**SAMPLE Informed Consent**

**VBAC - Labor & Birth after Cesarean
in the Birth Center Setting**

I have read the packet of information on Vaginal Birth After Cesarean (VBAC), given to me by
<INSERT BIRTH CENTER NAME>. This packet includes:

[the birth center may choose resources such as]:

* The latest *ACOG Practice Bulletin on Vaginal Birth After Previous Cesarean Delivery,*
* *The American Association of Birth Centers Position Statement: VBAC in Birth Centers,*
* And/or the chapter “Labor and Delivery after Previous Cesarean Section” from *A Guide to Effective Care in Pregnancy and Childbirth* (3rd ed.), by Enkin et al.

I meet the requirements of: [*the birth center should list their VBAC requirements here (such as)]*

* A single documented low transverse cesarean,
* A prior vaginal birth,
* An ultrasound for placental location,
* Birth location less than XX minutes from a hospital capable of performing surgery).

I am aware of the benefits of VBAC versus cesarean birth:

* Faster time to heal after birth
* Less risk of infection after delivery
* No chance of problems caused by surgery (wound infection, injury to bowel or urinary tract)
* Greater chance of having a vaginal birth in later pregnancies
* Less risk of problems with how the placenta attaches in future pregnancies

I understand that:

* Because my uterus is scarred from a previous cesarean, I have an increased risk that my uterus will rupture during this pregnancy or labor. If this should happen, it could be a life-threatening emergency for my baby and/or myself.
* Most cases of uterine rupture during TOLAC are not dangerous, but the chance that my uterus will rupture severely (causing a life-threatening emergency that requires immediate surgery) is between 0.09% (1 in 1,000), and 0.22% (2.2 in 1,000). Approximate rates of other complications are found in the table below:

|  | TOLAC in hospital studies1  | TOLAC in birth center/ home birth studies | Elective repeat cesarean after one cesarean1  |
| --- | --- | --- | --- |
| Successful vaginal birth | 600-800/1,000 | 778-960/1,0002-5 | NA |
| Uterine rupture | 7.1/1,000 | 1.9/1,0002 | 0.2/1,000 |
| Infectious morbidity | 46/1,000 | 77/1,0002 | 32/1,000 |
| Surgical injury | 3.7-13/1,000 |  | 3-6/1,0000 |
| Maternal blood transfusion | 6.6/1,000 |  | 4.6/1,000 |
| Hysterectomy | 1.4/1,000 |  | 1.6/1,000 |
| Maternal death | 0.01/1,000 |  | 0.096/1,000 |
| Hypoxic ischemic encephalopathy | 0.0-8.9/1,000 |  | 0.0-3.2/1,000 |
| Seizures | 0.2/1,0006 | 1.9/1,0006 |  |
| Neonatal intensive care unit admission | 8.0-262/1,000 | 11.1-42/1,0002,3,6 | 15-176/1000 |
| Intrapartum stillbirth | 0.1-0.4/1,000 | 2.85/1,000 | 0.0-0.04/1,000 |
| Perinatal mortality | 1.3/1,000 |  | 0.5/1,000 |
| Neonatal mortality | 1.1/1,000 | 1.3-1.9/1,0002,6 | 0.6/1,000 |

I understand that if severe uterine rupture does occur, the best chance to avoid serious harm or death to me and/or my baby is to perform a cesarean birth as soon as possible. Continuous electronic fetal monitoring, which is not used in the freestanding birth center setting but is available in the hospital, may detect uterine rupture earlier than intermittent auscultation.

I fully, freely, and knowingly assume the risk that, in the event of an emergency to myself or my baby, needed equipment, procedures, and health professionals will not be available at the birth center, and treatment may be delayed until I have been transported to the hospital.

I understand that this delay in necessary care and treatment may result in serious harm, disability, and death to me and/or my baby. I am assuming the risk that such complications may occur at my birth.

The closest hospital to my birth center with an obstetrical unit capable of doing a cesarean is: <INSERT NAME OF HOSPITAL>, which is a XX minute drive from my birth center. I understand that in an emergency transport to the hospital, a birth center staff member will notify the labor and delivery unit by phone that we are transferring to the hospital, but birth center staff has no control over how quickly the hospital will be able to respond once we arrive. The ability of the hospital to respond quickly depends on hospital procedures.

I have read and understand all the foregoing. The actions and process of a planned TOLAC/VBAC outside the hospital and reasonably known risks have been explained to me. All of my questions have been answered to my satisfaction. I hereby request, and consent to, a TOLAC/VBAC in the birth center setting attended by the <INSERT TYPE OF BC PROVIDER> at <INSERT NAME OF BIRTH CENTER>.

Signature of Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Spouse or Partner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Discussion Guide: VBAC Informed Consent**

This is not a client handout but rather a resource for birth centers
to use in discussing birth center VBAC for informed consent.

When discussing with clients, note that the research on TOLAC/VBAC is limited by low numbers (especially of community births), rare but important outcomes, differences in TOLAC management in different birth sites and by different providers, and a general lack of consideration of social determinants of health and systemic racism.

**Factors Associated with Higher Success of VBAC**

* Prior vaginal birth
* Prior VBAC
* Nonrecurring indications for prior cesarean (breech, fetal distress, etc.)
* Pregnancy interval > 2 years
* BMI < 30
* Spontaneous labor
* Cervical dilation > 4 cm on admission
* Birth weight < 4000 gm

**Factors Associated with Lower Success of VBAC**

* Recurring indication for cesarean (cephalopelvic disproportion, dystocia)
* Birth at a rural or private hospital
* Increased maternal age (> 40 years)
* Maternal disease (e.g., diabetes, hypertension)
* Obesity (BMI > 30)
* Labor induction or augmentation
* Cervical dilation < 4 cm on admission
* Birth weight > 4000 grams

**Generally Recommended Criteria for VBAC Eligibility Include:**

* Only one previous cesarean section
* Low transverse cesarean section documented on operative report
* Placental location not over previous scar and 2 cm or greater from cervical os, verified by ultrasound

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1. ACOG Practice Bulletin No. 205: Vaginal Birth After Cesarean Delivery. *Obstet Gynecol.* 2019;133(2):e110-e127.

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3. Rowe R, Li Y, Knight M, Brocklehurst P, Hollowell J. Maternal and perinatal outcomes in women planning vaginal birth after caesarean (VBAC) at home in England: secondary analysis of the Birthplace national prospective cohort study. *BJOG : an international journal of obstetrics and gynaecology.* 2015.

4. Beckmann L, Dorin L, Metzing S, Hellmers C. [Birth in Out-of-Hospital Settings--Differences in Maternal and Neonatal Outcome of Women with their Second Child and a Prior Caesarean Section Compared to First Paras]. *Zeitschrift fur Geburtshilfe und Neonatologie.* 2015;219(6):281-288.

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6. Tilden EL, Cheyney M, Guise JM, et al. Vaginal birth after cesarean: neonatal outcomes and United States birth setting. *Am J Obstet Gynecol.* 2017;216(4):403.e401-403.e408.