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Women's self-reported experience of unplanned caesarean section: Results of a Swedish study

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ABSTRACT

Background: women´s experience of emergency caesarean section is often described as less positive compared to a vaginal birth or a planned caesarean section. Midwifery care for women where deviations from a normal birth process are present is a challenge. The aim of study was to compare self-reported birth outcomes for women undergoing birth through spontaneous onset of labour between those who actually had a vaginal birth and those who eventually had an emergency caesarean section.
Design and setting: the study was part of a prospective longitudinal cohort study of parents' experiences, attitudes, and beliefs related to childbirth.
Method and findings: questionnaires were answered by 870 women in midpregnancy, two months postpartum and one year after birth. 766 women (88%) had a vaginal birth, and 104 (12%) had an emergency caesarean section. The most common indications of emergency caesarean section were dystocia, foetal distress, and malpresentation. Women in the emergency caesarean group were more likely to be primiparous (59.6%) and have a body mass index > 30 (10.7%). Childbirth fear was twice as common among these women, and they were more likely to have preferred a caesarean delivery when asked about birth preference in the middle of pregnancy (OR 3.7, Cl 1.8–7.5). Induction of labour (OR 2.5, Cl 1.6–4.0), the use of oxytocin for augmentation (OR 1.9, Cl 1.3–2.9), and the use of epidural as pain relief during labour (OR 5.6, Cl 3.6–8.7) were more common among women having an emergency caesarean section. Transport of the new-born to a neonatal intensive care unit was three times as common. More than a third (37%) of the women in the caesarean group preferred a caesarean section in case of another birth. Childbirth fear was more common one year after birth with 32% of these women describing their fear as moderate or strong (OR 3.6, CI 2.1–6.0).
Key conclusions: women undergoing emergency caesarean section are more likely to experience fear and to have a negative birth experience. It is essential for the midwife to promote a sense of control, involve the woman in the procedure, and create security in a threatening situation. This is made possible in relationship characterized by mutuality, trust, on-going dialogue, shared responsibility, and enduring presence.

Introduction

The importance of appropriate caesarean section to improve the health of mothers and infants with identifiable risk factors is unquestionable. Nevertheless, caesarean section (CS) carries a higher risk of maternal complications than vaginal birth. During the past two decades, the CS rates have risen above what is assumed to be optimal with respect to the well-being of the woman and the new-born (WHO, 1992; Villar et al., 2007). The Swedish CS rate has been stable since the mid-1990s and was 16.8% in 2014. The emergency CS accounted for 9.2% in the same year; elective CS was 7.6% (Swedish Pregnancy Register).

Several studies have reported that the rate of severe maternal morbidity was three to four times higher in CS than vaginal birth (Waterstone et al., 2001; Liu et al., 2007; Pallasmaa et al., 2008). Elective surgery has less morbidity to the mother but more to the neonate compared to emergency CS (Alexander et al., 2007; Van Dillen et al., 2010). Regardless of whether CS is performed as an elective or emergency surgery, maternal morbidity is related to post-surgical complications such as infections, haemorrhage and thrombotic events. The result of a Swedish case-control study revealed no differences in maternal outcome such as haemorrhage and infections. The groups were divided into those women who had a CS without recorded medical indication and women with emergency CS after a spontaneous onset of labour (Karlström et al., 2013). CS also affects the women's future reproductive life due to the risk of placental complications (Jackson et al., 2012) and uterine rupture (Lydon-Rochelle et al., 2001; Sturzenegger et al., 2016) in subsequent pregnancies and births. A

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large population based cohort study reported that a prior caesarean section is associated with a small increased rate of subsequent stillbirth and ectopic pregnancy (O'Neill et al., 2013).

An association between childbirth fear and emergency CS was described by Wijma et al. (2002). In a national sample, 7% of Swedish women had a negative birth experience related to emergency CS, induction, augmentation of labour and infant transfer to neonatal care (Waldenström et al., 2004). Other psychosocial implications of a caesarean birth include delayed breastfeeding, shorter period of breastfeeding and difficulties in maternal bonding with the new-born (Lobel and De Luca, 2007).

Women's experiences of emergency CS are of interest for midwives because unexpected complications during birth might affect the health and wellbeing of women. More knowledge about the consequences following an emergency CS can enhance midwife care during labour and birth. This study reports the experience of women who had an emergency CS. The aim of the study was to compare self-reported outcomes for women undergoing birth through spontaneous onset of labour between those who actually had a vaginal birth and those who eventually had an emergency caesarean section.

Methods

Design

This study was part of a prospective, longitudinal cohort study of parent's experiences, attitudes and beliefs related to childbirth. Previous papers from this project have been reported and details of the recruitment process are presented elsewhere (Hildingsson et al., 2010). The study was approved by the Regional Research and Ethics Committee at Umeå University, Sweden (Dnr 05–134 Ö).

Obstetric context

The Swedish midwife is independently responsible for women with normal pregnancies and births. Antenatal care is provided on a one to one basis from the same midwife throughout pregnancy. If complications occur, the midwife collaborates with an obstetrician. In the case of an emergency CS, the midwife prepares the woman for surgery and assists the obstetrician. In this region, the midwife cares for the mother in the postpartum ward during the immediate postoperative period. In case of serious postoperative complications, the woman is transferred to the intensive care unit. Continuity of midwifery care during pregnancy and birth is not available in the Swedish obstetric context. In this region the intention is to prioritize primiparous women giving birth. Continuous support given by the same midwife is mandated when the working load in the birthing suite allows one midwife to stay continuously with the woman.

Recruitment

Pregnant women undergoing a routine ultrasound at three hospitals in mid-Sweden were invited to participate in the study in 2007. This region includes three hospitals; one is a referral hospital with approximately 1600 births annually, and the other two are smaller hospitals with around 300–500 births. Only Swedish-speaking women with a normal ultrasound examination were approached. The midwife in charge of the ultrasound examination asked the women if they were willing to participate in the study. The women signed a consent form and were given the first questionnaire at the ultrasound ward. They could complete the questionnaire immediately after the examination and leave it in a sealed envelope. The women also had the opportunity to take the questionnaire home and return it in a stamped envelope. Two reminder letters were sent to non-responders after two and four weeks, respectively.

Data collection

The longitudinal survey consisted of four questionnaires: mid-pregnancy (gestation week 18–19), late pregnancy (gestational week 32–34), two months and one year after childbirth. Data from women with spontaneous onset of labour ending with vaginal birth or emergency caesarean section were used and collected from three questionnaires. In the first questionnaire, background data were used (age, civil status, and education, country of birth, tobacco use, parity). Women's self-rated childbirth fear was collected from this first questionnaire. The question regarding childbirth fear was: “Worries and fears are common feelings among women when facing childbirth. To what extent do you experience worry and fear at present?” The women answered using a four-point rating scale ranging from “a great deal” to “not at all.” In the analysis the variables were dichotomized into “a great deal/very much” and “somewhat/not at all.” Women in mid-pregnancy were also asked to indicate their preferred mode of birth determined by the question: “If you had the possibility to choose, how would you prefer to give birth to your baby?” The response alternatives were “vaginal birth” and “caesarean section.” The third questionnaire was completed two months after birth and included questions about self-assessed pregnancy complications, length of pregnancy, onset of labour (spontaneous/induction), method of pain relief, mode of delivery (vaginal birth/ emergency CS) and the women's birth experience. The birth experience was assessed on a five-point scale ranging from “very positive” to “very negative” two months after and again one year after giving birth. In the analysis, the variables were dichotomized into very positive/positive and less than positive. This dichotomization was based on the skewed nature of the data, with very few women reporting negative birth experiences.

The fourth questionnaire was only sent to women who had completed the first three questionnaires. One year after giving birth the question about childbirth fear was repeated and slightly rephrased: “Worries and fears are common feelings among women when facing childbirth. To what extent do you experience worry and fear when thinking of a future birth?” One year after giving birth the question about preferred mode of birth was repeated and slightly rephrased: “If you consider having more children, which mode of birth would you prefer?” and the option “I cannot think of having more children” was added.

The questionnaires included previously used questions from a national survey of Swedish-speaking women modified for the present study (Waldenström et al., 2004).

Analysis

Differences in the characteristics of women, birth outcome and experiences of labour and birth were calculated using odds ratios with 95% confidence intervals (Rothman, 2002). A P-value < 0.05 was interpreted as statistically significant. Statistical analyses were conducted using the Statistical Package for Social Sciences, SPSS, and version 17.0 (SPSS, Inc., Chicago, IL, USA).

Findings

There were approximately 2300 women eligible for the longitudinal survey. Those who were not fluent in Swedish were excluded as well as women with an abnormal ultrasound and those who moved from the area shortly after the examination or where the midwife in charge of the ultrasound examination forgot to ask about participation. There were 1506 women in mid-pregnancy who consented to participate, and 1212 (80%) returned the first questionnaire; the second questionnaire was completed by 1042 women (70%). Of the 936 women who completed the questionnaire two months after birth, 870 were selected for this study after excluding 64 who had a planned CS at the onset of labour. The sample corresponds to 57% of those who originally

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