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Fear, blame and transparency: Obstetric caregivers' rationales for high caesarean section rates in a low-resource setting

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ABSTRACT

In recent decades, there has been growing attention to the overuse of caesarean section (CS) globally. In light of a high CS rate at a university hospital in Tanzania, we aimed to explore obstetric caregivers' rationales for their hospital's CS rate to identify factors that might cause CS overuse. After participant observations, we performed 22 semi-structured individual in-depth interviews and 2 focus group discussions with 5–6 caregivers in each. Respondents were consultants, specialists, residents, and midwives. The study relied on a framework of naturalistic inquiry and we analyzed data using thematic analysis. As a conceptual framework, we situated our findings in the discussion of how transparency and auditing can induce behavioral change and have unintended effects. Caregivers had divergent opinions on whether the hospital's CS rate was a problem or not, but most thought that there was an overuse of CS. All caregivers rationalized the high CS rate by referring to circumstances outside their control. In private practice, some stated they were affected by the economic compensation for CS, while others argued that unnecessary CSs were due to maternal demand. Residents often missed support from their senior colleagues when making decisions, and felt that midwives pushed them to perform CSs. Many caregivers stated that their fear of blame from colleagues and management in case of poor outcomes made them advocate for, or perform, CSs on doubtful indications. In order to lower CS rates, caregivers must acknowledge their roles as decision-makers, and strive to minimize unnecessary CSs. Although auditing and transparency are important to improve patient safety, they must be used with sensitivity regarding any unintended or counterproductive effects they might have.

1. Introduction

In recent decades, caesarean section (CS) rates have risen globally (Betrán et al., 2007). As a result, there has been growing attention to the under- and over-use of CSs within different settings and the problems unnecessary CSs might cause (Althabe and Belizán, 2006). Unnecessary CSs can put strains on both institutional and individual resources and threaten health equity in low- and middle-income countries (Gibbons et al., 2012). CS performed on non-medical indications in low-resource settings is associated with higher maternal risks than vaginal delivery (Souza et al., 2010) and the CS scar can cause problems in subsequent pregnancies (Silver, 2012). CS might also have psychological implications for the mother, with slower recovery, more time away from her family, and increased pain (Wendland, 2007).

Although there has been a media rhetoric of women being "too posh to push", implying that women want CS to avoid labor pains and have an "easier" birth (Lynn Bourgeault et al., 2008), most research on women in both high-and middle-income countries (Hopkins, 2000; Lynn Bourgeault et al., 2008; Mazzoni et al., 2011), as well as low-income countries (Chigbu and Iloabachie, 2007; Khan et al., 2012), argue that there is little evidence for such a declaration. Instead, previous literature suggests that obstetrical policies, a change in doctors' perceptions of CS, and a lower threshold for performing CS can explain the current trend (Bagheri et al., 2013; Bailit, 2012; Habiba et al., 2006; Hopkins, 2000; Lynn

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Bourgeault et al., 2008; Maaløe et al., 2012; Monari et al., 2008; Murray, 2000). Reasons for obstetric caregivers to perform CSs on doubtful indications are suggested to be convenience (Bagheri et al., 2013; Bailit, 2012; Murray, 2000), economic incentives (Bagheri et al., 2013; Hopkins, 2000; Murray, 2000), fear of legal consequences (Bagheri et al., 2013; Fuglenes et al., 2009; Habiba et al., 2006), and a wish to keep private patients happy (Murray, 2000), but there are also reports that staffing patterns affect CS decision-making (Bailit, 2012). As high CS rates have been a concern mostly for high-and middle-income countries, there is little research from the developing world exploring doctors' and midwives' perceptions of high CS rates (Chigbu et al., 2010).

In light of a high CS rate at a university hospital in Tanzania (Litorp et al., 2013), we wished to explore obstetric caregivers' rationales for their hospital's CS rate in order to identify factors that might cause CS overuse. We conceptualize our study based on three empirical observations at the hospital. First, the CS rate has increased rapidly among low-risk groups, for example multipara without previous CS scars, suggesting that many CSs are performed on questionable indications (Litorp et al., 2013). Second, the maternal mortality ratio has increased (Litorp et al., 2013) and CS complications account for a large proportion of the hospital's severe maternal morbidity and deaths (Litorp et al., 2014). Third, women often fear to undergo CS, while caregivers are prepared to take high maternal risks in order to guarantee a good perinatal outcome (Litorp et al., 2015).

In the current study, we situate our discussion within the debate of how transparency and auditing (Strathern, 2000) can have unintended effects through reactivity mechanisms (Espeland and Sauder, 2007; McGivern and Fischer, 2012). These concepts have not, to our knowledge, been applied before to understand high CS rates. In the following section we explain transparency, auditing, and reactivity mechanisms. We then present our research methods and findings. Finally, by taking a social constructionist approach (Erlandson et al., 1993; Menzies, 1960; Waring, 2009) and using our conceptual framework, we outline a model to explain what role transparency might have in CS overuse.

1.1. Transparency and reactivity

Transparency is fixed and published rules within a clearly demarcated field of activity that are accessible to everyone (Hood, 2007). It advocates openness, independent scrutiny, and accountability, and make activity visible to the public (McGivern and Fischer, 2012), but can also involve reporting within smaller groups of experts (Hood, 2007). Transparency can include rankings (Espeland and Sauder, 2007) or auditing, of which the latter has become widespread both inside and outside medical practice (Strathern, 2000; The Cochrane Collaboration, 2005). In a medical audit cycle, care is critically analyzed and measured against standards, and feed-back is continually provided to the staff (The Cochrane Collaboration, 2005). In recent years, the use of audit has been increasingly promoted to reduce the number of adverse outcomes within obstetric care (World Health Organization, 2004), and audits are currently becoming more common in developing countries (Richard et al., 2009).

Despite its potential advantages, there are, however, reports that auditing may be associated with a “blame game” (Combs Thorsen et al., 2014) and have unintended, and even counterproductive, effects (McGivern and Fischer, 2012; Strathern, 2000; The Cochrane Collaboration, 2005). The notion among professionals that they are continually observed, evaluated, and measured, can induce so called reactivity mechanisms (Espeland and Sauder, 2007; McGivern and Fischer, 2012). These can include emotional reactions, such as fear, anxiety, guilt, and shame, which might lead to tension, distress, and uncertainty (Menzies, 1960; Nicolini et al., 2011), but reactivity might also encompass a reconstruction of truth. In an organization or group, diverging realities are constructed to form convergent conclusions and realities, which act as a framework for the way in which people behave (Erlandson et al., 1993; Menzies, 1960), and when staff share narratives and notions with each other, new truths, norms, and customs can develop (Waring, 2009). Previous literature has described how staff cope with anxiety and fear by detachment and denial of feelings (Menzies, 1960). But staff might also react with a shift in focus, for example by concentrating on the work made visible in the auditing process whilst neglecting other obligations (McGivern and Ferlie, 2007), prioritizing to safeguard themselves over what is best for their clients, or focusing on the outcome of the evaluation process rather than the outcome of the client (Espeland and Sauder, 2007; McGivern and Fischer, 2010, 2012).

2. Methods

2.1. Setting

We performed our study at a university hospital in Dar es Salaam, Tanzania. The Tanzanian health care system has a hierarchical structure, in which most deliveries take place at health centres and peripheral hospitals and the university hospital serves as a teaching and referral institution. After an upgrade of the peripheral hospitals in Dar es Salaam in the first years of the 21st century, the proportion of referred patients at the university hospital increased (Litorp et al., 2013), and the hospital strengthened its position as a tertiary institution. Still, however, two-thirds of the hospital's 9,000 annual deliveries are self-referred. Since 2004, the obstetric department runs as a public-private partnership, where costs for public patients are covered by the government and costs for private patients are debited to patients or their insurance companies. After its introduction, private practice has gradually increased and currently accounts for 25% of the deliveries. Women with private status are attended by the same staff as public patients, but they select a specialist whom they see continually during antenatal care and who is responsible for their delivery. During labor, women with private status are allocated to separate wards. When a private patient undergoes CS, doctors receive extra economic compensation. In recent years, the hospital's CS rate has increased from 16% in 2000 to 51% in 2011 among public patients, and from 36% in 2004 to 50% in 2011 among private patients.

The obstetric department is well-staffed with senior consultants (specialists with more than ten years' experience), specialists, residents (medical doctors doing their three-year specialist training), interns (medical graduates doing their one-year practical training), and midwives. CS decisions are formally taken by a doctor. The on-call team consists of one specialist, two residents, and one intern who are on duty for a 24 h shift. During the night, the specialist can rest either at home or at the department, but should be available for phone consultations and be able to come to the hospital within two hours. All specialists can delegate the responsibility of their private patients to the residents on call. After each call, residents and interns report at the doctors' morning meeting and midwives report at the midwives' meeting. Maternal death audits are conducted monthly since 1973 by a maternal mortality committee comprised of obstetricians, midwives, nurses, and the heads of the pharmacy and the central laboratory services. The committee has to comment on quality of care, identify gaps in the management, and decide if negligence, lack of resources, or understandable circumstances led to the death. All of the committee's recommendations are noted and handed to the hospital management for action, and every week, cases are discussed at a meeting with the department staff. In