Whereas, Trial of labor after cesarean (TOLAC) is a procedure where women who have undergone a previous cesarean section undergo trial of vaginal birth; and

Whereas, Many hospitals ban the practice of TOLAC1-3; and

Whereas, Hospital bans on TOLAC increase the number of unnecessary cesarean sections because women eligible for vaginal birth are not given the opportunity for TOLAC4; and

Whereas, Women may have to travel far distances to find a hospital or provider that is willing to let them attempt TOLAC5; and

Whereas, Cesarean section rates are at a medically unjustifiable level, reaching 32% of all United States births in 20176-8; and

Whereas, Cesarean sections are major surgeries that have inherent risks for the mother not associated with vaginal birth, such as increased risk of blood loss, hysterectomy, and preterm delivery for future pregnancies9; and

Whereas, Vaginal births result in decreased rates of respiratory distress and other complications for newborns as compared to cesarean section births10,11; and

Whereas, While relative risk of uterine rupture is higher for women undergoing TOLAC than elective repeat cesarean deliveries (ERCD), the absolute risk remains low at 0.47%12; and

Whereas, There are no significantly different rates of hemorrhage, hysterectomy, or infection between women undergoing TOLAC versus ERCD12; and

Whereas, TOLAC is associated with lower risk of maternal mortality at 3.8 deaths per 100,000 deliveries than ERCD at 13.4 deaths per 100,000 deliveries, showing it to be a safe option for women with no contraindications13; and

Whereas, The American College of Obstetrics and Gynecology recommends TOLAC at hospitals that provide at least basic maternal care14,15; and

Whereas, TOLAC is a viable alternative to cesarean section that should be considered during the antepartum course of care and be part of the physician-patient decision process16; and

Whereas, Opinion 1.1.3 in the AMA Code of Medical Ethics states that choice in treatment allows patients control and autonomy over their healthcare decisions; and
Whereas, Hospital bans on TOLAC infringe on patient autonomy by preventing providers from respecting patient choice; and

Whereas, Hospital policies regarding TOLAC are not always easily accessible to patients; and

Whereas, Opinion 1.1.1 in the AMA Code of Medical Ethics supports shared decision making between patient and physician in order to help patients make informed decisions about their health care; therefore be it

RESOLVED, That our American Medical Association encourage hospitals that can provide basic maternal care as defined by the American College of Obstetrics and Gynecology not to prohibit trial of labor after cesarean (TOLAC) (New HOD Policy); and be it further

RESOLVED, That our AMA encourage hospitals that do not have resources to perform TOLAC to assist in the transfer of care of patients who desire TOLAC to a hospital that is equipped to perform TOLAC. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 10/12/22

References:

RELEVANT AMA POLICY

Code of Medical Ethics Opinion 1.1.1 Patient-Physician Relationships

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians’ ethical responsibility to place patients’ welfare above the physician’s own self-interest or obligations to others, to use sound medical judgment on patients’ behalf, and to advocate for their patients’ welfare.

A patient-physician relationship exists when a physician serves a patient’s medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited patient-physician relationship may be created without the patient’s (or surrogate’s) explicit agreement. Such circumstances include:
(a) When a physician provides emergency care or provides care at the request of the patient’s treating physician. In these circumstances, the patient’s (or surrogate’s) agreement to the relationship is implicit.
(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.
(c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.

AMA Principles of Medical Ethics: I,II,IV,VIII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

Code of Medical Ethics Opinion 1.1.3 Patient Rights

The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians, for example. Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients’ advocates and by respecting patients’ rights. These include the right:
(a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.
(b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician’s objective professional judgment.
(c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.
(d) To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.
(e) To have the physician and other staff respect the patient’s privacy and confidentiality.
(f) To obtain copies or summaries of their medical records.
(g) To obtain a second opinion.
(h) To be advised of any conflicts of interest their physician may have in respect to their care.
(i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without
AMA Principles of Medical Ethics: I, IV, V, VIII, IX

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Obstetrical Delivery in the Home or Outpatient Facility H-420.998

Our AMA (1) believes that obstetrical deliveries should be performed in properly licensed, accredited, equipped and staffed obstetrical units; (2) believes that obstetrical care should be provided by qualified and licensed personnel who function in an environment conducive to peer review; (3) believes that obstetrical facilities and their staff should recognize the wishes of women and their families within the bounds of sound obstetrical practice; and (4) encourages public education concerning the risks and benefits of various birth alternatives. Res. 23, A-78 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Shared Decision-Making H-373.997

Our AMA:
1. recognizes the formal shared decision-making process as having three core elements to help patients become active partners in their health care: (a) clinical information about health conditions, treatment options, and potential outcomes; (b) tools to help patients identify and articulate their values and priorities when choosing medical treatment options; and (c) structured guidance to help patients integrate clinical and values information to make an informed treatment choice;
2. supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions;
3. opposes any efforts to require the use of patient decision aids or shared decision-making processes as a condition of health insurance coverage or provider participation;
4. supports the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice;
5. supports efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures; and
6. will continue to study the concept of shared decision-making and report back to the House of Delegates regarding developments in this area.