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Vaginal Birth after Cesarean Section: Provider Perspectives and Maternal Decision Making

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ABSTRACT

Although evidence suggests vaginal birth after cesarean section (VBAC) leads to fewer complications in subsequent pregnancies, lower risk of maternal morbidity, and fewer cesarean sections overall, VBAC rates in Florida are at 5.5%, notably lower than the U.S. average of 8.0%. This exploratory study examines the factors contributing to these low VBAC rates through a qualitative investigation using grounded theory. Semi-structured interviews with women and maternity care providers were conducted to explore attitudes, motivations, and experiences regarding VBAC. Findings reveal a distinction between providers' and women's attitudes toward and experiences with VBAC and identify factors involved in decision-making. Three themes emerged: (1) patient-provider interactions; (2) perceptions of risks; and (3) rejection/adoption of biomedical authority. Women weighed the risks and benefits of VBAC through their perceptions and experiences of physical and emotional consequences, whereas providers relied on their experiences with medical practice, legal outcomes, policy, and evidence-based medicine. This exploratory research identifies a critical need for further attention to the disconnects between providers' and women's perspectives on and experiences with VBAC to address the tensions between biomedical and alternative forms of birth knowledge better and develop comprehensive VBAC guidelines that integrate the needs and concerns of women and providers.

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BACKGROUND

Vaginal birth after cesarean section (VBAC) is a contested issue in the United States (U.S.). Although evidence suggests that VBAC leads to fewer complications in subsequent pregnancies and a lower risk of maternal morbidity compared to repeat cesarean sections (RCS), one-third of hospitals in the U.S. no longer offer VBAC (Cheng et al., 2011). In 2006, the national VBAC rate was 8.5% (Cheng et al., 2011) and was even lower in Florida, at 5.5% (MacDorman, Declercq, & Menacker, 2011). As demonstrated by the *Healthy People 2020* goal to decrease the RCS rate from 90.8% to 81.7% in the U.S., there is growing concern about low rates of VBAC (U.S. Department of Health and Human Services, 2011). The concern with the rise in cesarean section is twofold. First, women appear to be undergoing unnecessary surgery, facing the potential complications of major surgery and its expenses. Second, high rates of cesarean section call into question women's autonomy in decision-making in regards to labor and delivery. Thus, this exploratory research sought to understand why VBAC rates in Florida are so low if evidence based research supports

VBAC as a legitimate birth option for many women. The objectives of this investigation were to: (1) explore maternal care providers' (MCP) attitudes toward VBAC; (2) identify potential motivations behind these attitudes; and (3) document women's experiences with VBAC in Tampa, Florida.

The most commonly reported risk associated with VBAC is uterine rupture, which occurs at the site of the previous cesarean scar on the uterine wall (Guise et al., 2010). Although the risk is less than 1% (Shanks & Cahill, 2011) the possibility of maternal and infant mortality has resulted in this being a focal point when discussing VBAC. Since the 1970s, the incidence of cesarean section has increased steadily and is associated with a high risk of uterine rupture during attempted VBAC (American College of Obstetricians and Gynecologists, 2010). Consequently, the commonly heard phrase coined in 1916, "once a cesarean, always a cesarean," continues to influence popular beliefs regarding VBAC risks (Cragin, 1916; Flamm, 2001).

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In 1980, the VBAC rate in the U.S. was 3.5%. However, rates rose to nearly 25% in 1993 in response to evidence based research indicating VBAC as a safe birth option. In 1996, rates peaked at 28.3%, but declined thereafter, and in 2004, were down to 9.2% (MacDorman et al., 2011). This decline coincided with the 1999 revised American Congress of Obstetricians and Gynecologists (ACOG) guidelines indicating that women attempting a VBAC should have “immediate” access to an emergency cesarean section (American College of Obstetricians and Gynecologists, 2004). This strict guideline triggered one-third of hospitals in the U.S. to discontinue offering VBAC (Cheng et al., 2011).

In 2010, ACOG released another revision that “requires a thorough discussion of the local healthcare system, the available resources, and the potential for incremental risk between the provider and the patient” (American College of Obstetricians and Gynecologists, 2010). This revised guideline also states that the decision to attempt VBAC should be the patient’s, as long as she has been counseled on the risks and provide informed consent. Despite this, Florida banned VBAC in birth centers in 2010, further limiting labor and delivery options for women who desire a VBAC.

METHODS

After approval by the University of South Florida Institutional Review Board (IRB #6831), study participants were recruited through chain referral sampling, which relies on potential study participants to lead the researchers to other individuals that meet the inclusion criteria (Bernard, 2012). MCPs were by contacted through hospital networks via email or phone, and women with VBAC experience were recruited through the local chapter of the International Cesarean Awareness Network (ICAN) on Facebook. Semi-structured interviews (n = 11) were conducted with individuals living in Florida who were currently working as a MCP (n = 6) and women who had experienced VBAC (n = 5). Provider interview questions were aimed at elucidating VBAC knowledge, experiences, practices, and attitudes. Interviews with women focused on basic obstetric history, cesarean and VBAC experiences, and knowledge and attitudes toward VBAC.

Interview notes and target transcription from audio files from each interview were analyzed. An iterative process of qualitative analysis was conducted to identify salient and recurrent trends, which were coded and later grouped into overarching themes (Saldaña, 2012). Grounded theory was employed to allow themes to emerge from the data, as opposed to searching for specific constructs within the text

(Corbin & Strauss, 1990). After each team member conducted individual analysis, the group discussed the findings and created a codebook. Interviews were re-coded using agreed upon codes and definitions. After the second round of coding, the team worked together to identify three prominent themes: (1) patient-provider interactions; (2) perceptions of risks; and (3) rejection/adoption of biomedical authority. These themes are discussed below in regards to women and provider decision-making. All names used are pseudonyms to protect participant privacy.

Sample Characteristics

The MCPs had been practicing from nine to 30 years at the time of interview. Five MCPs were obstetricians (OB) and one was a certified nurse midwife (CNM). Providers attend deliveries in three different hospitals and represent four distinct physician groups and one certified nurse-midwife group in Tampa, Florida. The women interviewed were between 30 and 37 years of age at the time of interview and had two children and two total pregnancies, the first of which was a cesarean section and the second, a VBAC delivery. All of the cesarean sections took place in a hospital. Three VBACs took place at home with a midwife and two in hospitals (one with a midwife and the other with an OB).

RESULTS

Women’s Decision-Making: Seeking Support, Negotiating Risk, and Embodying Knowledge

The most prevalent theme in women’s VBAC decision-making focused on perceptions of provider support. Support, or lack thereof, from their MCP regarding their desire to have a VBAC influenced their attitudes toward their provider. The lack of support from OBs was connected with a distrust of the hospital settings, which contributed to women’s consistent references to control. Jessica, a 37-year-old mother of two, alluded to this distrust and struggle for control: *“They [OBs] always give a scare tactic, like, ‘if you don’t do this then you are jeopardizing the baby.’ Of course you don’t want to jeopardize the baby, so you agree to the procedure.”*

Women mentioned that previous MCPs did not allow them to follow through with their agreed on birth plans, although they recognized that it was the hospital, as well as the provider, that controlled the birth process. The lack of support from OBs motivated four women (80%) to turn to midwife care for their second birth because of the perception that midwives had more supportive attitudes. When describing her choice to seek a midwife for her second birth, Jessica explained: *“I want a team that’s for me, not fighting*

against me.” Additionally, three women (60%) chose to give birth at home because they felt the hospital environment was not supportive of their needs. Overall, women expressed more satisfaction with the support they received from midwives, feeling their midwives took care of them “*physically and mentally.*”

Alongside these desires for support and control, women’s search for information and an understanding of potential risks played an important role in their decision-making. Participants often reported that their MCP did not discuss the risks of VBAC with them. Lisa, a 30-year-old mother of two, described her previous medical records: “*Patient and I spoke about the extreme risks of VBAC and how a C-section is. They never told me the risks of VBAC. EVER.*” Women in this study reported that they received more information with midwives, and therefore felt more control over their birth decisions.

Discussing potential risks, Jen, a 33-year-old mother of two, noted: “*Mostly we hear about uterine rupture, a catastrophic uterine rupture, which could result in death.*” Whereas uterine rupture was seen as a serious risk, women also believed the risk to be lower than those associated with an RCS, frequently expressing that cesarean section was “*major surgery.*” Lisa shared that she felt “*more likely to come out of it [a cesarean section] with issues than I did with the VBAC.*” A common theme among participating women was that recovery from cesarean section was extremely difficult. Beyond physical risks, the emotional consequences of cesareans and VBAC were also important in women’s decision-making. A previous cesarean was often expressed as “*giving up,*” and some felt guilt and personal responsibility. Time spent away from the baby after surgery was difficult. Claire, a 30-year-old mother of two explained: “*I was drugged. I didn’t know what was going on. I didn’t feel anything. If I had a repeat [cesarean], I’d have a repeat of those feelings, and I don’t think I could do that again.*” Emotional recovery was a major part of women’s distress, and several women mentioned difficulty with breastfeeding and bonding after their cesarean. “*I would think that if I had a repeat C-section, I would probably have to be checked into a mental hospital. Honestly, it was that traumatic,*” shared Claire.

In making these decisions, women considered not only their MCP’s input, but also their own prior experiences and those of women they knew. The women in this study all discussed pursuing alternative, non-biomedical birthing options, particularly as a consequence of their previous experiences. Jen explained that she chose a midwife for her second

pregnancy because with an OB, there are “*far too many interventions.*” In considering midwife-assisted homebirth, Jessica shared: “*I know that my grandmothers, both of them, gave birth to their children at home, each of them had eight children... I was just thinking logically... so it [her grandmothers’ experiences] kind of gave me confidence that, you know, I’m picking what was best for me.*”

Nonetheless, participants were not completely disillusioned with the biomedical system, as several women acknowledged the importance of biomedical attention in certain situations. Moreover, embodied knowledge also served to support biomedical intervention. For example, when discussing her cesarean section, Jen said that she made her decision based on the fact that her “*body was not prepared for labor,*” which she concluded after three days of induction and waiting. In this situation, Jen chose a biomedical intervention based on her own perceptions of her body. Women often expressed notions such as these that reflected the constant, personal struggle they experienced in navigating the biomedical system and balancing it with their own desires and understandings of their childbirth experiences.

Providers’ Risks: Counseling, Candidacy, and the Medico-legal Climate

Participating providers discussed patient interactions in terms of working toward outcomes for “*a healthy mother and healthy baby,*” focusing on patient counseling and the continual evaluation of VBAC candidacy throughout pregnancy. The five participating MCPs who offer VBAC reported discussing the risks with interested patients. Dr. Amy, a female OB/GYN with 26 years of experience who offers VBAC, explained: “*First visit, we go over all those rules. If the patient indicates that they are not interested, we do not force it on them. We have to feel comfortable with it. They have to feel comfortable with it. Now sometimes they need a little time to think about it, so we give them the form [informed consent]... We need to get that signed ahead of time so it sort of indicates to us that they have been thoughtful about this process, that it’s not a last minute decision.*”

Dr. Ursula, a female OB with 17 years of experience who offers VBAC at a large, state hospital, commented: “*Our job is to counsel women... make sure they understand the risks of major surgery, and that they understand the risks of the VBAC. We want them to know the difference... and that they are making an informed choice.*” However, providers also admitted that counseling is time-consuming, which does not fit with the current medical model that limits time with patients. As Charlotte, a CNM with 30 years

of experience who offers VBAC at a state-hospital expressed: *“I think well-informed, well-educated people about what’s going to happen to them will make good choices, but it’s time-consuming.”* Thus, whereas providers emphasized the importance of counseling, in practice, the time committed to it was limited.

The practice of patient counseling is closely linked with the issue of VBAC candidacy. From an *“evidence-based medicine perspective,”* the phrase consistently used by the MCPs, candidacy is based on set-criteria disconnected from the desires of women. As Dr. Amy commented: *“Out of the few people that do go for a VBAC, in my experience, I’ve got about half of them who are pretty reasonable people. I’ve got the other half that are totally, totally fixated on this and want a VBAC no matter what, and unfortunately, they are difficult to deal with because they have a mental problem with failure.”* Statements like these demonstrate how providers are also constantly negotiating their relationships with patients and that individual judgments are also taking place alongside the set-criteria for VBAC candidacy.

From the provider perspective, VBAC was considered an appropriate procedure under the right circumstances, but also a procedure that can result in *“catastrophic outcomes.”* Indeed, the term ‘catastrophic’ was used by two-thirds of providers, and uterine rupture was named as the most significant potential complication by all MCPs. Dr. Nancy, a female OB with nine years of experience who offers VBAC at a state hospital, explained: *“Aside from failing, having to have a repeat C-section and uterine rupture are really the only complications. It’s just that uterine rupture has going along with it a laundry list of significant complications as a result.”* All providers repeated these complications and noted the importance of discussing them during patient counseling.

Providers reported that an important aspect of counseling was the number of children a woman planned to have because subsequent cesareans carry higher risks. Dr. Thomas, a male OB with 23 years of experience who does not offer VBAC, noted: *“By the time you have the third cesarean, your risk of hemorrhage requiring transfusion or hysterectomy exceeds the risk of uterine scar separation.”* All providers discussed the role of the ACOG VBAC guidelines in their decision-making regarding counseling and VBAC candidacy, and every provider specifically referenced the ACOG requirement for immediately available emergency care to ensure the safety of delivery. Charlotte stated: *“You need to have that type of timing in an emergency.”* This specific requirement plays a significant role in determining whether or not to provide VBAC, with a clear

emphasis on the need for VBAC to occur within a biomedical setting. Dr. Nancy explained that the *“immediately available”* wording in the ACOG guidelines is what led to hospitals no longer offering VBAC, resulting in entire regions without access to hospital VBAC.

Providers felt the increasingly limited availability of VBAC care created an ethical obligation to continue offering VBAC to prevent women from seeking alternative providers and places for delivery. Physicians shared that they believe publicizing and providing VBAC are important so that patients do not seek home birth. Dr. Ursula explained: *“It’s the right thing to do. You know, more often than not, you’re going to see successful VBAC. And, it’s the natural process. The other is a surgical intervention. Two, I think, if we don’t offer it, then who? ... There are plenty of women who really want to VBAC and if they can’t find a provider in the standard sense, they’ll find somebody and that would not be the most ideal situation.”*

Dr. Thomas also mentioned the issue of immediately available emergency care, but did not feel that it was influential in his practice’s decision not to offer VBAC. He explained: *“But that [emergency care] is really not our biggest issue. Our biggest issue is that we need protection from something [referring to VBAC complications] I guarantee will happen one in 200 times.”* In fact, the most prominent theme in MCPs’ perceptions of risks was the medico-legal climate. Dr. Amy noted that the rise in cesareans is a *“medico-legal thing; we’re covering our rear ends.”* Every MCP identified medico-legal concerns as the reason why providers avoid VBAC. Dr. Nancy explained: *“The sorts of events that can happen with VBAC are the sorts of things that are much more likely to lead to huge claims against physicians... it comes across when you have lost a mom or lost a baby as something indefensible... and it leads to huge multi-million dollar claims that can be a career-ender.”*

Although ACOG guidelines recommend allowing a trial of labor after cesarean (TOLAC) for eligible VBAC candidates, many providers simply ignore these because, as Dr. Thomas explained: *“In a court of law, those mean nothing.”* Physicians fear lawsuits or buckle under the cost of the malpractice insurance, and therefore, only offer VBAC to women in particular circumstances or stop offering it altogether. Dr. Thomas shared: *“We decided it [VBAC] wasn’t worth exposure and that’s really the wrong answer as a doctor, but it’s the right answer living in this system.”* Thus, the ethical motivations influencing providers’ decisions to offer VBAC still stemmed from a trust in and adherence to biomedical authority, dichotomizing

hospital birth and homebirth. Like the women in this study, participating providers also attempted to balance the risks and benefits of VBAC while operating within a larger system that also constrains their agency.

DISCUSSION

This exploratory study provides insight into women's and providers' attitudes on and experiences with VBAC, revealing a clear distinction between women's and providers' perceptions and experiences. Although variations between the two groups are to be expected, these findings illustrate the complex nature of decision-making surrounding birth practices and echo the relevant literature in regards to birth decision-making and knowledge and practice (Emmett, Shaw, Montgomery, Murphy, & Di, 2006; Goldberg, 2009; Irwin & Jordan, 1987; Redshaw & Hockley, 2010). The medicalization of birth and authority of biomedical knowledge in birth have resulted in a shift in maternal decision-making and increased negotiations between patient and provider throughout gestation and delivery (Browner & Press, 1996; Davis-Floyd & Cheyney, 2009; Ivry, Teman, & Frumkin, 2011; Markens, Browner, & Preloran, 2010). This mechanization of the body, or the idea that the body and mind are separate and the body has parts that can be broken down, has led to the view that parturition is pathological and must be controlled with technology (Davis-Floyd, 2001). All women, low-risk or high-risk, receive the same birth management based on the assumption that the parturient woman is a patient and standardization improves patient safety (Davis-Floyd, 2004; Jordan, 1978). Authority and decision-making power are in the hands of the hospital staff, and this authoritative knowledge is present throughout the continuum of pregnancy (Jordan, 1997).

However, ethnographic research shows that women play an active role in negotiating the various recommendations they receive during pregnancy, often balancing authoritative knowledge given in biomedical settings with their own embodied knowledge and the experiences of friends and family (Browner & Press, 1996; Ivry et al., 2011; Markens et al., 2010). Similarly, women in this exploratory study shared analogous experiences with negotiating these various sources of knowledge. The authority of biomedicine functions differently across the MCPs and women's experiences as well as within them. Whereas some women in this study expressed hesitation toward the biomedical system and its ability to undermine their birth plan, others openly questioned its credibility. Some women chose to integrate other sources of knowledge, including their own experiences and the experiences of other women, with biomedical

knowledge when making decisions about birth, whereas others opted out of the system entirely. Those who opted out of the system were a group that was of particular interest to the providers supporting VBAC. These providers specifically stated that VBAC delivery at home is dangerous, and, they offer VBAC to avoid a potentially dangerous situation. Here, the providers appear to be negotiating with women's desires, while continuing to maintain the authority of biomedicine.

Furthermore, all maternal participants successfully achieved VBAC, three of whom occurred at home with the support of a midwife. These successes demonstrate the potential for the application and validity of alternative forms of knowledge when utilized by trained professionals. Approximately 1% of women in the U.S. give birth at home or at a birth center for reasons similar to those identified in this study (Boucher, Bennett, McFarlin, & Freeze, 2009; Hickman, 2010). However, there is a dearth of literature regarding alternative birth choices, such as the choice to engage in a "free birth," which is birth without trained professional assistance (Miller, 2009). As women's decision-making is increasingly impinged on by a lack of alternative birth options, it is necessary to examine these options further as women may increasingly be seeking substitutes for biomedical birth. Research indicates that women seeking VBAC in Western countries struggle within the biomedical arena as they go against the common medical discourse that promotes RCS (Fenwick, Gamble, & Hauck, 2007). Some women engage in homebirth as a way to challenge medical hegemony (Worman-Ross & Mix, 2013) or to challenge the current system of biomedical knowledge (Cheyney, 2008).

Dissatisfaction with MCPs impacted women's experiences. In this study, women were more satisfied with midwives than with OBs. Others have found that women feel there is a lack of support by all healthcare professionals, including midwives, in their desire to have a VBAC (Lundgren, Begley, Gross, & Bondas, 2012; McGrath, Phillips, & Vaughan, 2010). Although the women in this study successfully challenged the biomedical system in achieving VBAC, their reasons for doing so varied. As such, each woman's dissatisfaction arose, in part, from differing experiences. A better understanding of the varying biomedical experiences of women will allow for a more focused solution to aid MCPs and patients in coming to an understanding about the importance of VBAC to many women.

Time commitment was often cited as a reason for MCPs' lack of willingness to provide VBAC, particularly in regards to counseling. Cox (2011) reported similar findings in her study examining

providers' perspectives on the VBAC guidelines in Florida. She, too, found that fear of liability, minimizing risk, defining the term "*immediately available*," and the marginalization of midwives contributed to providers' perspectives. Based on this study's exploratory findings, our recommendations for overcoming the time commitment issue include an increase in the training and hiring of midwives who utilize a time-intensive and relationship-focused model of care (Boston Women's Health Book Collective & Norsigian, 2011). Moreover, hospitals that require their labor and delivery units to have full-time, on-site emergency access, like residency hospitals with an attending physician 24 hours a day, would address the time commitment barrier.

This study also revealed that attitudes toward the patient-provider relationship differ between MCPs and women. Providers view this interaction as an opportunity to counsel women so that the ultimate outcome of the pregnancy is a healthy mother and baby. Some MCPs openly discussed the use of a court order to ensure that their patients had a cesarean, implying that they would go to any length to follow the principles of biomedicine, even if it were in contradiction with the mother's informed consent. Although a healthy outcome for both mother and child is ideal, scenarios such as these call in to question maternal rights, which precipitate the following inquiry: *Do women have autonomy in decision-making regarding their birth choices, and should they?* In the U.S., VBAC is legal, although laws adopted by certain states can limit women's birth choices seemingly in favor of the fetus (Spence & Diaz-Tello, 2010). The 2010 law making VBAC illegal in birth centers in Florida further limited women's choices for alternative birth care. As is clear from the results of this exploratory study, women will choose other options if they feel that they are not receiving provider support in the biomedical setting.

Finally, it is important to note how much MCPs and women agree on issues like RCS generally having greater health risks than VBAC and that VBAC can be successful. Both groups thought that VBAC should be offered more widely. However, as a consequence of medical malpractice lawsuits, providers' interests are often put ahead of patients'. VBAC is not unique in this regard. Many other medical procedures are likely influenced by fears of malpractice suits (Nahed, Babu, Smith, & Heary, 2012). Additional areas of further research should include an investigation of how laws regarding medical malpractice could be adapted so that medicine can be practiced with the best interests of the patients at the forefront.

Implications for Public Health Practice

Through the narratives of mothers and MCPs, this exploratory research identifies a critical need for further attention to the incongruence between providers' and women's perspectives on and experiences with VBAC to develop comprehensive VBAC guidelines that integrate the needs and concerns of women and providers. As participants explained, women will seek alternative birthing options if they do not find the support and information they desire within the biomedical setting, and providers continue to struggle with the often conflicting demands of addressing women's individual needs, adhering to VBAC policies, and negotiating medico-legal risks.

As an exploratory study, a limitation of this research is the small sample size. Whereas this limitation prevents findings from being generalizable, findings nonetheless identify an important gap in patient-provider perspectives regarding VBAC in Florida. This research demonstrates a public health need to elucidate the tensions between biomedical and alternative forms of pregnancy and childbirth knowledge further to inform VBAC guidelines and policy reform more comprehensively. This is of particular concern in light of the *Healthy People 2020* goal to decrease the RCS rate in the United States (U.S. Department of Health and Human Services, 2011). Future studies should elaborate on the patient-provider dialogue laid out in this exploratory research and advance the conversation toward an integrated solution.

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