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Interview Questions for VBAC Providers

BY JEN KAMEL

What is your philosophy on planned VBACs? The American College of Obstetricians & Gynecologists' (ACOG) VBAC guidelines states, "The preponderance of evidence suggests that most women with one previous cesarean delivery with a low-transverse incision are candidates for and should be counseled about and offered TOLAC [trial of labor after cesarean aka planned VBAC]."

Date: Provider Name:	Date: Provider Name:	Date: Provider Name:

What is your philosophy on planned VBACs going past 40 weeks? ACOG's VBAC guidelines clarify that going beyond 40 weeks of pregnancy should not prevent a woman from planning a VBAC: "Although the likelihood of success may be lower in more advanced gestations, gestational age greater than 40 weeks alone should not preclude TOLAC."

What is your philosophy on suspected "big babies" (macrosomia) among planned VBACs? ACOG's VBAC guidelines affirm, "suspected macrosomia alone should not preclude the possibility TOLAC."

How many VBACs have you attended?

Of the last 10 planned VBACs you attended, how many had a VBAC? If it's less than 7 or 8, I would ask what happened in those 2-3 labors that ended in a cesarean.

What is your philosophy on inducing VBACs? ACOG'S VBAC guidelines note, "Induction of labor remains an option for women undergoing TOLAC. However, the potential increased risk of uterine rupture associated with any induction, and the potential decreased possibility of achieving VBAC, should be considered."

What is your philosophy on monitoring planned VBACs? ACOG's VBAC guidelines explain, "Most authorities recommend continuous electronic fetal monitoring. There are no data to suggest that intrauterine pressure catheters or fetal scalp electrodes are superior to external forms of continuous monitoring. In addition there is evidence that the use of intrauterine pressure catheters does not help in the diagnosis of uterine rupture. However, the most common sign indicative of uterine rupture is fetal heart rate abnormality, which has been associated with up to 70% of cases of uterine ruptures. Therefore, continuous fetal heart rate monitoring during TOLAC is recommended."

Does your hospital have telemetry (wireless monitoring)? How often is it used? The second question is important because while some hospitals have telemetry, it may not actually be used so it might be stuffed in a storage room. You might also want to call the L&D unit and ask the nurses who work there.

What is your philosophy on waters being broken for more than 24 hours?

How long do you think it's safe for VBACs to labor? ACOG's VBAC guidelines do not identify a time limit for VBAC labors.

What is your philosophy on epidurals in planned VBACs? ACOG's VBAC guidelines state "No evidence suggests that epidural analgesia is a casual risk factor for unsuccessful TOLAC. Therefore, epidural analgesia for labor may be used as part of TOLAC, and adequate pain relief may encourage more women to choose TOLAC. However, epidural analgesia should not be considered necessary. In addition, effective regional analgesia should not be expected to mask signs or symptoms of uterine rupture, particularly because the most common sign of rupture is fetal heart tracing abnormalities." ACOG does not support policies that require or forbid epidurals during planned VBAC. Epidurals should be available to the pregnant person.

What are your standing orders for planned VBACs and do they differ from your standing orders for first time parents? Standing orders include things like, you can't eat or drink "nothing by mouth," you can only labor in bed, monitoring, IV placement, etc.

How does your on-call schedule work? Do the other providers in your practice approach VBAC like you? Will they attend your birth or will it be whoever is on-call at the time?

What is your cesarean rate? This seemingly simple statistic is actually quite complicated. A high cesarean rate could indicate more unnecessary cesareans or it could reflect a high risk practice where more cesareans are truly needed.

What is your perspective on movement during labor and delivery positions?

What is your philosophy on IVs or saline locks?

Do you offer family-friendly cesareans and what does that look like? Could include immediate skin to skin, lowered/clear drapes, breastfeeding in the operating room, birthing parents arms are not restrained,etc. Even if your provider does not offer these options, you can still advocate for them.

Special Circumstances

In the event that the baby isn't head down, do you manually turn babies? (This is called an external cephalic version or ECV.) ACOG's VBAC guidelines report, "Limited data suggest that external cephalic version for breech presentation is not contraindicated in women with a prior low-transverse uterine incision who are candidates for external cephalic version and TOLAC."

Are you trained in vaginal breech delivery? Do you attend vaginal breech deliveries? If not, can you refer me to a provider who does? About 3% of babies are breech at term, so it's good to know what would happen if you were in that 3%.

Do you attend vaginal twin VBACs? ACOG's VBAC guidelines assure that suspecting twins should not prevent a pregnant person from planning a VBAC: "Studies have consistently demonstrated that the outcomes of women with twin gestations who attempt TOLAC are similar to those of women with singleton gestations who attempt TOLAC (92–97). Women with one previous cesarean delivery with a low-transverse incision, who are otherwise appropriate candidates for twin vaginal delivery, are considered candidates for TOLAC."

Do you attend VBAC after 2 cesareans? ACOG's VBAC guidelines affirm, "Given the overall data, it is reasonable to consider women with two previous low-transverse cesarean deliveries to be candidates for TOLAC, and to counsel them based on the combination of other factors that affect their probability of achieving a successful VBAC. Data regarding the risk for women undergoing TOLAC with more than two previous cesarean deliveries are limited."

Do they attend VBACs with a classical (high vertical), T, or J scar? ACOG's VBAC guidelines reason, "Those at high risk of uterine rupture (eg, those with previous classical uterine incision or T-incision, prior uterine rupture, or extensive transfundal uterine surgery) and those in whom vaginal delivery is otherwise contraindicated (eg, those with placenta previa) are not generally candidates for planned TOLAC."

Do they attend VBACs with a low vertical or unknown scar? ACOG's VBAC guidelines for an unknown uterine incision state "two case series, both from large tertiary care facilities, reported rates of VBAC success and uterine rupture similar to those of women with a documented prior low-transverse uterine incision. Therefore, women with one previous cesarean delivery with an unknown uterine scar type may be candidates for TOLAC, unless there is a high clinical suspicion of a previous classical uterine incision such as cesarean delivery performed at an extremely preterm gestational age."

References

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