Midwifery 28 (2012) e900–e909

Contents lists available at SciVerse ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

'Off everyone's radar': Australian women's experiences of medically necessary elective caesarean section

Sara Bayes, Dip Nurs, PGDipMid, MMid, PhD, RN, RM (Research Fellow)[a,*], Jennifer Fenwick, BHlthSc(Ng), MNgSt, PhD, RN, RM (Professor of Midwifery)[b], Yvonne Hauck, BScN, MSc, PhD, RN, RM (Professor of Midwifery)[c]

[a] Nottingham University Business School Collaboration for Leadership in Applied Health Research and Care – Lincolnshire, Nottinghamshire and Derbyshire (CLAHRC-NDL), Jubilee Campus, Triumph Road, Nottingham NG8 1BB, UK
[b] Griffith University & Gold Coast Hospital, Logan Campus, University Drive, Meadowbrook, Queensland 4131, Australia
[c] Curtin University and King Edward Memorial Hospital, Curtin Health Innovation Research Institute, GPO Box U1987, Perth 6845, Western Australia

ARTICLE INFO

Article history:
Received 11 October 2011
Received in revised form
3 January 2012
Accepted 7 January 2012

Keywords:
Caesarean section
Qualitative research
Women's experiences
Grounded theory

ABSTRACT

Introduction: despite an exponential rise in the number of medically initiated elective caesarean sections over the last two decades, women's experiences of this birth mode remain largely unknown. The aim of this study was to address this gap by describing women's experiences of medically necessary elective caesarean section.
Methods: a grounded theory approach was used to collect and analyse interview data collected from 28 Australian women who had an elective caesarean section for a medical reason, 14 of whom were also observed during their caesarean section. The analyses of the non-participant observations were used to contextualise the women's experiences.
Findings: prior to having their baby, women expected to play an active part in their caesarean section and to be supported to take up their 'mother' role as soon as their baby was delivered. Postnatally however, they reported having felt invisible, superfluous and disregarded during the event. There was evidence that hospital routines and processes contributed to women feeling displaced and unimportant in their baby's birth. Three sub-categories were formed from the analysis of the data that together are represented by the in-vivo label 'off everyone's radar'. These were 'just another case on an operating list', 'striving to be included while trying to behave' and 'unable to be my baby's mum'.
Discussion: our findings suggest that when women are ignored during childbirth, any fear they hold may escalate into peritraumatic disassociation, which in turn has implications for women's postnatal mental and emotional health in the short and long term. In addition, the separation of the mother–baby dyad was found to have a devastating impact on maternal–newborn attachment that lasted well into the postnatal period. To optimise women's childbirth satisfaction and foster their attachment to their baby, both of which are essential for ongoing emotional well-being, it is vital that they are located at the centre of their birth experience and that if at all possible they are not separated from their newborn.

Introduction

Childbearing represents a seminal event in women's lives, and research suggests that most women expect and/or want to give birth naturally (Fenwick et al., 2005). Despite this, caesarean section now accounts for one quarter to one third of births in many developed countries. From a rate of around just two per cent in the 1950s (Birth Choice UK Professional, 2009) the incidence of caesarean section across the world's most developed countries, where childbearing women are now arguably the healthiest they have ever been, has grown exponentially. In the most recently available perinatal statistics reports for the United States of America, Australia, Canada and the United Kingdom, for example, the incidence is cited to be 26.8–32.3% (Laws et al., 2010; Birth Choice UK, 2011; Canadian Institute for Health Information, 2011; March of Dimes Perinatal Data Centre, 2011). This is despite the World Health Organization's view that there is no need for any more than 15% of births in any geographical region to be by caesarean section, pending evidence that higher levels benefit either mothers or babies (Joint Interregional Conference on Appropriate Technology for Birth, 1985).

* Corresponding author.
E-mail addresses: sara.bayes@nottingham.ac.uk, s.bayes@curtin.edu.au (S. Bayes), j.fenwick@griffith.edu.au (J. Fenwick), y.hauck@curtin.edu.au (Y. Hauck).

0266-6138/$ - see front matter © 2012 Elsevier Ltd. All rights reserved.
doi:10.1016/j.midw.2012.01.004

In addition to a predominant assumption that birth will be natural, evidence suggests that women carry a set of additional expectations with them into childbearing. Among these are a presumption that that they will be acknowledged as the central 'actor', will feel valued, be given information, feel supported to actively participate and be in control during the event (Green et al., 1990; Gibbins and Thomson, 2001; Kao et al., 2004; Fenwick et al., 2005; Hauck et al., 2007). It is unsurprising therefore that loss of centrality and control feature heavily in women's childbirth fears (Fenwick et al., 2010) and are often cited as a key determinants of women's disappointment with all modes of childbirth (Heaman et al., 1992).

In the main, research concerning women's expectations and experiences of childbirth has focused on the adverse consequences for women's mental and emotional health of childbirth interventions that were not anticipated and which engendered loss of control; this work has predominantly documented the experience of women who experienced intervention such as non-elective caesarean section during the course of labour and/or vaginal birth (Menage, 1993; Creedy, 1999; Creedy et al., 2000; Koo et al., 2003; Somera et al., 2010). On the contrary, the research and discourse surrounding elective caesarean section over the last 15 years or so has been concerned with issues and debate related to the steady rise in the incidence of the procedure; discussion around women's right to choose the procedure in the absence of a medical indication – the so-called 'maternal request caesarean section' – has also featured increasingly over this time (Wax et al., 2004; Turner et al., 2008; Klein and McDowl, 2010). The childbirth expectations and experiences of women who have no choice but to undergo an elective caesarean section for a medical reason, however, although alluded to in previous research (see for example Schindl et al., 2003; Stadlmayr et al., 2004; Keogh et al., 2005), have yet to be explicitly described. The primary aim of this study therefore was to explore and explain women's experience of the day they give birth by medically necessary caesarean section that was scheduled during pregnancy.

Methods

Design

This qualitative study was conducted using a grounded theory approach (Glaser and Strauss, 1967) in order to conceptualise the meaning of the participants' experience and behaviour (Sidani and Sechrest, 1996). Ethical approval to conduct the study was obtained from the human research ethics committee of the hospital where the study was conducted, and from Curtin University, Perth, Western Australia.

Setting, sample and recruitment

The setting for this study, conducted between October 2006 and March 2008, was an Australian tertiary ('all risk') maternity hospital. At the time the study was undertaken, approximately 5,500 women gave birth at the hospital every year. On average there were 34 elective caesarean sections performed at term per month.

Two forms of sampling were utilised in this study. Firstly, purposive sampling was employed. This is a non-probability sampling method in which the researcher selects any participants within that exposure (Polit and Beck, 2006). As data analysis progressed and saturation of the emergent categories was reached (after interviews with 12 women), theoretical sampling was then used in order to further refine and confirm the emerging theory. Examples of theoretically sampled informants include woman of different cultural backgrounds to, or whose caesarean section was booked for a different reason than, those already interviewed. Women were eligible to participate if they spoke English, were over 18 years of age and were required to have a first elective caesarean for medical reasons.

Posters about the study were placed in the antenatal clinics and antenatal education areas. Women who were booked to have a caesarean section for medical reasons were also identified by clinic staff and followed up by the first author whereupon an information sheet was provided. Women were given an opportunity to ask questions and seek clarification. Those willing to participate provided signed consent to be interviewed. Women were also asked if they would consent to being observed while undergoing their caesarean section.

Data collection

Data sets included semi-structured interviews with women and non-participant observations of the operating room during elective caesarean sections. Field notes were also recorded before and after each interview and each observed birth.

Interviews with women

Semi-structured interviews were conducted with each participant woman 10–14 weeks after birth. Consent to participate was reaffirmed at the start of the interview, after which women were asked to describe and reflect upon their experience of elective caesarean section and how closely it reflected their expectations. All interviews (average length 1 hr 53 mins) were digitally recorded and transcribed verbatim.

Non-participant observations of the operating theatre during elective caesarean section

Non-participant observations of women during their time in the operating room were primarily collected for the purpose of data triangulation (that is, to confirm and further illuminate the women's experience as described in their interviews); they were also used as part of the iterative process in that they served to inform subesequent interviews with women. All women who consented to it were observed during their caesarean section, and were visited in their hospital room on the morning of the procedure by the first author for their consent to be reaffirmed. Once in the operating room, the researcher stood behind and to the right of the operating table, out of the woman's and the surgical team's view. At intervals of 5 mins observational records and drawings were made that recorded women's behaviour and interactions in this environment. All operating theatre staff involved in the woman's birth experiences consented to the study.

Data analysis

Analysis of data occurred concurrently with data collection. Data obtained from women's interviews were analysed through the 'constant comparison' cycle of data coding and categorisation associated with the grounded theory methodology (Glaser and Strauss, 1967). Each interview was transcribed and 'first level' coded – that is, a code, or label, was ascribed to each meaningful statement – by the first author within 24 hrs. Codes that were alike were then grouped together and given a working label in the subsequent days. As new raw data became available, they were compared to the previously formed groupings, which were then refined to reflect the essence of all women's experiences. Once it became apparent that no new information was being received