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Water VBAC: Exploring a new frontier for women's autonomy

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ABSTRACT

Background: although Vaginal Birth After Caesarean section (VBAC) has been promoted successfully as one means of reducing the caesarean section rate, the practice of VBAC using water immersion (Water VBAC) is restricted. Very little valid, reliable research evidence is available on this birth method, although initial small-scale audits indicate that Water VBAC has no adverse effect on maternal and neonatal outcomes.

Method: in-depth semi-structured interviews were carried out with a purposive sample of eight women who had undergone Water VBAC in one midwife-led unit. The interviews aimed to explore their reasons for requesting this birthing method, and their experience of the process. An interpretative phenomenological analytical approach was adopted.

Findings: the women pursued Water VBAC for two main reasons: in order to prevent a repeat of the obstetric events that previously led to a caesarean section, and to counteract their previous negative birth experiences. The women reported improved physical and psychological outcomes from their Water VBAC experience when compared with their previous experience of caesarean section. Three main themes emerged: 'minimising', 'maximising' and 'managing'. Water VBAC entailed an attempt to minimise the medicalisation of the women's childbirth experience. This was achieved by limiting medical staff input in favour of midwife-led care, which was believed to minimise negative physical and psychological experiences. Correspondingly, Water VBAC was perceived as maximising physical and psychological benefits, and as a means of allowing women to obtain choice and assert control over their labour and birth. The women planning a Water VBAC believed they had to manage the potential risks associated with Water VBAC, as well as manage the expectations and behaviour of friends, family and the health care professionals involved in their care.

Conclusions: for the women participating in this research, actively pursuing Water VBAC constituted a means of asserting their autonomy over the childbirth process. The value accorded to being able to exercise choice and control over their childbearing experience was high. These women's accounts indicated that information-giving and shared decision-making require improvement, and that inconsistencies in the attitudes of health care professionals need to be addressed.

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Introduction

Contemporary maternity care in the United Kingdom (UK) is heavily influenced by the debate around choice and women's autonomy. Although this topic is certainly not new, being 20 years since the seminal *Changing Childbirth* report (DoH, 1993), recent years have seen the debate evolve. For some, 'choice' is felt to be controlled and only offered within certain constraints (Levy, 2004), with a *Healthcare Commission* (2007) report finding that

many women reported choice to be limited. Nevertheless, some women with significant risk factors manage to exercise choice and autonomy even in the face of clinical opposition (Symon et al., 2010). There is legal support for this expression of autonomy: the landmark ruling in *Re MB* (1997) held that informed decision-making involved 'a reasoned choice made by a reasonable individual using relevant information about the advantages and disadvantages of all the possible courses of action, in accord with the individual's beliefs' (per Butler-Sloss, L.J.). The question of what is 'reasonable' is often framed against a backdrop of risk – another of the mantras of the modern age.

The debate about the applicability of risk factors is not new either – their poor predictive value was noted in the first edition of *Effective Care in Pregnancy and Childbirth* (Alexander and Keirse,

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1989) – but contemporary maternity care is largely organised on the premise that increasing risk factors will limit choice (Symon, 2006). Having a caesarean section (CS) usually indicates that a subsequent pregnancy will not be classified as ‘low risk’, thus restricting the birth choices available to the mother. These often include place of birth (Rogers et al., 2005), and sometimes mode of birth (Soltani and Sandall, 2012). In light of the potential risks of CS (as discussed below), particularly for the mother (RCOG, 2007; NICE, 2011), attempts have been made to reduce the CS rate which has increased in the UK from 9% in 1980 to over 24% in 2009 (Bragg et al., 2010).

An increasing number of women are challenging the restriction on their birth choices due to their risk label by requesting water birth as part of their right to Vaginal Birth After Caesarean Section (VBAC). However, the background to/circumstances of these requests, and the experience of the actual Water VBAC process, are unexplored areas. In order to set out the context of the women’s desire/wish for Water VBAC, we now briefly discuss the three central factors: VBAC, water birth, and Water VBAC.

VBAC

Part of the drive to reduce the overall CS rate has included promoting VBAC (Emmett et al., 2006). VBAC has been proven to produce better outcomes than repeat planned CS with regard to maternal mortality (RCOG, 2007; NICE, 2011), but it is associated with a slightly higher risk of intrapartum maternal morbidity (post partum haemorrhage [PPH], uterine scar dehiscence, uterine rupture, hysterectomy, blood transfusion and endometritis) compared with repeat elective CS (RCOG, 2007; NICE, 2011). However, these examples do not relate to longer term morbidity such as prolonged recovery time (NICE, 2011) and the risk of serious complications in future pregnancies (RCOG, 2007), which are both associated with CS.

Compared with repeat elective CS, neonatal morbidity – specifically respiratory problems (RCOG, 2007) and admission to the Neonatal Unit (NICE, 2011) – is improved with VBAC, but the neonatal mortality rate is slightly raised. VBAC is also associated with a reduced need for pharmacological analgesia and a shorter hospital stay for women (RCOG, 2007; NICE, 2011), as well as increased reported maternal satisfaction (Meddings et al., 2006), and a more positive impact on health care professionals (NICE, 2011).

Although the National Institute for Health and Clinical Excellence (NICE) guidelines maintain that women should not be deterred from undertaking VBAC as adverse outcomes associated with VBAC are extremely rare, they also recommend that VBAC is attempted only in a delivery unit with immediate access to CS and on-site blood transfusion services, and that continuous electronic fetal monitoring be performed throughout labour (NICE, 2011). These factors need to be addressed in any exploration of the experiences or motivations of women planning a Water VBAC.

Water birth

Water birth has become a popular option for labouring women in the last 20 years (Cluett and Burns, 2011). The Royal College of Midwives (RCM), Royal College of Obstetricians and Gynaecologists (RCOG) and NICE all advocate offering the use of a water pool to labouring women with uncomplicated pregnancies at term (RCOG/RCM, 2006; NICE, 2007). Labouring in water can reduce the need for pharmacological analgesia and reported maternal pain without adversely affecting labour duration, operative delivery rates or neonatal well-being (RCOG/RCM, 2006; NICE, 2007; Cluett and Burns, 2011). Immersion in water also increases women’s reported satisfaction with the second stage of labour,

and with the childbirth experience in general (Cluett and Burns, 2011). Although there are criticisms that water birth presents potential dangers to mother and infant, namely aspiration and infection, Young and Kruske (2013) observe that the empirical basis for these claims is often lacking. They note in addition that appropriate practice guidelines can help to avert such potential poor outcomes.

Water VBAC

Despite the attempts to reduce the CS rate by offering VBAC, and the now widespread use of water labour and water birth, the combination of VBAC and water birth is a step too far for some policy makers and practitioners. Such opposition comes regardless of an apparently growing demand for Water VBAC (Garland, 2006; Sellar, 2008). Correspondence with practitioners from a number of units confirms two principal reasons for this opposition: the need for continuous electronic fetal monitoring (EFM), and the need to site an intravenous cannula in view of the potential risk of PPH or transfer to Theatre due to uterine scar dehiscence/uterine rupture (various personal communications). Yet the recent availability of telemetry for EFM means that underwater continuous monitoring is now feasible, and an intravenous cannula can be secured safely, even in water. From the available (albeit limited) literature, it is clear that Water VBAC has indeed been offered in certain birth units, with some limited evidence from audits as to its efficacy.

Brown (1998) reports a clinical audit of birth outcomes in the English Midlands for 541 mainly low risk primigravid and multi-gravid women who laboured in water. She noted that 343 (63.4%) went on to give birth in the pool, of whom 10 had undergone previous CS. This audit reported several outcomes, including infection risks, perineal trauma, blood loss and maternal satisfaction. However, it did not analyse separately the outcomes for women attempting Water VBAC, simply noting that ‘all ten delivered in the pool with no adverse effect’ (Brown, 1998: 237).

Garland (2006: 217) reports a three-year audit of a risk assessment process intended to ascertain if it was ‘safe and realistic’ for suitable pre-selected women in a maternity unit in England to attempt Water VBAC. The article also outlines the care plan for Water VBAC, and presents data on mode of birth and use of analgesia. Of the 92 women who wanted Water VBAC, 80 were included in the audit, but only 15 women actually laboured in water, with just four experiencing water birth. The initially promising number of participants was thus reduced to a very limited sample size, and no comparison was made between the outcomes for these four women with the equivalent statistics for non-VBAC water births or VBACs without the use of water immersion.

Sellar’s (2008) audit of 26 women who experienced VBAC in a Scottish midwife-led unit (MLU) noted that 10 of these women had a water birth. The audit reported no adverse effect for these 10 cases in terms of neonatal morbidity (based on Apgar scores, infection rates and admissions to a Neonatal Unit), but its small scale and the fact that it provided no comparative statistics limit its impact. Sellar also reported an increase in maternal satisfaction levels among women who perceived themselves as being able to exercise choice and control over their labour and birth. However, resistance from senior management and medical staff was noted, meaning that Water VBAC was not routinely offered to antenatal women. For women to ‘opt in’, they must therefore have prior knowledge of this birth method.

Audits and empirical research are important in helping to establish whether practice is safe and acceptable in terms of clinical outcome, but the actual/lived experience of health care is much more than the reflection of clinical outcome variables, particularly because the offer of choice and control are integral

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