TO THE EDITORS: The June 2021 issue of *American Obstetrics & Gynecology* reports the development of a modified algorithm (calculator) for the prediction of vaginal birth after cesarean (VBAC) delivery.1 The original calculator received criticism for the use of “race” (Black, Hispanic, neither) as a predictor of VBAC, producing a systematically lower likelihood of VBAC for non-White persons. When the scores are used to regulate access to labor after cesarean (LAC) delivery, the existing racial disparities are institutionalized rather than disrupted.

Eliminating the “non-White” variable is important, but it is unlikely to impact the racial disparities in cesarean delivery, LAC, or VBAC. The replacement variable “chronic hypertension requiring treatment” correlates well with race across age and gender. More importantly, the systematic disparities in the likely success are real. They were included in the algorithm, because they existed in the data used to develop both the calculators; they also had predictive power.

As measured by the receiver operator characteristic area under the curve, the new calculator is identical to the original (0.75%). The authors claim that the calibration of scores across deciles also demonstrates validity, but this is unclear. It is clear though that as the predicted success diminishes, so does the reliability and precision of the scores. As with the original calculator, scores below 40% are essentially meaningless. Yet, these are the patients most likely to be denied or discouraged LAC based on low scores. Given the similarities to the original calculator, we should expect that these patients are also more likely to be non-White, until shown otherwise.

We respect the authors who have worked for many years to make LAC more accessible. We appreciate their efforts to

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**REFERENCES**


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argue for a patient-centered and shared decision-making approach to options counseling. Yet, statements such as “Because...the chance of morbidity is highly related to VBAC probability, this estimation also can be informative regarding other important health outcomes” are problematic. This implies that the calculator scores are clinically useful and are statistically-valid estimators of morbidity. This is entirely different from the estimation of likely success. The literature is replete with references of making LAC safer by limiting candidacy based on the calculator scores.2 We have also documented this in a pilot survey of 1400 practicing midwives in the United States (though we did not quantify the extent of the practice). Although the safety profile for people with high scores is particularly reassuring,3 the risks to those with lower scores are ambiguous at best. To use such data to “inform other important outcomes” is not ethically or clinically justified for persons with low predicted success. We would ask the authors to clarify this for readers.

Studies linking the calculator scores to morbidity are based on small numbers and composites conflating death, hypoxic encephalopathy, and transfer to neonatal intensive care.3 We do not minimize the significance of neonatal intensive care unit (NICU) transfer, but nationwide, the most common reason for NICU admission is transient tachypnea of the newborn.4 Absolute risks and long-term outcome differences between elective repeat cesarean delivery and LAC are uncertain and likely very small. Much larger numbers of low-scoring candidates should be studied before these scores are used in advising or managing patients regarding the morbidity risk, especially Black and Hispanic persons who scored systematically lower than Whites on the original calculator. The sensitivity and specificity, positive predictive power for harms, and the numbers needed to treat should be thoroughly evaluated across the range of possible scores. If racial disparities continue to be predicted (which is likely), this should be critically investigated with an eye on whether individual or systems of care limitations are reflected.

We thank Dr Thornton and colleagues for their note regarding our recent article1 and appreciate their recognition of our interest in making labor after cesarean delivery more accessible and equitable. We know that their goals are the same. The question then, is how to achieve that end. It also is well-established that some individuals who labor with prior cesarean delivery will have a repeat cesarean delivery. It also is well-established that this chance is strongly related to the chance of morbidity and that knowledge about this chance is important for some individuals to make an informed decision about the approach to delivery that is most concordant with their own preferences.2,3 With these facts in mind, it seems reasonable that a tool, if it were to be reliable and have good calibration, that provides information as to the chance of having a vaginal birth after cesarean delivery, has potential value to individuals. As with any potential intervention (be it a decision tool, a pharmacologic intervention, or a medical device), it is important that the tool is used appropriately. We have never advocated that a “cutoff” be used to determine the eligibility for planned labor after cesarean delivery; quite