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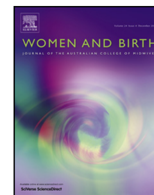

Original Research - Qualitative

Seeking control in the midst of uncertainty: Women's experiences of choosing mode of birth after caesarean

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ABSTRACT

Problem: Clinical practice guidelines indicate that over 80% of women with a previous caesarean should be offered a planned vaginal birth after caesarean (VBAC), however only one third of eligible women choose to plan a VBAC. To support informed choices for birth after caesarean, it is necessary to understand the factors that influence women's decision-making.
Aim: The goal of this study was to explore attitudes towards and experiences with decision-making for mode of delivery after caesarean from the perspectives of Canadian women.
Methods: In-depth, semi-structured interviews were conducted with 23 women eligible for VBAC in three rural and two urban communities in British Columbia, Canada, during summer 2015. Constructivist grounded theory informed iterative data collection and analysis.
Findings: Women's decision-making experiences were a process of "seeking control in the midst of uncertainty." Women formed early preferences for mode of delivery after their primary caesareans and engaged in careful deliberation during their inter-pregnancy interval, consisting of: reflecting on their birth, clarifying their values, becoming informed, considering the feasibility of options, deliberating with the care team, and making an actual choice. Women struggled to make trade-offs between having a healthy baby and social attributes of delivery, such as uninterrupted bonding with their newborn.
Conclusions: Women begin decision-making for birth after caesarean earlier than previously reported and their choices are influenced by personal experience and psychosocial concerns. Future interventions to support choice of mode of delivery should begin early after the primary caesarean, to reflect when women begin to form preferences.
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Statement of Significance

Problem or issue

Only one third of eligible women choose to plan a vaginal birth after caesarean (VBAC).

What is already known

Bonding with one's newborn and psychological health are key factors in women's choices for mode of birth.

What this paper adds

Women formed a preference for mode of birth immediately after the first caesarean. Decision support from clinicians did not address their concerns for newborn bonding or psychological health. Women would benefit from early decision support after the primary caesarean. This support should include discussion of women's values and first caesarean experience.

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1. Introduction

The caesarean section rate has risen steadily worldwide since the 1990s. One key reason for this trend is an increase in repeat caesareans, which account for one-third of all caesareans in most high-income countries.[1] Caesarean sections expose mothers and newborns to excess risk of morbidity and mortality, including uterine rupture, hysterectomy, operative injury, puerperal fever, and newborn respiratory problems.[2,3] Consequently, clinical practice guidelines recommend that eligible women be offered a vaginal birth after caesarean (VBAC).[3–5] In Canada, where this recommendation was first published by the Society of Obstetricians and Gynecologists of Canada (SOGC) in 2005,[3] the repeat caesarean rate has continued to rise, demonstrating a clear gap between best evidence and practice. Canadian caesarean rates are highest in the westernmost province of British Columbia (BC).[6] In 2012–13, 82% of women with a previous caesarean were eligible to attempt a VBAC; however, only 33% of these women attempted a vaginal birth.[7] Among those women who did attempt a VBAC, 71% had a vaginal birth as planned.[7] These rates suggest that the dissemination of best evidence does not guarantee that women will be supported to make informed choices for birth after caesarean.

In response to this evidence-to-practice gap, there has been rapid development of shared decision-making (SDM) interventions to support women making the choice for mode of birth after caesarean.[8] SDM is a model of decision-making in which care providers give information on clinical risks and benefits to the woman, support her to gain clarity about her values, listen to her personal health goals and how these align with standards of care, and engage with the woman to make a shared decision for mode of birth.[9] Women who are informed of the risks of repeat caesareans may be more likely to prefer planned VBAC, which would in turn lead to a decrease in caesarean rates and adverse outcomes.[10] SDM interventions include patient resources (e.g. decision aids, pamphlets, websites, or videos), interactive decision coaching approaches, and skills training for care providers. The study of SDM interventions has been dominated by effectiveness studies focused on the quality of the decision-making *process*.[9] Randomized controlled trials of SDM interventions for birth after caesarean have been associated with a significant increase in women's knowledge of the clinical risks and benefits of mode of birth.[8,9]

However SDM interventions for mode of birth have been difficult to implement in routine practice. In Horey et al.'s meta-analysis of three randomized controlled trials involving SDM support for mode of birth after a caesarean (n = 2270 women; high-income countries), the authors found no difference in the proportion of women who achieved a match between their preferred and actual mode of birth (RR 1.02, 95% CI 0.96–1.07, n = 1921 women), suggesting that contextual factors mediated the effectiveness of the interventions.[8] Previous qualitative studies have observed that women's attitudes towards and experiences with mode of birth vary by health service resources, care provider type, and culture. A systematic review and meta-analysis of 38 international quantitative studies involving 19,403 women found that women in North America express a greater preference for elective repeat caesarean (21.3%; 95% CI 16.4–26.7) in comparison to women from Australia (13.8%; 95% CI 2.0–33.6) and high-income countries in Europe (11.0%; 95% CI 7.6–15.0). Emerging research suggests that clinical relationships and care provider preferences,[11] hospital levels of services,[12] and the availability of in-house anaesthesia[13] also may be associated with variation in caesarean section rates.

In order to implement SDM for birth after caesarean in Canada, it is necessary to develop an understanding of "local evidence" including different stakeholders' attitudes and experiences with birth after caesarean, and the health services and policy context in which decision-making takes place.[14] To that end, the aim of this study was to understand the factors that support or impede SDM for birth after caesarean in British Columbia. This paper presents findings from interviews with women who had a history of caesarean; findings from analysis of interviews with care providers and decision maker stakeholders are presented elsewhere.

2. Participants, ethics, and methods

2.1. Research design

This study employed a qualitative design informed by constructivist grounded theory[15] and was conducted in partnership with knowledge users in the British Columbia Optimal Birth Fraser Health Task Force, a multidisciplinary group of clinicians and health service decision makers mandated to increase women's access to vaginal birth. Knowledge users are individuals who are "likely to be able to use the knowledge generated through research in order to make informed decisions about health policies, programs and/or practices."[16] These partners provided input in developing the study design and interpretation of data to ensure that the study results would be relevant to the needs of knowledge users in the BC health care system, and to increase the likelihood that clinicians and service decision makers would accept and trust the findings. Ethical approval was sought and obtained from the UBC Behavioural Research Ethics Board and the ethics boards of Northern and Fraser Health Authorities. The funding organisations that provided financial support for the study had no role in the collection of data, its analysis and interpretation, or in the right to approve or disapprove publication of the finished manuscript.

2.2. Setting and participants

A purposive sample of communities in British Columbia, Canada, was selected. Each "community" was defined as the population catchment residing within 2 h travel time of a hospital facility with obstetrical services that support planned VBAC.[3] In our choice of communities we sought diversity in annual numbers of births, annual VBAC rate, the type of surgeon who provided local caesarean section (obstetrician, general surgeon, or general practitioner with enhanced surgical skills [GPESS]), and geography (rural, semi-urban, and urban sites). We identified the initial sample of communities and, following feedback from our stakeholder partners, we included an additional criterion: on-call vs. in-house access to obstetric and anaesthesia services for caesarean section.

Participants included English-speaking women of childbearing age (18–45 years old), who had given birth by caesarean, were considering a future pregnancy, were eligible for VBAC birth based on the Canadian clinical practice guidelines,[3] and who resided in one of the purposively sampled communities. Recruitment occurred through three methods: (a) third-party recruitment by maternity clinic staff, public health nurses, and leaders of community-based perinatal health programs; (b) poster advertisement in community settings and antenatal clinics; and (c) "snowball" sampling whereby participants shared the study information with potentially eligible women in their social networks and interested women then contacted the study team by email. Recruitment continued until categories suggested by the data demonstrated "theoretical sufficiency," that is, "when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories."[15, p. 113] All participants who met eligibility criteria and agreed to participate engaged in an interview; none declined to participate.

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