

# A Case Study of Maternal Response to the Implied Antepartum Diagnosis of Inevitable Labor Dystocia

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## Keywords

advocacy  
birth center  
birth choice  
cesarean  
natural birth  
informed consumer  
nurse-midwife  
vaginal birth

## ABSTRACT

Two pregnant women, one obese and one of extremely small stature, received antepartum recommendations from their health care providers to schedule cesarean births. In response, both women sought providers who would support their desire to attempt vaginal birth. The women's perspectives on their birth experiences along with the pertinent medical record data from their pregnancies and births provide a reminder about the inherent normalcy of birth amid the current culture of interventive obstetrical practices.

JOGNN, 42, 138-147; 2013. DOI: 10.1111/1552-6909.12005

Accepted September 2012

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Despite the apparent growing acceptance of cesarean birth without medical indication, many women still consider vaginal delivery the preferred method of childbirth. The purpose of this article is to expand the dialogue regarding the impact that informed obstetric consumers can have upon their own health care outcomes. Two women, one with a body mass index (BMI) of 38.3 and one of extremely small stature, received antenatal recommendations for cesareans from their hospital-based health care providers (one an obstetrician, the other a certified nurse-midwife), solely because of their physical sizes. The women interpreted these recommendations as premature pronouncements of their inability to birth vaginally. Both women transferred to new providers who agreed to support their desires for vaginal birth. The unique combination of the clinical case study model coupled with the narrative case study approach reveals the actual data from maternal-newborn health records as well as the women's perspectives on their decisions to pursue vaginal birth.

## Background and Significance

According to 2011 *National Vital Statistic Reports*, the average rate of cesarean births in the United States for 2009 was 32.9% (Martin et al., 2011). This figure represents an almost 60% increase in national cesarean rates since the most recent low in 1996 (Martin et al.). According to the *National Vital Statistic Reports* the repeat cesarean delivery rate was nearly 90% in 2003 (Menacker, 2005). Today surgical delivery is viewed by many health care professionals and consumers as a desirable option (Hewer, Boschma, & Hall, 2009; McAra-Couper, Jones, & Smythe, 2010).

Increasing cesarean rates and the emerging sociocultural acceptance of surgical birth have influenced research and created controversy. Cesareans were formerly reserved only for select high-risk maternal/fetal dyads and failed attempts at vaginal birth (Sewell, 1993). However in the 1990s the term *elective cesarean* began appearing in the medical literature with some regularity. Popular media began devoting significant

The author reports no conflict of interest or relevant financial relationships.



attention to this new concept of cesarean by maternal choice. Yet Childbirth Connection's Listening to Mothers II survey indicated that out of nearly 1,600 women, only one reported that despite lack of obstetric/medical complications, she requested a scheduled cesarean birth (Declercq, Sakala, Corry, & Applebaum, 2007). Meanwhile the American College of Obstetricians and Gynecologists (ACOG; 2007) estimated that 2.5% of all cesareans could be attributed to maternal request. Adams, Hirsch, Macgregor, Kirschner, and Silver (2010) contended that although the actual numbers of cesarean deliveries by maternal request (CDMR) are thought to be quite low, it is the mere recognition of CDMR as an acceptable paradigm in obstetrics that heralds the demise of long-held psychological barriers to cesarean delivery: "If a physician elects a cesarean delivery for no indication, why hesitate when there is an unequivocal indication?" (Adams et al., p. 36). Maternal habitus and stature are exemplars of such equivocal indications.

Experienced labor and delivery nurses know that the likelihood for complications and intervention increases for either very large or very small women. Indeed the literature is replete with examples of how disparities in maternal habitus heighten the chances of complications of labor and delivery and subsequently cesareans (Barau et al., 2006; Benjamin, Daniel, Kamath, & Ramkumar, 2012; Bergholt, Lim, Jorgenson, & Robson, 2007; Bohlman et al., 2010; Fyfe et al., 2011). Nevertheless there is insufficient evidence to recommend planned cesarean delivery in the instance of maternal obesity. Instead health care providers should evaluate potential risk factors according to the individual woman's unique case (Homer, Kurinczuk, Spark, Brocklehurst, & Knight, 2011).

The following two case studies clearly illustrate that neither small stature nor obesity alone should relegate a pregnant woman to scheduled prelabor surgical birth. The primary purposes of this article are to inspire frank conversations among nurses regarding the rising cesarean rate, to incite nurses to become involved in maternal/fetal advocacy and education efforts, and ultimately to provide foundation for future research into the topic of interventional obstetric practices.

## Review of Literature

### Maternal/Fetal Health Consequences of Cesarean Birth

The obvious question and arguably the most crucial one involves the safety of cesarean for the

### Health care provider practice patterns influence the timing and mode of delivery and maternal and neonatal outcomes.

low-risk mother and her newborn in comparison to vaginal birth. As the number of cesareans rises, concern about short- and long-term maternal/fetal complications grows (Clark & Silver, 2011). The surging primary cesarean rate and the accompanying declining vaginal birth after cesarean (VBAC) rate of less than 10% (MacDorman, Menacker, & Declercq, 2008) demonstrated that for women with a primary cesarean who desire more than one infant, repeat surgical birth is to be anticipated.

Mounting evidence suggests that maternal/fetal risks increase with every subsequent cesarean birth. Repeat surgical birth has been linked to a variety of maternal complications, including but not limited to adhesions, bladder injury, hysterectomy, infection, and infertility (Adams et al., 2010; Lyell, 2011). The risk of abnormal placentation increases with each subsequent cesarean and has been linked to serious complications such as hemorrhage, hysterectomy, and maternal death (Bauer & Bonano, 2009; Boutsikou & Malamitsi-Puchner, 2011; Clark & Silver, 2011; Yang et al., 2007).

Mothers do not incur the increased risks of cesarean in isolation. Neonates have demonstrated increased incidence of persistent pulmonary hypertension (Winovitch, Pakilla, Ghamsary, Lagrew, & Wing, 2011), respiratory morbidity, special care admissions, and mortality (De Luca, Boulvain, Irion, Berner, & Pfister, 2009). Long-term potential risks of cesarean for the newborn include breastfeeding difficulties (Zanardo et al., 2010) and increased likelihood of developing asthma and Type I diabetes (Steer & Modi, 2009). Large cohort studies over the past decade have produced conflicting evidence regarding the relationship of repeat cesareans to stillbirths and highlight the need for more investigation of this potentially devastating outcome (Clark & Silver, 2011).

### Practice Patterns

Factors that influence the increasing rates of surgical birth are of paramount interest to maternal/fetal researchers. Declercq, Menacker, and MacDorman (2006) conducted a large secondary analysis of a decade of birth certificate data to explore factors contributing to the rising rate of primary cesareans. After controlling for a wide variety of potential risk factors such as maternal

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