The Ethics of Hospital Regulations on Vaginal Births After Cesarean Sections

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Abstract: In recent decades, the cesarean section has become an increasingly common mode of childbirth. Since 1999, there has also been a drastic decrease in vaginal births after cesarean sections (VBACs), with more women and physicians instead opting for repeat cesarean sections among women who have already undergone cesarean sections. Further, many hospitals have gone so far as to prohibit vaginal births for women who have previously given birth through cesarean section. In this research I consider the ethical implications of hospital regulations on vaginal births after cesarean sections through an application of the principles of patient autonomy and patient dignity. I argue that these principles, though infrequently applied to VBAC regulations, are more reasonable and conclusive than arguments based on beneficence, which rely on weak claims regarding the health risks of vaginal births and cesarean sections. Ultimately, I conclude that VBAC regulations in hospitals constitute ethical violations, and I call for updated regulations by hospitals and the American College of Obstetrics and Gynecologists regarding VBAC practices in order to improve the public approval of the practice and increase the rate of vaginal births after cesarean sections.
Introduction

Since the late twentieth century, the cesarean section (C-section) has quickly become a normal and, often, expected method of childbirth. The implications of a cesarean section for a woman’s subsequent pregnancies, however, have been historically inconsistent. While it generally seems to be the case that, “once a cesarean, always a cesarean,” the typical birthing process for a woman who has already undergone a cesarean section has drastically changed over time. Vaginal births after cesarean sections (VBACs), though common in the 1990s, have become increasingly less common after 1999 guidelines from the American Congress of Obstetricians and Gynecologists regulating the practice. Roughly 30 percent of hospitals prohibit VBACs, and additional hospitals likely have a “de facto” bans in place if the physicians employed by the hospital refuse to perform VBACs.¹

The major debates surrounding VBAC policies generally extend only into issues of medicine and public health, rarely considering ethical questions. Sonya Charles authored one of the few ethical analyses of VBACs in 2012, but her argument relies heavily on the principle of beneficence, hindering the potential for truly progressive thought in the realm of VBAC ethics. A sole focus on beneficence does not go beyond the existing public health research on the medical viability and safety of VBACs. Charles also incorporates considerations of autonomy into the ethical framework; however, this principle appears to be secondary to the principle of beneficence. Research suggesting that VBACs are significantly more dangerous than repeat cesarean deliveries could, according to Charles’ argument, deem the principle of autonomy to be irrelevant to the ethical discussion of VBACs.²
I propose a shift in focus to the autonomy and dignity of expectant mothers. Beneficence, while a necessary component in the ethical discussion, does not provide a generalizable ethical stance on the use of VBACs, and it should be incorporated as an ethical consideration on a case-by-case basis. With the considerations of autonomy and dignity of the patient, I will argue that hospital prohibitions on VBACs ought to be considered unethical treatment of women. Hospital restrictions on vaginal births after cesarean sections ignore a woman’s right to autonomy in her medical decisions, remove her right to experience the process of childbirth, and disregard the risks of both cesarean sections and vaginal deliveries. Ultimately, these multiple failings on the part of the hospitals which prohibit VBACs must be acknowledged, labeled as ethical violations, and corrected to give women greater voice in the decisions regarding birthing practices.

**Background**

A cesarean section is the surgical delivery of an infant through an incision in the mother’s uterus. The practice is very common in the United States, and it is intended to be used as an alternative to a high-risk or dangerous vaginal delivery. Still, the rate of cesarean sections in the United States is about one in every three deliveries. Vaginal birth after cesarean section is the successful vaginal delivery of an infant by a patient who has already undergone a C-section for a previous pregnancy. The practice of VBACs has fluctuated historically due to inconsistent support for or opposition to the practice by physicians and researchers. In the United States, VBAC rates rose from six percent in 1985 to nearly thirty percent in 1996, but they declined to under ten percent by 2004. This sharp decline between 1996 and 2004 took place despite support for VBACs by the American Congress of Obstetricians and Gynecologists (ACOG). The ACOG showed support for VBACs, but acknowledged that there is an increased chance of vaginal rupture if a woman attempts a vaginal delivery after a previous C-section. So, the ACOG
released a recommendation in 1999 that allowed hospitals to perform VBACs only if they were equipped to treat vaginal ruptures. The decline in VBACs, then, is likely due to this recommendation by the ACOG, which led many hospitals unequipped to treat vaginal ruptures to prohibit the practice of vaginal birth after cesarean section, despite the overall approval of the practice by the ACOG.\(^5\)

Thus, the source of hospital restrictions on VBACs can be traced back to fears about the safety of the practice. But this concern about the safety of VBACs, whether legitimate or not, does not justify the prohibition of the practice by a hospital. Rather, the ethical implications of this prohibition are far greater than the safety considerations of the practice. Hospital prohibitions on VBACs completely remove the woman’s right to autonomy in her own medical care. Further, these prohibitions disregard the woman’s childbirth experience, disrespect the woman’s and infant’s immediate health needs, and do not acknowledge the long-term consequences of multiple cesarean sections for a woman.

**Autonomy**

The problem of VBACs and patient autonomy is perhaps the most fundamental problem with hospital prohibitions of VBACs. These prohibitions are clear violations of the code of ethics set forth by the American Congress of Obstetricians and Gynecologists to guide ethical practice of physicians. This code of ethics places a high value on patient autonomy through competence, understanding, and voluntariness. According to this document, physicians must:

Respect… the rights of patients to make their own choices about their health care *(autonomy)*… serve as the patient’s advocate and exercise all reasonable means to ensure that the most appropriate care is provided to the patient… obtain the informed consent of each patient… present to the patient… pertinent medical facts and recommendations consistent with good medical practice. Such information should be presented in reasonably understandable terms and include alternative modes of treatment and the
objectives, risks, benefits, possible complications, and anticipated results of such treatment.

The ACOG Code of Professional Ethics calls for transparency in the potential medical treatments for a patient. Then vaginal delivery, as the normative delivery method, should always be understood as the standard or most likely treatment for a patient. In addition, the cesarean section should be presented as a viable alternative to vaginal birth. Insofar as vaginal birth is the norm, it must be discussed with the patient as a primary treatment option. Categorical prohibition of VBACs in hospitals is nothing short of a violation of the woman’s right to autonomy in choosing whether or not to undergo another C-section. In any other situation, the obstetrician would be expected to discuss delivery methods with the patient; however, prohibiting VBACs creates an illegitimate and paternalistic mode of treatment, disregarding the patient’s ability to make an informed decision about the birth of her child.

**Beneficence**

A proponent of VBAC restrictions might argue that the restrictions are justified by the potential harm caused by VBACs as opposed to cesarean sections. According to a 2010 study by C. Edward Wells, MD, at the University of Texas Southwestern Medical Center, the primary reason physicians do not offer VBACs to their patients is a concern for the maternal and fetal consequences of possible uterine rupture. Uterine rupture is a potentially fatal labor complication in which there is a complete separation through the thickness of the uterine wall, often at the site if a previous cesarean section. Indeed, some studies do show a statistically significant difference in the safety risks of elective repeat cesarean delivery versus vaginal birth after cesarean delivery. One study, for example, concludes that VBAC creates a .7 percent to .9%
chance of uterine rupture, which is roughly double the risk of uterine rupture in an elective repeat cesarean delivery.9

The health risks of VBACs and repeat cesarean deliveries are, in reality, too intricate to reduce simply to the likelihood of vaginal rupture. A 2010 meta-analysis prepared by the Oregon Health & Science University sheds some light on the health consequences of VBACs, although it is clear that rates of maternal harms were low for both repeat cesarean sections and vaginal deliveries after cesarean sections. The report reveals that among major studies regarding the safety of VBACs, maternal mortality was increased for repeat cesarean deliveries, at 13.4 per 100,000 deliveries, compared to 3.8 per 100,000 VBAC deliveries. However, rates of uterine rupture were significantly higher among VBACs than cesarean deliveries (4.7/1,000 deliveries versus 0.3/1,000 deliveries), and perinatal mortality was increased for VBACs (1.3/1,000 deliveries versus 0.5/1,000 cesarean deliveries).10 It is apparent that the safety concerns used to justify prohibitions against VBACs were not entirely accurate. The Oregon Health & Science University meta-analysis shows that for the vast majority of women, VBACs are completely safe. Although this report did see certain risks associated with VBACs, it also noted potential risks of cesarean sections, such as increased maternal mortality.

The risks associated with cesarean sections are key to understanding the practice of VBACs—they are commonly ignored or considered secondary to VBAC risks. The most immediate effects of C-sections as opposed to vaginal deliveries are the extended recovery time and the extended hospital stay. Cesarean sections are major surgeries; a woman who undergoes a C-section will need to remain in the hospital for multiple days and will take a few weeks to months to recover from the surgery. There are also additional potential complications associated with C-sections, such as infection, blood loss, and reactions to medications.11
Because a cesarean section is a major surgery, it is generally only recommended for high-risk pregnancies. The risks of cesarean sections put the mother in more danger than a vaginal delivery and call for an extended recovery time for the mother. Forcing women to undergo C-sections on the basis of medical safety is irrational because C-sections contain their own significant risks. VBACs are not proven to be more dangerous than C-sections, so hospitals cannot justify forced C-sections on the basis of maternal wellbeing.

One must also consider the long-term consequences of undergoing multiple C-sections. With every additional cesarean section, a woman is more at risk of certain medical complications. If a woman plans to have a large family, but she is forced to have multiple C-sections, she would be risking serious complications during her later C-sections. For example, accrete, the attachment of the placenta too deeply into the uterine wall, is a life-threatening complication. The risk of developing accrete increases significantly with each additional C-section. Risks of other complications, such as emergency hysterectomies, preterm deliveries, and obstetric hemorrhaging all increase with subsequent C-sections. These potential health risks of Cesarean sections are equally as important as the potential risks of VBACs. These potential complications caused by multiple C-sections still highlight the fact that the health risks of both C-sections and VBACs are complicated. Both C-sections and VBACs carry risks, but in most cases, the difference between a C-section and VBAC alone will not determine whether the mother and infant remain healthy.

Thus, VBAC safety concerns do not justify a prohibition of the practice. The fact that cesarean sections introduce additional health concerns further complicates the issue, as either mode of delivery presents risks. When accounting for these risks in the principle of beneficence and an ethical analysis of VBACs, the data does not support a generalized moral stance for all
patients based solely on beneficence. Rather, it points to the need for a case-by-case analysis of the potential risks of both cesarean sections and vaginal deliveries. Drawing this back to patient autonomy, it is clear that safety concerns surrounding vaginal births after cesarean sections are not conclusive enough to warrant an infringement of patient autonomy. VBAC is a generally safe mode of delivery, so women must be informed of the possibility of pursuing a vaginal delivery instead of a cesarean section. In the case of high-risk pregnancies or hospitals without the proper equipment to treat possible complications, the patient must still be informed of all possible childbirth options, and the physician must work with the patient in order to mutually determine the best and safest mode of treatment.

**Dignity**

Another ethical hindrance of VBAC restrictions in hospitals is their inability to acknowledge the patient’s desires and expectations for the childbirth process. Related to autonomy, this is a fundamental problem with the failure of these restrictions to allow women to experience vaginal childbirth. By no means are women required to pursue vaginal childbirth, but some women might seek the experience of a vaginal birth. For example, a 2010 qualitative study of women’s experiences with VBACs suggests that some women feel an innate desire or sense of duty to give birth vaginally.\(^{13}\) The study also claims that women can be made to feel guilty for seeking a vaginal birth after a previous C-section. Finally, it mentions the possibility of vaginal childbirth being satisfying and empowering for some women. For some women, actively participating in childbirth is a spiritual experience and a crucial part of their roles as mothers.\(^{14}\)

Removing the option for vaginal childbirth from women disempowers them from pursuing the childbirth experiences that they seek. As a significant biological and psychological event,
women must be provided the right to seek vaginal deliveries. Prohibiting certain forms of childbirth, especially vaginal childbirth, which is often a profound experience for a woman, disrespects the dignity of women to embrace the process of childbirth.

To bring these arguments into perspective, consider Emily, a young, healthy single mother of a two-year-old boy, Jack, living in a rural town with only one nearby hospital. Emily is pregnant with another child, and she is hoping to deliver vaginally. During her last pregnancy, she had a last-minute C-section because Jack was breech. Emily has done extensive research on vaginal deliveries after cesarean sections, and she appears to be in a position to successfully deliver vaginally. Further, she hopes to have the experience of vaginal childbirth, and she does not want to spend weeks recovering from a C-section while taking care of two children by herself. Emily’s gynecologist confirmed that she is in a healthy position to deliver vaginally, but the local hospital does not permit VBACs because it is not in a position to treat vaginal rupture. Emily’s only option at the hospital is to undergo a C-section, and there are no other hospitals or birth centers near her small town. In due time, Emily delivers her baby safely. However, Emily is now responsible for the care of two young children, and she needs to recover from the surgery. She is also devastated that she will not be able to have the experience of vaginal childbirth. From Emily’s perspective, her forced C-section caused more complications than the vaginal delivery would have caused, and the hospital should not have prohibited her from pursuing a vaginal childbirth.

Emily’s situation encapsulates many of the problems with hospital restrictions on vaginal births after cesarean sections. Emily, a healthy and young pregnant woman, had her right to autonomy revoked by the hospital, leaving her with no way of pursuing a vaginal delivery, despite her doctor’s support. The hospital’s position appears to be short-sighted and narrow-
minded, ignoring Emily’s unique situation as a single mother and her desire to experience vaginal childbirth. The hospital’s actions in this situation constitute unethical treatment of the patient.

**Conclusions**

Thus far, I have outlined ethical considerations of hospital regulations on vaginal births after cesarean sections, incorporating considerations of patient autonomy and dignity. Given the sharp drop in VBAC rates since 1999, however, the application of this VBAC ethic would need to address the justifications of VBAC bans in hospitals. Safety concerns regarding VBACs, as already explained, are likely not significant enough to lead hospitals to ban the practice. Physician malpractice risks are another major factor limiting access to VBACs for women. A 2010 ACOG survey found that 19.5% of obstetricians increased their cesarean rate and 19% decreased their VBAC rate due to potential risks of malpractice litigation.\(^\text{15}\) It is difficult to pinpoint the exact cause of this shift toward cesarean sections, but the ACOG survey does suggest that physicians are more likely to face malpractice litigation from vaginal deliveries than from cesarean sections. Motives such as these malpractice concerns, unrelated to the wellbeing or integrity of the patient, reveal a fundamental flaw in the treatment of expectant women. The autonomy, dignity, and wellbeing of the patient must once again be at the forefront of medical treatment decisions.

A potential solution to the legal issues surrounding VBACs and physician liability would be for the ACOG to retract its suggestion that hospitals unable to treat vaginal rupture abstain from VBACs. It appears that this regulation has contributed to the increased malpractice risks for physicians who allow VBACs. Although it is preferable for a hospital to have the ability to treat
vaginal rupture, retracting the ACOG regulation could potentially lead to increased autonomy for women and their physicians to make informed delivery decisions, factoring in the health risks of each patient individually. Giving women the opportunity to take on some liability for their deliveries could reduce the malpractice risk for physicians who allow VBACs, ideally leading to pre-1999 VBAC rates. This issue, however, requires more research in order to fully understand why VBAC prohibitions are so common and how VBAC rates can be increased.

As cesarean sections become more common in the United States, there seems to be a trend toward paternalism in obstetrics. With hospital restrictions on vaginal births after cesarean sections, women are given very little control over their own medical treatment. Despite efforts from medical organizations such as the American Congress of Obstetricians and Gynecologists to reduce cesarean section rates and promote VBACs, the practice of vaginal births after cesarean sections is significantly less common than it was twenty years ago. Today, it does seem to be the case that “once a cesarean, always a cesarean.” But hospitals must not abide by this policy. The public health basis for prohibitions against VBACs is unsupported and answers few questions about the health consequences of vaginal births versus cesarean sections. Instead of forcing women to undergo repeated cesarean sections, physicians must take into account the individual patient needs, considering the potential consequences of both vaginal birth and cesarean sections. Physicians must also take into account the personal views and expectations of patients, trying to accommodate the wishes of the woman. Hospital restrictions on vaginal birth after cesarean sections ignore a woman’s autonomy, dignity to control her own child’s birth, and short-term and long-term health prospects. Hospitals with prohibitions on VBACs treat patients unethically, and it is time for women to once again be granted the power to pursue vaginal births after cesarean sections.


5. Ibid., 321.


10. Ibid., v.


