Claudia Breglia LM, CPM

Claudia Breglia began her practice in 1993 as a direct entry midwife providing prenatal, birth, and postpartum care in an Old Order Amish community on the Tennessee/Kentucky border. She moved to California in 2000 where she was licensed through the Seattle Midwifery School California challenge mechanism. In addition to catching close to 1,000 babies, she has served as President of the Tennessee Midwives Association, the California Association of Midwives, and on the Board of the Midwives Alliance of North America. She is currently the Executive Director and Chief Academic officer of the Nizhoni Institute of Midwifery in San Diego and on the Midwifery Advisory Council to the Medical Board of California. Recently, Claudia added the Mexican Partera Profesional Certificada, to her CPM and LM credentials so that she can see clients with colleagues on both sides of the border for fun in her spare time.

Vaginal Birth After Cesarean

With a California Licensed Midwife

Statistics

Maternal Risk

Table 1. Composite Maternal Risks From Elective Repeat Cesarean Delivery and Trial of Labor After Previous Cesarean Delivery in Term Patients

Maternal Risks	ERCD (%) [One CD]	TOLAC (%)
Infectious morbidity	3.2	4.6
Surgical injury	0.30–0.60	0.37–1.3
Blood transfusion	0.46	0.66
Hysterectomy	0.16	0.14
Uterine rupture	0.02	0.71
Maternal death	0.0096	0.0019

Data from Guise JM, Eden K, Emeis C, Denman MA, Marshall N, Fu R, et al. Vaginal birth after cesarean: new insights. (Archived) Evidence Report/Technology Assessment No.191. AHRQ Publication No. 10-E003. Rockville (MD): Agency for Healthcare Research and Quality; 2010.

Neonatal Risk

Table 2. Composite Neonatal Morbidity From Elective Repeat Cesarean Delivery and Trial of Labor After Previous Cesarean Delivery in Term Infants

Neonatal Risks	ERCD (%)	TOLAC (%)
Antepartum stillbirth	0.21	0.10
Intrapartum stillbirth	0–0.004	0.01–0.04
HIE	0–0.32	0–0.89
Perinatal mortality	0.05	0.13
Neonatal mortality	0.06	0.11
NICU admission	1.5–17.6	0.8–26.2
Respiratory morbidity	2.5	5.4
Transient tachypnea	4.2	3.6

Data from Guise JM, Eden K, Emeis C, Denman MA, Marshall N, Fu R, et al. Vaginal birth after cesarean: new insights. (Archived) Evidence Report/Technology Assessment No.191. AHRQ Publication No. 10–E003. Rockville (MD): Agency for Healthcare Research and Quality; 2010.

Birth Rate and VBAC Rate – California 2018
Data from the California Healthcare Almanac

- Total Births: 454,920
- Hospital births: 99% of total births
- Cesarean Section rate: 30.9%
- Low-risk, first birth cesarean rate: 24.5%
- VBAC rate: 13.2%

Birth Rate and VBAC Rate – California LM 2018

Data from the Licensed Midwife Annual Report

- **Planned out-of-hospital births at the onset of labor: 4148**
- **Transfer rate: 17%**
- **Cesarean rate: 8%**

- **Planned VBACS at term: 187**
- **Total completed VBACS: 151**
- **VBACS completed after transfer: 14**
- **Success rate: 81%**

1. **Midwifery Education and Accreditation Council**
   - MEAC outlines educational content for accredited schools of midwifery in the Curriculum Checklist of Essential Competencies which is aligned with the ICM Essential Competencies.
2. **North America Registry of Midwives**
   - NARM provides our National Certification Exam and California Licensing exam. The NARM Examination Test Specifications include what we are expected to know and will be tested on.
3. **California State Law and Regulation**
   - Requirements for the education of Licensed Midwives is outlined in the Licensed Midwife Practice Act of 1993, and corresponding regulation.

What Guides Midwifery Education?

MEAC

Knowledge competencies are taught in the classroom

Skills competencies are taught using hands-on simulation in practice scenarios and in longterm clinical placements.

MEAC includes Competencies Specific to VBAC or VBAC Complications

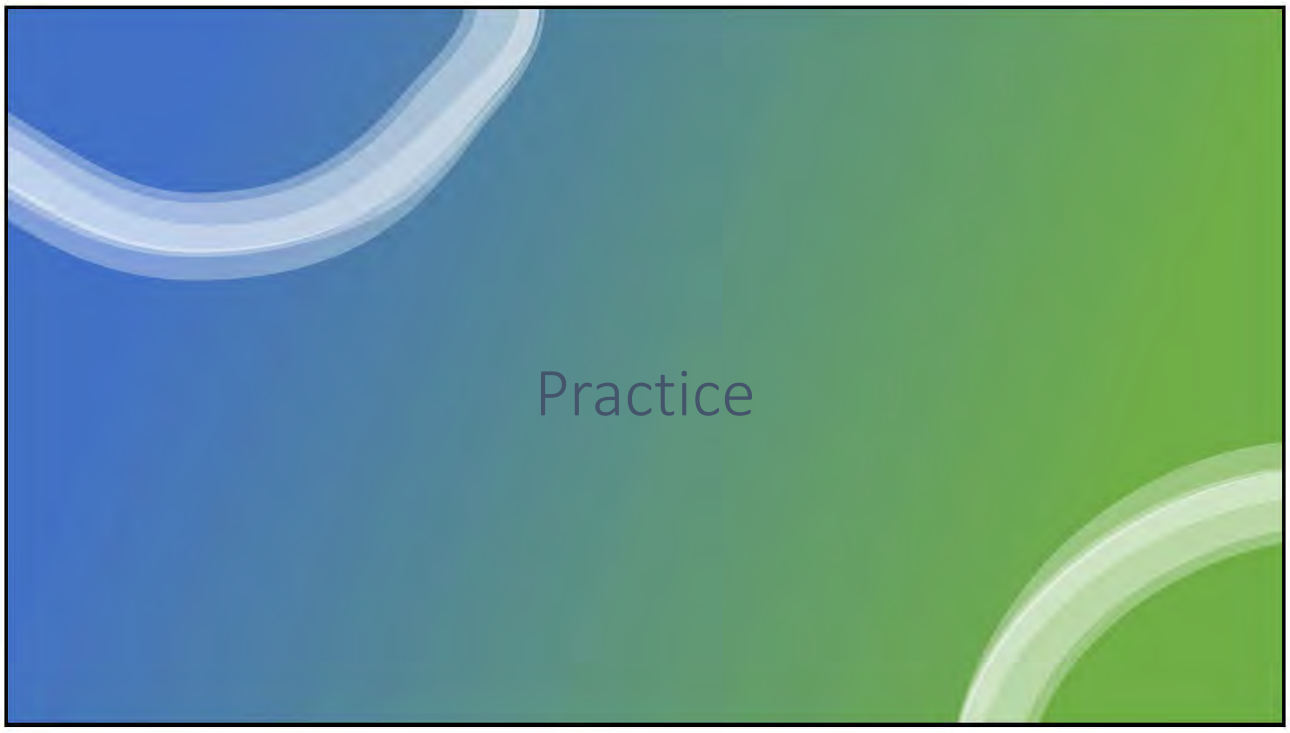
- criteria for risk assessment
- midwifery management of vaginal birth after a cesarean
- indicators of need for emergency management, referral, or transfer for obstetric emergencies

NARM Examination includes test items specific to VBAC or VBAC Complications

- indications and contraindications for out-of-hospital birth
- management strategies for VBAC
- identification of risk factors for uterine rupture
- recognition of signs and symptoms of uterine rupture
- provision of emergency treatment

Nizhoni Institute of Midwifery VBAC Curriculum

- Indicate the rate of success of vaginal birth in patients who attempt a VBAC
- List factors that are predictive of higher success rates for TOLAC
- List factors that are associated with lower success rates of TOLAC
- List common signs and symptoms of uterine rupture



California Regulation Specific to VBAC or VBAC Complications

no longer current

§ 1379.19. Standards of Care for Midwives.

(b) With respect to the care of a client who has previously had a cesarean section (“C-section”) but who meets the criteria set forth in the SCCLM, the licensed midwife shall provide the client with written informed consent (and document that written consent in the client's midwifery record) that includes but is not limited to all of the following:

(1) The current statement by the American College of Obstetricians and Gynecologists regarding its recommendations for vaginal birth after caesarean section ("VBAC").

(2) A description of the licensed midwife's level of clinical experience and history with VBACs and any advanced training or education in the clinical management of VBACs.

(3) A list of educational materials provided to the client.

(4) The client's agreement to: provide a copy of the dictated operative report regarding the prior C-section; permit increased monitoring; and, upon request of the midwife, transfer to a hospital at any time or if labor does not unfold in a normal manner.

(5) A detailed description of the material risks and benefits of VBAC and elective repeat C-section. (*no longer current*)

Intake

Midwives make a careful determination about who is low risk and more likely to be successful in their VBAC attempt.

Of 168 VBAC clients whose obstetric history was reported on the LMAR:

- 151 had 1 prior cesarean and 14 had 2.
- Half had at least 1 prior vaginal delivery

Prenatal Care

- Focused informed consent and shared decision-making conversations. Most midwives use the consent outlined in regulation including ACOG's position statement.
- Counseling on nutrition, vitamins, exercise, and healthy practices is basic to midwifery care.
- Clients are asked to have an ultrasound in the third trimester to locate the placental implantation site in relation to the uterine scar.
- In some areas, clients are asked to meet with a physician or preregister at their preferred hospital in case of transport.

Labor and Birth

- Labor is not induced. Home VBAC clients begin labor on their own prior to 41 weeks + 6 days.
- Clients are instructed to call early in labor, often earlier than other clients, and typically long before they would be admitted to a hospital. Continuous observation and begins earlier than non-VBAC clients.

- Midwives use intermittent monitoring with a handheld doppler Our VBAC clients must agree to be monitored more frequently and for longer intervals to ensure warning signs evidenced by abnormal fetal heart tone patterns are not missed.
- Labor is observed and assessed for normal progress and the expected time frames for first and second stage.
- Clients with warning signs of potential problems are transported for hospital care earlier than non VBAC clients.

Labor and Birth

Conclusion

Vaginal birth after cesarean in California: before and after a change in guidelines

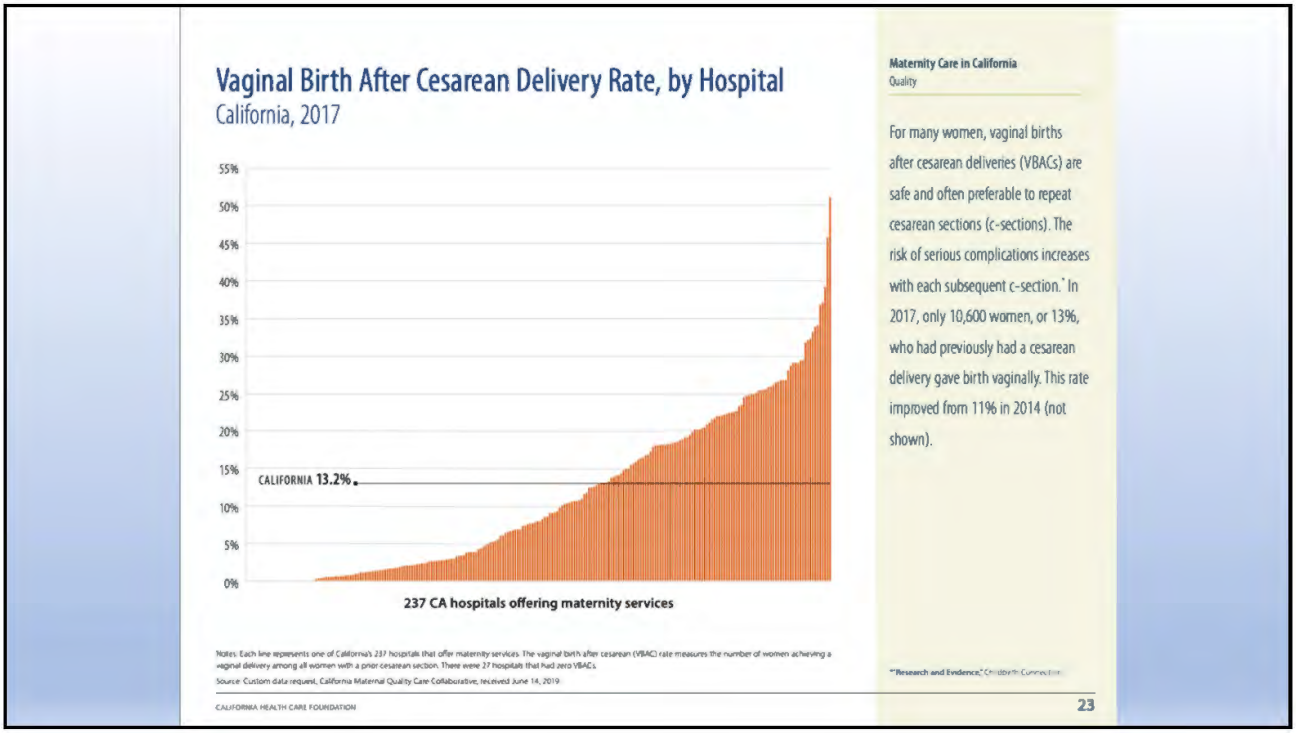
In 1999, ACOG released updated VBAC guidelines in response to concerns about increased numbers of complications resulting from rapidly increasing cesarean and VBAC rates,.

- Prior to 1999: Pregnant women should be encouraged to undergo a trial of labor.
- After 1999 Guidelines: VBAC should only be attempted in hospitals equipped to respond to emergencies with physicians immediately available to provide emergency care.

The VBAC rate plummeted from 24% - 13.5% in response. Disproportionate numbers of rural hospitals stopped offering VBAC.

- Zweifler, J., Garza, A., Hughes, S., Stanich, M. A., Hierholzer, A., & Lau, M. (2006). Vaginal birth after cesarean in California: before and after a change in guidelines. *Annals of family medicine*, *4*(3), 228–234. https://doi.org/10.1370/afm.544

CONCLUSIONS: Neonatal and maternal mortality rates did not improve despite increasing rates of repeat cesarean delivery during the years after the ACOG 1999 VBAC guideline revision. Women with infants weighing ≥1,500 g encountered similar neonatal and maternal mortality rates with VBAC or repeat cesarean delivery.



VBAC at Home with a Licensed Midwife

45% of patients who delivered via cesarean in their first birth want to have their next baby born vaginally.[1]

The majority will decide upon an elective repeat cesarean or have no option for a TOLAC.

Of the remainder, most will choose a hospital trial of labor even though success rates are greater in the community setting.

[1]Attanasio, L. B., Kozhimannil, K. B., & Kjerulff, K. H. (2019). Women's preference for vaginal birth after a first delivery by cesarean. *Birth (Berkeley, Calif.)*, *46*(1), 51–60. https://doi.org/10.1111/birt.12386

ACOG Committee Opinion number 664
Refusal of Medically Recommended Treatment During Pregnancy

- Pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life. Therefore, a decisionally capable pregnant woman's decision to refuse recommended medical or surgical interventions should be respected.
- The use of coercion is not only ethically impermissible but also medically inadvisable because of the realities of prognostic uncertainty and the limitations of medical knowledge. As such, it is never acceptable for obstetrician–gynecologists to attempt to influence patients toward a clinical decision using coercion.

Language changes requested by the Midwifery Task Force and approved by the Medical Board in 2017 have not been proposed in legislation.

the licensed midwife shall provide the client with a referral to a physician and surgeon trained in obstetrics for an assessment of risk factors that may adversely affect the outcome of the pregnancy or childbirth. A licensed midwife may assist the client in pregnancy and childbirth only if the risk factors presented by the client's disease or condition are not likely to significantly affect the course of pregnancy or childbirth.