13 Myths About Vaginal Birth After Cesarean

Many women believe that the only safe choice after a cesarean is another cesarean. Social pressure plays a huge role in a woman's decision making process and the prevailing conventional wisdom is greatly influenced by persistent and pervasive myths about VBAC. The result is a 90% repeat cesarean rate in America[1] despite the fact that most women are candidates for VBAC and most VBACs are successful. Let's draw a clear line between myth and fact.

Myth: Once a cesarean, always a cesarean.
According to the National Institutes of Health (NIH), "VBAC is a reasonable and safe choice for the majority of women with prior cesarean."[2] The American College of Obstetricians & Gynecologists (ACOG) concurred when they said "most" women with one prior cesarean and "some" women with two prior cesareans are candidates for VBAC.[3]

Myth: VBAC after one cesarean has a 60-70% risk of uterine rupture.
The risk of uterine rupture after one low transverse (bikini) cut cesarean is about 0.5% - 1% depending on factors.[2] First time moms are at risk for complications that are equally serious to uterine rupture and occur at a similar rate such as placental abruption,[4] cord prolapse,[5] and shoulder dystocia.[6]

Myth: Hospitals ban VBAC because it's such a serious and unusual complication that they cannot manage it appropriately.
Hospitals with labor and delivery units have protocols in place to respond to obstetrical emergencies. The guidelines used to manage the complications from first time moms and repeat cesarean moms are also used to address uterine rupture in VBAC moms.

Myth: To expedite an emergency cesarean, epidurals are required in VBAC moms. VBAC moms can't have epidurals because it will obscure the pain of uterine rupture.
Per ACOG, epidurals may be used in a VBAC[3] and evidence suggests that epidurals do not mask uterine rupture-related pain.[7, 8] However, only 26% of women who experience a uterine rupture report abdominal pain, so it is an inconsistent and unreliable symptom.[9]

Myth: There is a 25% chance that either baby or mom will die during a VBAC.
The risk of maternal mortality is very low whether a woman plans a trial of labor after cesarean (0.0038%) or an elective repeat cesarean (0.0134%).[2] Limited evidence suggests that there is a 2.8 – 6.2% risk of infant death after a uterine rupture.[2, 10]

Myth: There are no risks associated with cesareans other than surgery.
The most serious cesarean-related complications become more likely as an individual woman has more cesareans.[11] These complications include placental abnormalities such as placenta accreta which carries up to a 7% maternal mortality rate[12] and a 71% hysterectomy rate.[13] After two cesareans, the risk of accreta is 0.57%, [11] similar to the risk of uterine rupture after one cesarean.

Myth: I can't have a VBAC in my state because it's illegal.
VBAC is legal throughout America and in some states, it's legal for a midwife to attend an out-of-hospital VBAC.

Myth: My doctor will lose their medical license if I have a uterine rupture.
Farah Diaz-Tello from the National Advocates of Pregnant Women clarifies, "I have never heard of a situation in which a physician has lost their license for adhering to a woman's wishes after providing them will full informed consent, and attending them in a manner that is consistent with the standard of care. Even physicians who have been found liable for medical malpractice do not automatically lose their license."

Myth: VBACs can't, or shouldn't, be induced.
When a mom or baby develops a complication that requires the baby be born sooner rather than later, but not necessarily in the next ten minutes, induction can make the difference between a VBAC and a repeat cesarean. This is why ACOG maintains that medically indicated Pitocin and Foley catheter induction "remains an option" during a VBAC.[3, 14]

Myth: Hospitals ban VBAC because they can't meet ACOG's "immediately available" requirement.
Some hospitals interpret ACOG's "immediately available" recommendation to mean an anesthesiologist must be in the hospital 24/7. Some hospitals that cannot provide that level of coverage have banned VBAC. However, "immediately available" does not have a standard definition and various hospitals implement the guideline in different ways.[15]

Myth: Hospitals that do not have 24/7 anesthesia coverage ban VBAC.
There are motivated hospitals that offer VBAC without 24/7 anesthesia coverage. The rural hospitals that serve the Navajo Nation are an example and they report a 38% VBAC rate.[16] The American VBAC rate is 10%.[1]

Myth: The evidence shows that 24/7 anesthesia coverage creates a safer environment for VBAC.
ACOG confirms that this data is not available: "Although there is reason to think that more rapid availability of cesarean delivery may provide an incremental benefit in safety, comparative data ... are not available."[3, 15] Thus the "immediately available" recommendation is based on the lowest level of evidence which is "consensus opinion."[3] Hospitals without 24/7 anesthesia implement a variety of policies to make VBAC safer including fire drills and cesarean under local anesthesia.[15] The lower response times that result benefit all birthing mothers including those who schedule repeat cesareans and first time mothers.

Myth: If your hospital doesn't offer VBAC, you have to have a repeat cesarean.
As Howard Minkoff MD said at the 2010 NIH VBAC Conference, "Autonomy is an unrestricted negative right which means a woman, a person, anybody, has a right to refuse any surgery, at any time."[16] ACOG affirms that "restrictive VBAC policies should not be used to force women to undergo a repeat cesarean delivery against their will."[3]

There are real risks and benefits to VBAC and elective repeat cesarean section. Make the right decision for yourself: understand your options, discern truth from fiction, know your legal rights, and get down to the facts. Learn more at vbacfacts.com.

Jennifer Kamel is the Founder & Director of VBAC Facts whose mission is to close the gap between what the best practice guidelines from ACOG and the NIH say about VBAC and repeat cesarean and what people generally believe. While making information relative to post-cesarean birth options easily accessible to the people who seek it, VBAC Facts strives to create a deep understanding of "the why" by providing political and historical context of the current VBAC climate as well as medical and scientific context for understanding obstetrical risk and evaluating birth-related research. VBAC Facts is an advocate for accurate and fair information and does not promote a specific mode of delivery, type of health care professional, or birth location. She presents her class "The Truth About VBAC: History, Politics, & Stats" throughout the United States.

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