Women and Birth xxx (2016) xxx–xxx

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi

ORIGINAL RESEARCH – QUALITATIVE

Caring for women wanting a vaginal birth after previous caesarean section: A qualitative study of the experiences of midwives and obstetricians

Maralyn Foureur [a], Sabera Turkmani [a], Danielle C. Clack [a], Deborah L. Davis [b,c], Lyndall Mollart [a], Bernadette Leiser [d], Caroline S.E. Homer [a,*]

[a] Centre for Midwifery, Child and Family Health, Faculty of Health, University of Technology Sydney, New South Wales, Australia
[b] University of Canberra, Australian Capital Territory (ACT), Australia
[c] The ACT Government, Health Directorate, Australia
[d] Central Coast Local Health District, Holden Street, Gosford, New South Wales, Australia

ARTICLE INFO

Article history:
Received 3 April 2016
Received in revised form 30 May 2016
Accepted 31 May 2016

Keywords:
Caesarean section, repeat
Caesarean section
Vaginal birth after caesarean
Midwifery
Obstetrics

ABSTRACT

Problem: One of the greatest contributors to the overall caesarean section rate is elective repeat caesarean section.
Background: Decisions around mode of birth are often complex for women and influenced by the views of the doctors and midwives who care for and counsel women. Women may be more likely to choose a repeat elective caesarean section (CS) if their health care providers lack skills and confidence in supporting vaginal birth after caesarean section (VBAC).
Aim: To explore the views and experiences of providers in caring for women considering VBAC, in particular the decision-making processes and the communication of risk and safety to women.
Methods: A descriptive interpretive method was utilised. Four focus groups with doctors and midwives were conducted.
Findings: The central themes were: 'developing trust', 'navigating the system' and 'optimising support'. The impact of past professional experiences; the critical importance of continuity of carer and positive relationships; the ability to weigh up risks versus benefits; and the language used were all important elements. The role of policy and guidelines on providing standardised care for women who had a previous CS was also highlighted.
Conclusion: Midwives and doctors in this study were positively oriented towards assisting and supporting women to attempt a VBAC. Care providers considered that women who have experienced a prior CS need access to midwifery continuity of care with a focus on support, information-sharing and effective communication.

Summary of relevance:

Problem

In many countries, the caesarean section (CS) rate is rising and shows little sign of reduction. One of the greatest contributors to the overall caesarean section rate is elective repeat caesarean section.

What is already known

Decisions around mode of birth are complex for women and influenced by the views and experiences of their doctors and midwives. Women may be more likely to choose a repeat elective caesarean section (CS) if their health care providers lack skills and confidence in supporting vaginal birth after caesarean section (VBAC).

What this paper adds

Midwives and doctors in this setting were generally positive towards supporting women to have access to VBAC. A number of

* Corresponding author at: Centre for Midwifery, Child and Family Health, Faculty of Health, University of Technology Sydney, PO Box 123, Broadway, New South Wales 2007, Australia. Tel.: +61 2 9514 4886.
E-mail address: caroline.homer@uts.edu.au (Caroline S.E. Homer).

http://dx.doi.org/10.1016/j.wombi.2016.05.011
1871-5192/

elements were seen as important to increase likelihood of success including access to midwifery continuity of care with a focus on support, information-sharing and effective communication.

1. Introduction

1.1. Background

Caesarean section (CS) operation is a lifesaving intervention in the presence of an obstetric emergency.[1,2] However, it is also associated with short and long term health risks for mother and baby and increases the economic burden on the health system.[2–5] As the risks of performing CS may be greater than its benefits,[6] it is only recommended for recognised clinical reasons.[5] In 1985, the World Health Organization (WHO) has suggested there are no additional advantages of CS above a rate of 10–15%.[7,8] While many countries have safely achieved this, others, including Australia show a rise in the rate of CS far above this figure.[1,2,5,9,10] One of the greatest contributors to the overall percentage of women having a CS is an elective repeat CS.[11,12]

As an alternative to elective repeat CS, women who have had an uncomplicated pregnancy can be offered a vaginal birth after a caesarean section (VBAC).[13] Many clinicians however are concerned about VBAC due to concerns about an increased risk of uterine rupture although these risks are low in absolute terms.[14] This has resulted in the rate of VBAC declining in many high and middle income countries[9,15–17] despite studies demonstrating no significant difference in the risk of uterine rupture between women experiencing VBAC and women without a prior CS.[14,18,19]

Decisions around mode of birth are complex and include an interplay between women's choices and health provider views, support from the health system, influences from the media and medico-legal concerns.[3,4,20–24] Previous research has shown that a lack of providers' skills and confidence as well as fear of liability and legal action were the main factors that influence whether a woman is offered a vaginal birth or a repeat CS.[3,4,25,26] Given that most women rely on their provider's recommendations regarding the mode of birth,[27] the provider's role in the process of decision making is likely to be a crucial influence. Equally, hospital guidelines play a role in determining the support of the local health services towards VBAC. Unfortunately, an analysis of guidelines has shown considerable inconsistency, making access to VBAC very limited in some hospitals.[20,28]

The way information is communicated to women is known to influence women's decision-making around childbirth.[26,27,29] Information provided by the media, family and friends has a significant influence on women's choice towards CS. For example, one Swedish study showed that it was difficult to change women's minds towards natural birth once they had decided to have an elective CS.[23] Therefore, the way clinicians communicate with women after the primary CS is also likely to be an important mediator in the decisions around the next birth.

Most studies in the area of VBAC are focused on clinical outcomes or perspectives from women; few have examined the experiences of the providers, which are likely to drive behaviour.[21,24] Therefore the aim of this study was to explore the views and experiences of providers in caring for women who would be eligible for a VBAC. In particular, we were interested in the maternity care providers' communication of risk to women, the influence of their experience on their practice, and their views about what hinders or helps women to achieve a VBAC.

2. Method

A descriptive interpretive method[30,31] was utilised to understand the experiences of health care providers in relation to the care of women who had a CS in a previous pregnancy. Focus group discussions were used as the primary approach to data collection. Ethical approval was gained from relevant health service and university Human Research Ethics Committees (1207-215M).

The study was conducted in a maternity unit in an outer metropolitan area of New South Wales (NSW), Australia. The hospital offers women access to VBAC and is fully staffed and equipped for care and monitoring in labour, emergency CS and neonatal resuscitation. It caters for over 2600 births annually,[32,33] and has an overall CS rate of 30%. The hospital is typical of many maternity units across the country.[33]

This maternity unit has a midwife whose employed role is to meet with all women who have experienced a prior CS in order to ensure all VBAC and/or elective CS options are explained so that women know what choices are available. Her role is well recognised with her attendance and reporting of VBAC rates regularly required at multidisciplinary unit meetings.

The study recruited a purposive sample of two professional groups involved in women's care at the hospital, specifically midwives and obstetricians. Information flyers were displayed in the staff common areas and an invitation letter was sent by internal mail to all obstetric medical staff and midwives providing antenatal and intrapartum care to women who had experienced a previous CS. This included midwives working in the medically-led antenatal clinic, the midwife-led antenatal clinic, the midwifery continuity of care and the birth unit.

Focus group discussions (FGD) were simulated initially through the use of the trigger question: 'can you tell us about your experience of caring for women who have had a previous CS?' The facilitators asked further probing questions to deepen the group's reflection and recall about the issue. Each person had an opportunity to speak, add to the conversation and build on or contradict one another's ideas.

Four FGDs with a total of 18 participants were conducted between March and September 2014 by one or two members of the research team (MF, ST). The facilitators were experienced research and clinical midwives who knew some of the participants professionally. One focus group comprised of three obstetricians and one midwife (FGD 1) and the others comprised of groups of five, six and three midwives (FGD2, FGD3 and FGD4 respectively). The FGDs were scheduled at the time of clinical handover to avoid any disruption in the provision of women's care.

Following consent, the FGDs were audio-recorded and transcribed. Data were analysed systematically using thematic analysis employed in five stages known as fundamental or generic qualitative description.[34,35] Each transcript was read several times by five individual research team members (MF, LM, BL, ST, DC) to familiarise with the content. The initial thematic analysis was conducted by manual coding based on the objectives of the study; identifying codes and grouping them into preliminary themes. Then, themes were grouped together to facilitate interpretation and data were summarised in charts with representative quotes to illustrate themes. To ensure consistency of the analysis, these themes and sub-themes were discussed and consensus among researchers was reached.[36,37]

3. Findings

Three central themes emerged from the analysis: 'developing trust', 'navigating the system', and 'optimising support'. Under each main theme, subthemes were identified. These are presented in the following section with illustrative quotations.

Please cite this article in press as: Foureur M, et al. Caring for women wanting a vaginal birth after previous caesarean section: A qualitative study of the experiences of midwives and obstetricians. Women Birth (2016), http://dx.doi.org/10.1016/j.wombi.2016.05.011