Association of Ontario Midwives
Delivering what matters.

Dr. Joshua Tepper
Health Quality Ontario
130 Bloor Street West, 10th floor
Toronto, ON M5S 1N5

April 13, 2017

Dear Dr. Tepper,

Re: Quality Standard: Vaginal Birth After Caesarean (DRAFT March 2017)

As the professional association for Ontario midwives we appreciate the opportunity to provide feedback on the document, *Quality Standard: Vaginal Birth After Caesarean (DRAFT March 2017).* Midwives are experts in the provision of primary care for individuals anticipating normal, low risk pregnancy and birth and as such we are interested in initiatives to increase the rate of vaginal birth through high quality, evidence based care and informed choice.

The AOM thanks Health Quality Ontario (HQO) for the opportunity to provide feedback about this important initiative. In particular, we would like to provide feedback regarding the report development process, aspects of the evidence analysis and the potential for the document to generate quality improvement. Our feedback includes several concerns about changes that occurred between the October 2016 and the March 2017 drafts. The Association of Ontario Midwives (AOM) fully supports the principles set out by HQO as the underpinning of this standard. We share the stated goal of providing pregnant people who have had a previous caesarean delivery with care that promotes informed choice, provides good access, experience and outcomes across the province and is respectful of gender, sexual orientation, socioeconomic status, housing, age, background (including self-identified cultural, ethnic, and religious background), and disability.

We agree that improved access to safe Vaginal Birth after Caesarean (VBAC) and the promotion of informed shared decision-making has the potential to increase the VBAC rate and substantially reduce the overall provincial caesarean section rate. This would be a positive contribution to Health Quality Ontario's mandate of delivering a better experience of care, better outcomes for Ontarians, and better value for money. HQO's goals are also shared by Ontario midwives.

Report Development Process: Changes from the October 2016 Draft to the March 2017 Draft

We received the October 2016 Draft VBAC Quality Standard for comment and it was apparent then that the expert panel who worked on the draft aptly represented the broad spectrum of maternal and child health care stakeholders in the province. The expertise and collaborative approach of the panel, including obstetricians, family physicians, nurses, midwives, hospital

managers and provincial representatives were well reflected in the quality statements. The October 2016 Draft was a quality standard for all practitioners and patients in the province.

We are concerned that the emphasis on scientific rigour and building of provincial consensus regarding standards of care, which are part of the mandates of Health Quality Ontario and the Provincial Council for Maternal and Child Health (PCMCH), have been lost in the March 2017 Draft. The March 2017 Draft provides a less thorough and less balanced discussion of the risks and benefits of VBAC and Elective Repeat Caesarean Section (ERCS), omits references to midwifery Clinical Practice Guidelines and reduces the emphasis on the rights of pregnant people to have their care providers give all of the available information and support their informed choice. These changes are not supported by an analysis of the quality of evidence which inform the standards. Given that one of the goals of the standards is to "help patients, residents, families, and caregivers know what to ask for in their care", we feel that the March 2017 Draft falls short in providing this to Ontarians.

Evidence Analysis

HQO and PCMCH undertook evidence analysis for the development of the Quality Standards for VBAC by searching for relevant Clinical Practice Guidelines (CPGs) and applying an AGREE II tool to assess rigour. The AOM's CPG *Vaginal Birth after Previous Low-Segment Caesarean Section* (2011), which used a modified version of the AGREE tool, was selected as one of four CPGs which met the standard. The October 2016 Draft presented numerous approaches to achieving safe, quality care. The expert panel referenced four CPGs whose recommendations differed, but the consensus quality statements supported a variety of safe approaches since there was no research evidence to recommend one approach over the others. The March 2017 Draft has significantly narrowed the definition of "quality" in some standards, and eliminated the reference to research evidence and the content of informed choice discussions found in the AOM CPG.

The Quality Statement *Timely Access to Caesarean Birth* (Number 5 in the October 2016 Draft and Number 6 in the March 2017 Draft) has changed significantly. The more recent Draft begins with a statement that "It is recommended that VBAC take place in hospital, with access to continuous intrapartum monitoring, neonatal resuscitation and timely access to Caesarean birth." The October 2016 Draft described the information which is needed by providers and pregnant people for shared decision- making about choice of birth place. Most of this information is omitted in the redraft, which now includes the statement, "The Society of Obstetricians and Gynaecologists of Canada recommends that approximately 30 minutes is adequate for the setup of an urgent laparotomy, based on expert consensus." In the 2015 SOGC *Guideline for Vaginal Birth After Previous Cesearan Birth*, the quality of evidence was described using the Evaluation of Evidence criteria outlined in the Report of the Canadian Task Force on the Periodic Health Exam. Here "expert consensus" is defined as "opinions of respected authorities, based on descriptive studies or reports of expert committees", where there is "poor

evidence" available. It is not made explicitly clear in the quality standard that the approximate 30-minute timing of access to surgery is *not* based on high quality research evidence. It is also unclear why the expert consensus of an SOGC guideline would be included in the Quality Statement when the expert consensus of the HQO's own panel on the important information to be included in shared decision making on choice of birth place has been deleted.

It should be acknowledged that timely access to Caesarean birth may not be a value that is shared by all pregnant people when making decisions about their health care. Some pregnant people may prefer to choose to birth at home, within the context of informed choice about the risks and benefits of this choice and potential delays in timely access to surgery. Others may have to choose between giving birth in their own communities, where access to Caesarean birth within 30 minutes (or at all) is not possible, and transferring out to access the possibility of needed surgical care. The AOM has concerns that explicitly articulating a 30-minute guideline for accessing timely Caesarean may deter smaller, community hospitals, particularly those in rural and remote communities, from providing the option of VBAC to pregnant Ontarians who may prefer to give birth close to home. It is our belief that this recommendation may have disproportionate impact on rural and Indigenous communities and poses an equity issue.

In providing guidance on informed choice for place of birth, the October 2016 Draft cites the AOM CPG in recommending, "Health care providers should inform people planning VBAC in out-of-hospital settings that there is little evidence available on maternal and neonatal outcomes." When there is insufficient evidence to recommend a specific definition of best care, this should be clear to patients. Quality care means the choice that best meets each person's needs and preferences based on the best information available. Replacing information for informed choice with an unqualified recommendation for hospital birth is contrary to the mandate of the Quality Standards. Neither the SOGC nor the AOM CPGs present sufficient research based evidence to recommend one choice of birth place over another. While the AOM CPG does not endorse out-of-hospital birth for VBAC, it acknowledges the responsibility of the provider to equip clients considering an out-of-hospital VBAC with accurate information to make an informed decision. The CPG ultimately recognizes that the client is the expert in assessing their own risk-tolerance with regards to choice of birth place. We believe the revision of the consensus Quality Statements of the expert panel in the March 2017 Draft compromises scientific rigour and commitment to client centered care.

Similarly, a recommendation for continuous electronic fetal monitoring (EFM) throughout labour was added to the Quality Statement *Signs and Symptoms of Uterine Rupture* (Number 7 in the October 2016 Draft and Number 9 in the March 2017 Draft) during the review process, while eliminating information about the risks and benefits of monitoring by intermittent auscultation (IA). The AOM certainly agrees with the quality statement that "pregnant people who have had a previous Caesarean birth [be] closely monitored for signs and symptoms of uterine rupture". The AOM supports offering either continuous EFM or IA within the context of an

informed choice regarding risks and benefits, along with 1:1 continuous care. Signs and symptoms of uterine rupture are inconsistent: there are small studies that indicate that fetal bradycardia is the most reliable sign, though the ability of routine EFM to *predict* uterine rupture in those labouring with a previous Caesarean section has not been definitively established.

Though EFM is routinely used for those labouring after a previous Caesarean and the majority of research on outcomes have been conducted using EFM, there is little evidence on the risks of adverse events in the *absence* of EFM or comparing the use of IA and EFM.

Research strongly supporting intermittent auscultation versus EFM to reduce the risk of Caesarean delivery is acknowledged by both the SOGC and the AOM, and by other authorities such as the Royal College of Obstetricians and Gynaecologists (RCOG) and the American Congress of Obstetricians and Gynecologists (ACOG). The omission of this important research evidence as well as the lack of evidence to support the ability of EFM to predict uterine rupture in the information provided to pregnant people considering VBAC cannot be supported by the AOM based on midwives' legislated commitment to informed choice.

The manner of presenting risk also changed significantly between the two drafts. The March 2017 Draft contains stronger statements about the 1:200 risk of uterine rupture during VBAC. This would not be inappropriate if the risks of ERSC were similarly elaborated. In fact, the objectives of HQO would be better met by the addition of more comprehensive descriptions of all of the elements of shared decision-making and informed choice discussions for providers and clients. The document recommends that decision making tools be used, but none are provided.

In the Quality Statement *Antenatal Counselling* (Number 3 in both Drafts), the March 2017 Draft states that providers should inform their clients/patients that "…VBAC is safe for most people, but is not without risk". The October 2016 draft advises providers to inform their clients/patients that "the absolute differences in risk between VBAC and ERCS are small". The same four clinical practice guidelines, SOGC, AOM, ACOG and RCOG, are cited as supporting both these statements. Discussion of absolute risks contributes to understanding and may aid decision-making. It is unfortunate that discussion of absolute risk and other useful comparisons and explanations of risk have been deleted from the March 2017 Draft. Ontario midwives see providing informed choice as *putting risk into perspective*, as well as to articulate benefits and alternatives. In Vicki Van Wagner's qualitative research about evidence-based practice in Canada and how physicians, nurses and midwives providing maternity care engage in explaining risk or "doing risk talk", health care provider informants described 'risk talk' as creating fear for pregnant people, which seemed to steer their choices toward intervention. (1) Van Wagner lists some strategies that informants employed to help put risk in perspective, including: comparing numbers to every day risks, using absolute risk, using numbers needed to treat (NNT), including long term maternal outcomes, sharing uncertainty, taking time to

build confidence and avoiding the word risk. (1) If the goal of HQO is to reduce ERCS over time, while supporting informed decision-making, describing differences in absolute risk with VBAC and ERCS (e.g. October 2016 draft recommendation) is more likely to help facilitate the process of informed decision-making. The antenatal counselling section would also be strengthened by suggesting strategies to help maternity care providers put risk into perspective when discussing VBAC, such as those described by Van Wagner.

The midwifery model of care is based on the concept of informed choice, a concept congruent with Ontario's Excellent Care for All (ECFA) and Patients First strategies, which put patients at the center of the health care system, as well as being enshrined in law as part of the Health Care Consent Act. The AOM believes that all individuals have the right to all information relevant to their choices for their births in order to be truly informed decision-makers at the center of care. This principle was well represented in the original consensus Quality Standards put forward by the expert panel in October 2016. It has been greatly eroded by the revisions leading to the March 2017 Draft.

Potential for the Quality Standards to Generate Quality Improvement

A consensus statement from a panel of Ontario maternity care experts respecting the right of shared decision-making of those who have had a previous caesarean delivery would be a powerful tool to improve access to safe, quality care. The March 2017 Draft falls short of this objective in the ways we have described above. It does not include the breadth and detail of information which midwives and midwifery clients would require for shared decision-making.

Good data collection and the ability to access data to assess improvement is essential for quality improvement. The involvement of BORN on the expert panel and the description of quality indicators and the tracking methods is a strength of the Quality Standards document. Unfortunately, it appears that all of the quality indicators related to shared decision-making will only be collected if the local facilities or providers create their own systems. HQO has acknowledged in the document that access for people seeking VBACs is not consistent across the province. There is substantial variation in VBAC rates between communities and regions. When identifying the reasons for regional disparity in VBAC rates in Ontario, the Quality Standards document states that, "Research has also found substantial variation among regions and institutions in the use of shared decision-making between clinicians and patients who are planning their next birth." There is a high likelihood that regional disparity will continue if local providers are left without support for data collection on shared decision-making and are not provided with tools which promote high quality shared decision-making. Lack of access to shared decision-making results in lack of access to VBAC as a choice. The two primary quality improvements intended by these Quality Standards, shared decision-making and access to VBAC as a choice, may not be achieved across the province without a greater health system commitment to both.

The AOM would welcome an opportunity to engage in further discussions and support efforts for quality improvement in the provision of safe care to support vaginal birth after caesarean. We believe that an excellent first step would be to return to the collaborative, patient centered approach of the original consensus Quality Standards prepared by the HQO's expert panel which we saw in the October 2016 Draft. We believe that document was the appropriate starting point from which to achieve the important objectives set out by HQO in undertaking this project.

Yours truly,

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