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Swedish caregivers' attitudes towards caesarean section on maternal request

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Summary
Background: Caesarean section (CS) is not an option that women in Sweden can chose themselves, although the rise in CS rate has been attributed to women. This study describes obstetricians' and midwives' attitudes towards CS on maternal request.
Methods: A qualitative descriptive study, with content analysis of 5 focus group discussions where 16 midwives and 9 obstetricians participated.
Results: The overarching theme was identified as "Caesarean section on maternal request—a balance between resistance and respect". On the one hand, CS was viewed as a risky project; on the other hand, request for a CS was understood and respected when women had had a previous traumatic birth experience. Still, a CS was not really seen as a solution for childbirth related fear. Five categories were related to the theme. Overall, our findings indicate that caregivers blamed the women for the increase, they considered the management of CS on maternal request difficult, and they suggested preventive methods to reduce CS and means to strengthen their professional roles.
Key conclusions and implication for practice: Both midwives and obstetricians considered the management of CS on maternal request difficult, and the result showed that they balanced between resistance and respect. The result also showed that the participants stressed the importance of professionals advocating natural birth with evidence-based knowledge and methods to prevent maternal requests. Ongoing discussions among health professionals on attitudes and practice would strengthen their professional roles and lead to a decrease in CS rates in Sweden.

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The caesarean section (CS) rate in Sweden was 17.7% in 2006, with regional variations between 11 and 27%.[1] For term pregnancies, the percentage increased from 9.2% in 1990 to 16.4% in 2006.[1] The increase has to some extent been explained by changes in the pregnant population, such as the increase in Body Mass Index, higher maternal age at first baby and lower parity (more primiparas).[2] Similar results have been showed by Joseph et al.[3] where the increase in primary caesarean rate was explained by changes in maternal characteristics like age, parity, weight and obstetric practice. The highest increase in CS in Sweden has been among full term pregnancies with singleton babies in vertex position[2,4] and in this group the increase was 50% during the years 1990–2001.[2]

Another rationale for the increasing CS rate, given much publicity in both the lay and medical press, is women's request for CS in the absence of clinical indication. International estimates on maternal request range from 4 to 18% of all CS[5] but these figures have been questioned.[6] Recent research has shown that the numbers of women requesting a CS are small.[7,8] However, in the Swedish Medical Birth Register, CS on maternal request has no explicit diagnosis, but is covered in the diagnose code for CS on psychosocial indication. Psychosocial indication was the diagnose code that increased the most from 1990 to 2001[2] suggesting that women's preferences do have an impact on the CS rates in Sweden. In a national Swedish cohort, 3061 women were asked in early pregnancy about their preferences regarding mode of delivery.[9] Eight percent of these women preferred to have a caesarean section, but among first time mothers and women with previous vaginal births the prevalence was lower, 3–4%. The strongest risk factors for the preference were fear of giving birth and previous caesarean sections.[9] This is supported by Weaver et al.[8] who reported psychological issues such as women's fear of giving birth and concerns about the safety of the baby as factors behind request for CS.

In addition to reports of prevalence and causes of the rise in CS on maternal request, caregivers attitudes are assumed to have an impact on the way women's requests are met. Previous research has shown that obstetricians offer several explanations for why women's inquiries about CS are rising. Bettes et al.[10] reported that obstetricians-gynaecologists perceived an increase in patients' inquiries regarding caesarean births attributed to the information of the media and to convenience. In a Swedish survey, 41% of the responses from 166 obstetricians and 69 midwives attributed the rising CS rate to factors related to the woman herself.[11] Another Swedish study reported that experienced (>10 years) obstetricians had a more positive attitude towards performing CS and were more likely to view CS as a safe alternative compared to younger and less experienced doctors.[12] Habiba et al.[13] concluded that obstetricians attitudes in European countries are influenced by cultural factors, legal liability and variables linked to the specific perinatal care organization.

It is likely that the attitudes and beliefs of the caregivers will affect the way women's request for caesarean birth is received and handled. Thus, it is important to elucidate the views of obstetricians and midwives' attitudes about caesarean section on maternal request.

The context of Swedish maternity care

Antenatal care in Sweden is organized within the public primary health care system with the midwife as the primary caregiver, taking care of all pregnant women in a certain geographical area during pregnancy. Care during labour, birth and the postnatal period occurs in hospitals with midwives as the independent caregiver for uncomplicated cases. Midwives work in collaboration with obstetricians if complications occur. There are no alternative birth settings in Sweden and continuity of caregiver between episodes of care is rare. Formally, caesarean section is not an option women can choose themselves. The obstetrician has to be convinced about the need to perform surgery without a medical indication. The majority of obstetric departments in hospitals have established qualified teams who provide support for women who suffer from childbirth related fear. If a woman wishes to have a CS she is referred to such a team before she meets the obstetrician for the final decision.

Method

Participants

The study used a purposive sample of midwives and obstetricians from three county hospitals and antenatal clinics in the middle of Sweden. Sixteen midwives (all women) and nine obstetricians (five women and four men) participated in five focus group discussions (FGDs) with four to six participants in each group. A focus group is an organized discussion with a group of individuals to gain information about their views and experiences of a topic presented to them in advance.[14,15] Focus groups are often used to examine people's experience of health care and to investigate the attitudes and needs of caregivers.[16] In order to get a range of variation, the focus groups differed in composition: two groups were composed of both obstetricians and midwives, one focus group included obstetricians only, and two groups midwives only. The intention was to study attitudes in a professional group co-working in the clinical practice, not to study differences in attitudes between groups of professionals (midwives and obstetricians). Five groups were chosen to be relevant based on results from previous focus groups studies.[16] The first author was moderator and an observer (last author) took detailed notes. The opening question was worded "Please tell us about your opinion regarding the rise in CS on maternal request". The discussions proceeded for 1.5–2 h and were open and lively. The observer provided a brief summary of each group discussion at the end of the session and the participants confirmed that the discussion was correctly understood. All focus group discussions were audiotaped.

Data analysis

The first author transcribed the FGDs verbatim. Each interview was read through several times to gain a sense of meaning, focusing on the manifest content. All significant