins, chairman of the American College of Obstetricians and Gynecologists' committee on obstetrics practice.

Small change, big effect

If that's the case, hospital CEO Wentz and many of his colleagues would cite Hankins' organization as the cause of death. In 1999, a one-word change in the obstetricians group's guidelines spurred community hospitals to begin prohibiting VBACs.

By Marcy E. Mullins, USA TODAY

Once a cesarian, always a cesarian? Increasingly, U.S. hospitals and doctors won't allow women to attempt a vaginal birth after having had a C-section or a VBAC. The U.S. rate of such births is seen above, according to the National Center for Health Statistics.

Previously, the group had recommended that only hospitals with a "readily available" surgical team — interpreted as no more than a half-hour drive away — allow VBACs. The revised guidelines call for an "immediately available" surgical team in case a uterine rupture necessitates an emergency C-section.

Many hospitals have interpreted that to mean they must have an anesthesiologist and operating room standing by whenever a patient attempts a VBAC, a luxury they say they can't afford. If they can't meet the guidelines, they argue, they're opening themselves up to lawsuits should mother or baby be injured during a VBAC attempt.

The contractions of normal labor can cause a C-section scar to rupture. At worst, uterine ruptures lead to blood transfusions or a hysterectomy and possibly fatal brain damage in the baby. But such catastrophes are uncommon.

In the most definitive study, published in December in *The New England Journal of Medicine*, about 75% of 18,000 women who attempted a VBAC were successful. The National Institutes of Health study found that ruptures occurred in fewer than 1% — or 124 — of those who tried to have a VBAC.

In most cases, mother and baby did fine. Of the babies born to the VBAC group, there were 12 cases of brain damage that appeared to have resulted from a lack of oxygen caused by maternal complications, such as a rupture. Seven of the 12, two of them fatal to the babies, were linked to uterine rupture.

The VBAC rupture complication rate may seem quite low, says Hankins, chief of obstetrics and maternal-fetal medicine at the University of Texas Medical Branch at Galveston, but "it's damn high if you're the one."

Only about 1 in 5 of his patients who have had a C-section opt to try for a VBAC, Hankins says, adding, "I truly believe in letting the women have the choice."

Increasingly, though, only women who deliver at large teaching hospitals can choose a VBAC.

In Oklahoma, women who want a hospital VBAC must go to academic medical centers in Oklahoma City or Tulsa, says Carl Hook, CEO of the state's Physicians Liability and Insurance Co. One reason: On Jan. 1, the company stopped covering claims arising from VBACs because of large awards in suits related to such births, Hook says.

The insurer covers about 75% of Oklahoma doctors who deliver babies, Hook says. "The vast majority of our obstetrician physicians, they were pleased" with the decision to drop VBAC coverage.

Mark Landon, the Ohio State University OB/GYN who led the National Institutes of Health study on VBACs, isn't surprised. "There is a group of obstetricians who probably are just as happy not to offer this service inasmuch as it simplifies things for them. There is no doubt that conducting a VBAC is clearly more labor-intensive than doing another C-section."

Even doctors at large urban medical centers are getting nervous. In Columbus, Ohio, a group of about 60 self-insured OB/GYNs is considering getting out of the VBAC business because of liability concerns, says Tammy Backenstoe, executive director of risk services for MaternOhio Management Services, which manages their practices.

"We've got some practices, if you have a patient who wants a VBAC, each partner in the practice has to sign off before they'll do it," she says.

If any patient could be fully informed about VBAC's risks, one would think Beth Claxton would be. After all, Claxton is a board-certified OB/GYN in Flagstaff.

Her firstborn was breech, or not in the optimal head-down position for delivery. Few doctors will deliver a breech baby vaginally, so Claxton tried everything to get her daughter to flip *in utero*.

"I thought the recovery would have been faster with a vaginal birth," she explains. "I also wanted to experience natural childbirth."

But the baby wouldn't budge, so Claxton delivered Eliza via a planned C-section in August 2003.

When she became pregnant again, Claxton assumed she would have to schedule a C-section. Although Flagstaff Medical Center didn't have a formal VBAC policy, she says, anesthesiologists refused to stand by while women attempting one were in labor. Flagstaff residents who wanted a VBAC had to drive two hours to Phoenix or Page.

But at her first prenatal visit, her OB/GYN asked whether she wanted a VBAC.

"I was dumbfounded," recalls Claxton, 38. "I said, 'Sure.' "

According to obstetricians groups' guidelines, Claxton was an excellent VBAC candidate: She had only one previous C-section, and it was for a reason unlikely to recur. Plus, her uterine scar was low and horizontal, less likely to rupture than a vertical scar.

Her OB, an anesthesiologist friend and a labor-and-delivery nurse all agreed to meet Claxton at the hospital whenever she arrived in labor. Claxton delivered Meg vaginally on April 16.

On July 8, she received a "letter of concern for failing to comply with the hospital and departmental guidelines regarding an elective VBAC." It came from the hospital's medical executive committee, Claxton says; her OB and anesthesiologist received similar letters.

Copies of the letters were placed in their credentialing files at the hospital, Claxton says. She's not sure what, if any, effect they'll have.

The hospital's Janet Dean says the medical staff leadership frowned upon a physician arranging to do what her own patients could not. "For approximately the past three years, we had had a working understanding between the hospital and our medical staff that the hospital did not provide elective VBAC," Dean says. "The decision not to offer elective VBACs needs to be applied equally to all expectant mothers."

Because few pregnant women have the kind of connections Claxton has, VBAC bans are driving some of them to labor at home, arriving at the hospital only when they are about to deliver and hoping it is too late to have a C-section.

"Some women think they can show up in active labor and just refuse" a C-section, says San Diego resident Tonya Jamois, president of the International Cesarean Awareness Network, a pro-VBAC group. "It's hard to be Rosa Parks when your contractions are just two minutes apart."

And some women, such as Barbara Roebuck, never bother going to the hospital. Roebuck, 37, delivered four babies vaginally before requiring a C-section for her fifth, who was breech. Pregnant with her sixth, she says she saw four doctors in a futile search for one who would let her try a VBAC.

"Every one of them said: 'Hospital policy. You don't have a choice,' " Roebuck recalls.

"Oh, yeah?" she replied. "If I don't need one, I'm not having one. You want me to recover from major surgery while taking care of an infant or toddlers?"

Her own solution

A letter to Roebuck May 27 from Cindy Bradley, CEO of Great Plains Regional Medical Center in North Platte, explained that the hospital has banned VBACs since 2002 because it cannot ensure immediate surgical support recommended by the obstetricians' group. Failure to meet those guidelines makes the hospital vulnerable to rupture-related lawsuits, Bradley wrote.

She suggested that Roebuck schedule a C-section or temporarily relocate to a town with a hospital that meets those guidelines. In an interview, Bradley said that the closest hospitals that

allow VBACs are in Omaha and Denver, each about 280 miles away.

Moving four hours from her family was out of the question, Roebuck says. So was scheduling a C-section. So, on June 29, Roebuck delivered 9-pound, 13-ounce Shane at home with only friends and family in attendance.

The thought of laboring or delivering at home after a C-section, without electronic fetal monitoring and an operating room close by in case of a uterine rupture, sends chills down Bruce Flamm's spine.

"It sounds like it is kind of spreading, which is just a disaster," says Flamm, a Kaiser Permanente OB/GYN in Riverside, Calif., who has written extensively about VBACs.

Roebuck was lucky; her home VBAC went smoothly, Flamm says. But it's only a matter of time before one goes wrong and a baby dies because a C-section could not be performed quickly enough, he says.

Flamm urges women to "search for the middle ground. Talk to the doctor, see if they would just be willing to stick around the hospital that one day they're in labor."

"Unfortunately," Flamm says, "nobody wants to do the middle ground."