Women's experiences and involvement in decision-making in relation to planned caesarean birth: An interview study

Abstract

Actively engaging women in decision-making about their own care is critical to providing woman-centred maternity care. The aim was to understand women's mode-of-birth preferences and shared decision-making experiences during planned caesarean birth (CB). Semi-structured telephone interviews were conducted with 33 women who had planned CB at eight Australian metropolitan hospitals. Inductive thematic analysis was conducted using NVivo. Many women preferred a vaginal birth but were willing to have a CB if clinician-recommended. Most women looked to their clinician for information and guidance. Although many women reported receiving enough information to make informed decisions, others felt pressured into having or not having a CB, or expected to make decisions themselves. Women wished for longer consultation times, more information, and care continuity.

Keywords: Women, Shared Decision-Making, Caesarean Section, Antenatal, Experiences

Background

Global rates of caesarean births (CB) have almost doubled from 12.1% in 2000 to 21.1.% in 2015 (Boerma et al., 2018; World Health Organization, 1985). As a surgical procedure, CB carries several widely debated risks and benefits (Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2016). Although CB may be lifesaving in the short-term and allow for moderately reduced rates of urinary incontinence and pelvic organ prolapse in the long-term, it carries several risks (Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2016). These include increased infection and transfusion rates and the potential in subsequent pregnancies for ectopic pregnancies, abnormal placentation, catastrophic haemorrhage and uterine rupture (Keag, Norman, & Stock, 2018; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2013; World Health Organization, 2018).

While emphasising that all women who medically-require a CB should be offered one, the World Health Organization estimates the optimal CB rates to be between 10-15% (World Health Organization, 1985, 2015), however this rate is exceeded in most high-income countries (Boerma et al., 2018; Gibbons et al., 2010). The rise in CB rates seems to be driven by planned CB rates rather than emergency CB (Australian Commission on Safety and Quality of Health Care, 2017). For example, in Australia the planned CB rate increased by 45% between 2001 and 2015, while the emergency CB rate increased by 22% during this period (Australian Commission on Safety and Quality of Health Care,, 2017). In addition to rising rates, there is also considerable unwarranted variation in CB rates between Australian hospitals that cannot be explained by case-mix, labour and delivery or hospital factors (Centre for Epidemiology and Evidence 2018; Nippita et al., 2015).

Variation in the rate of CB between hospitals can be explained, at least in part, by uncertainty in the literature surrounding what is considered an appropriate indication for CB (Coates et al., 2019). A recent guideline review that compared indications for planned CB across 49 guidelines found that there was inconsistency in recommendations; for example, while some guidelines suggest that women have the right to choose a CB, other guidelines state that this is not appropriate (Coates et al., 2019). While sometimes CB are clearly medically-indicated, decisions in relation to planned CB are often informed by preferences and beliefs (Fuglenes, Aas, Botten, Oian, & Kristiansen, 2012; Hildingsson, 2008), particularly in the context of mode-of-birth (MOB) decisions following a previous CB or during a CB on maternal request (Coates et al., 2019; Klein et al., 2009). Clinicians providing maternity care have different birth values and beliefs (Klein et al., 2009; Klein et al., 2011), and these beliefs and values have been shown to predict clinician behaviour and clinical practices (White VanGompel et al., 2019).

In relation to preference-based clinical decisions where there are multiple reasonable treatment options, it is increasingly recognised that patients' preferences (the woman in this context), rather than the clinicians', are paramount. Making clinical decisions together, informed by the women's beliefs and values is called shared decision-making (SDM), and its importance has been gradually recognised in best-practice guidelines as critical to providing woman centred-care (Australian Commission on Safety and Quality of Health Care,, 2017; National Health Service, n.d; National Institute for Health and Care Excellence, 2011). Consistent with conceptualisations of SDM (Elwyn et al., 2010), guidelines emphasise the importance of acknowledging women's preferences and providing sufficient evidence-based information in relation to procedural risks and benefits, when providing woman centred-care (Australian Commission on Safety and Quality of Health Care,, 2017; National Health Service, n.d; National Institute for Health and Care Excellence, 2011).

The aim of this study was to understand women's MOB preferences and their experiences of SDM in the context of planned CB, in Sydney public hospitals. This study was conducted within a larger service evaluation framework with an aim to provide feedback to the participating hospitals and identify opportunities for quality improvement.

Methods

Within a service evaluation framework, we conducted a qualitative interview study between May and August 2019 across eight Sydney public hospitals in Australia. Ethics approval was received from a human research ethics committee (HREC ref no: 18/169 (HREC/18/POWH/356)).

Participants and Recruitment

A total of 33 women who had undergone a planned CB participated in telephone interviews. All women had undergone a planned CB between two weeks and five months previously and were proficient in English. Nine of these women specified a cultural or ethnic background, including African, Afghan, Bengali, Indonesian, Pakistani, Lebanese, Sri Lankan and Vietnamese.

Recruitment occurred in two stages. First, in a separate survey study conducted by the authors between October 2018 and July 2019, women who would undergo planned CB were given the option to indicate their willingness to participate in interviews. Women who indicated a willingness were contacted with information about the study and a formal invitation to participate. A total of 26 women were recruited through this process. Secondly, information statements and consent forms were posted to 25 randomly-selected women who underwent planned CB between March and June 2019, at each of seven study hospitals. This

phase was not applied to one hospital, as sufficient women had already been recruited from this site. A further seven women were recruited through this process.

Data Collection

Women were offered either a telephone or face-to-face interview during their initial phone call; given they all had infants <6 months old, all women preferred a telephone interview. Each interview lasted between 15-35 minutes in length. Prior to the interview's commencement, all women were asked if they understood the information statement and had submitted their consent form. If not, the interviewer provided them with an overview of the statement's information and if satisfied, the consent form was read aloud for consent to be audio-recorded. Women were also given the opportunity to have information statements re-sent or ask questions to clarify their understanding.

An interview guide was developed to facilitate the semi-structured nature of the interviews and included five broad areas of questioning: reason for CB, MOB preferences, factors influencing decision-making, experiences of SDM and opportunities for improvement. Broad open-ended questions elicited women's perspectives, preferences and experiences of decision-making and the information they were provided and identified issues important to them surrounding decision-making. Focused questions prompted women to clarify issues previously raised. Member-checking was used to clarify that the interviewee's intended meaning was accurately understood by the researcher (Harper & Cole, 2012; Krefting, 1991). Interviews were conducted by a medical student researcher (PT) who had received training from and was supervised closely by a trained qualitative researcher (DC).

Data Analysis

Interview recordings were de-identified, transcribed verbatim and coded into the NVivo-12 qualitative analysis software (Halcomb & Davidson, 2006). Inductive thematic analysis was employed, following the steps outlined by Braun and Clarke (Braun & Clarke, 2006). Qualitative responses were analysed inductively across all respondents to generate key themes and identify the range of responses. Specifically, qualitative responses were coded to identify initial themes, which were then reviewed across all respondents to generate major themes (Creswel, 2009; Thomas, 2006).

To ensure rigour, the data was analysed in two rounds. In first instance, both PT and DC analysed the data independently and came together to discuss the themes and discrepancies. From this a coding frame was developed and a second round of analysis was conducted using this framework. Further modification of the framework based on the second round of analysis was discussed and agreed upon by both authors. Pseudonyms have been used.

Findings

The 33 women who participated in this study had CB for a range of reasons, including a previous CB (13 single previous CB and 8 multiple previous CB), breech presentation (n=6), placenta praevia (n=1), amniotic band obstruction (n=1), previous birth complications, including epidural abscesses, placental abruptions, fourth-degree tears and fistulas (n=3) and maternal request due to birth anxiety (n=1). Of the women who had a repeat CB, seven had requested the CB because their previous birth experience had been traumatic. Three main themes were identified: mode of birth (MOB) preferences, CB decision-making information sources and women's experiences of SDM.

Mode-of-Birth Preferences

The majority (17) of women had wished for a spontaneous vaginal birth (VB), eight had wanted a CB because of anxiety and/or a previous traumatic birth experience, and eight stated that they had no preference. Women who had no MOB preference saw benefits in having a CB, particularly in relation to avoiding an emergency CB (which they had previously experienced), being able to plan their pregnancy (e.g. maternity leave), and their fear of VB-associated pain and complications:

> *It meant something far more organized and that I could plan for than say a natural birth which is obviously far more unpredictable.* (Sofia, Medically-Indicated Breech)

While some women were '*happy*' to have a CB, the majority were not. Key reasons for wanting a VB included their own or societal perceptions of CB as unnatural or *'not actually giving birth*' (n=17), that it was skipping the hard work of labour (n=5) and made women less of a mother (n=9). Some women had wanted a VB because they viewed it as safer (n=6), or wanted to avoid requiring a CB in the future (n=3). Some women reported wanting the experience of '*giving birth*', and described CB as a medicalised, surgical procedure (n=7) during which a baby would be *'lifted from seven layers of skin*'. Women also wanted to avoid a CB because of practical concerns surrounding breastfeeding (n=4) and post-partum recovery (n=24).

[Insert Table 1: Mode-of-birth preferences: Reasons for wanting a VB]

Women also described cultural influences on their MOB preferences. Some women described that their cultural background influenced their preference for CB, whereas for others it influenced a preference for VB:

> *No one's had caesareans in my family. So it's not that looked down upon, but it's frowned upon. It's just like, 'oh you know try and be strong and GIVE birth' because they consider caesareans not giving birth. So I wanted to do that myself.* (Halima, Previous Traumatic VB)

> *Especially from South East Asia, the notion of having a natural birth is very frowned upon because that's what the poor people do. So yeah culturally there is a very strong push to have a caesarean because* […] *people feel like it's better.* (Amirah, Previous CB)

Even though many women would have preferred a VB, they were willing to have a CB if this was recommended by the clinician as safest for the baby or mother:

> *Every birth is good, as long as your baby is here and safe and healthy.* (Amirah, Requested Repeat CB)

> *Ideally I would love to give birth naturally, but you know* [CB] *is safest thing for me and the baby…so that's the way I would go. I wouldn't want to put me or the baby at risk.* (Carmen, Repeat CB due to Past Negative Experience)

CB Decision-making Information Sources

To make a MOB decision, most women relied on the information they received from medical staff and midwives (n=29) and trusted this information. However, while most women looked to their clinician for information and guidance, many supplemented this with

advice from friends and family members (n=16), their own previous experience (n=7) and their own research (n=21). When conducting their own research, they looked online (n=21) for journal articles and forums and read books (n=1). Some women appreciated how the online research could provide detail to the hospital-provided information:

> *I think the information I received from the hospital was good. Good, simple, basic… but then I still, I wouldn't have been happy unless I had looked further into it and got more details on the procedures and stuff.* (Jenny, Medically-Indicated Breech)

Other women were against online research, in fear of reading contradictory or confusing information, and thus primarily utilised the trusted hospital-provided information:

> *So I only got the information from the hospital staff. I did not do any research at all on my own because … I was afraid of reading fake news about it. So I just asked the midwives.* (Janet, Requested Repeat CB)

> *I think there's a lot of information out there and you can look. And everyone's got an opinion and I wanted to minimise it as much as possible so I think I tried to keep as small a circle of engagement as I could.* (Mary, Requested due to Previous Traumatic CB)

Some women also got information from childbirth classes (n=6), but this did not always address their information needs:

> *I went to one of the birthing classes … and about 90% of that class covered just vaginal birth options and covered caesarean in like one slide, so I felt that it's important that the doctor added to our understanding about what the caesarean would do.* (Tanya, Medically-Indicated Breech)

Women's Experiences of Shared Decision-Making

The majority of women described positive experiences of decision-making with their obstetrician and/or midwife, and reported that they were given the required information (n=19) and felt listened to (n=10). Comments such as '*I received the information I needed*' and *'I was very comfortable and very much listened to by my doctor*' were common.

However, while many women reported receiving the information they needed to make informed decisions, others reported feeling pressured into having or not having a CB (n=11), or conversely being expected to make a decision by themselves with little information or guidance from healthcare staff. Some women reported feeling pressured to have a CB (n=6) while others reported pressure to have a VB (n=5). These women emphasised the importance of clinicians maintaining a neutral stance when facilitating decision-making.

Women also reported that they were left to make their own decision, with little guidance from medical staff (n=4) or access to evidence-based information to help inform their decision (n=8). To be able to make informed decisions, women valued recommendations from clinicians based on the best-available evidence. For many, the information they had been given was '*too simple and basic*' (n=9), often presented in pamphlets, and they would have preferred an in-depth discussion of how the information was personally-applicable.

> *I could have had more information. Well…actually I think I just wanted the information to apply to me. I just wanted it to apply to me* (Lauren, Requested Repeat CB)

In relation to the actual information women would have liked, women commented that staff spent the majority of the consultation explaining the actual procedure, and that they would have liked more information in relation to how the birth would progress (n=4), skin-to-skin contact (n=3), MOB options (n=5), pain relief (n=7) and recovery (n=10). Multiple women voiced that the information they were given antenatally, did not line up with unexpected events that occurred during birth and recovery.

> *I probably didn't understand the post-recovery enough, and what happens after the 6 weeks. I knew that it had a 6 week recovery time but I probably didn't understand how major the surgery actually was in terms of just you know, slicing you open, dicing and then shoving your abdominals back together ?* […] *Recovery from natural labour is different from recovery from a c-section.* (Adrienne, Previous Traumatic VB)

Another common concern regarded insufficient time during medical consultations. Women frequently compared midwifery appointments to doctor's appointments and said they felt more comfortable to have in-depth discussions and ask questions in the former (n=6).

Women suggested that communication might be improved through enhanced medical continuity of care (n=9). They reported that the medical staff were often unfamiliar with their situation and that that they had to repeat their story each visit. They suggested that if medical

continuity of care was not possible, doctors' should '*look at the file properly before seeing the patient*'.

[Insert Table 2: Women's Experiences of Shared Decision-Making]

Discussion

This study provides an insight into women's MOB preferences and experiences with SDM during their planned CB in eight Australian hospitals. While the majority of women had wished for a VB, they were keen to follow clinicians' recommendations in order to ensure their own safety and the safety of the baby. MOB decision-making was strongly influenced by recommendations from clinicians. While some women reported feeling part of the decision-making process, others did not and felt they had not been given the information they needed to make an informed decision. While experiences varied, many women wished for more involvement in decision-making, more information, longer consultation times and more medical continuity of care. It appears that women want the decision to be shared, in the sense that they do not wish to make the decision by themselves, nor do they want the clinician to make decisions on their behalf. Instead, women wanted their clinicians to provide them with the appropriate information to facilitate SDM.

Despite the heightened recognition of SDM's importance, as highlighted in the literature and increasingly stipulated in clinical guidelines (Coates et al., 2019), this study suggests that SDM continues to not to be a part of routine maternity care. The finding that women are not provided with adequate information to make informed decisions in particular is supported by other studies conducted worldwide (Boz, Teskereci, & Akman, 2016; Kenyon, Johns, Duggal, Hewston, & Gale, 2016; Kingdon et al., 2009; Lazo-Porras et al., 2017).

Similar to our findings, other studies have shown that women are not consistently provided with information about the risks and benefits of CB (Chen & Hancock, 2012; Thompson & Miller, 2014). For example, one study found that 49% of women were unaware of the risks of CB-related neonatal complications (Chen & Hancock, 2012). Our finding that women particularly had wanted more information regarding the recovery period is also supported by the literature (Chen & Hancock, 2012; Grimes, Forster, & Newton, 2014; Puia, 2013; Weckesser et al., 2019). These studies found that women lacked knowledge about post-operative practices, long-term risks and benefits and the potential intra- and post-partum complications of CB (Chen & Hancock, 2012; Kenyon et al., 2016; Okonkwo, Ojengbede, Morhason-Bello, & Adedokun, 2012; Richard, Zongo, & Ouattara, 2014). Our finding that women would have liked longer consultations and more continuity of care is also consistent with existing studies that show women often feel pressured in time-limited consultations and appreciate more in-depth conversations with their clinicians (Kennedy, Grant, Walton, & Sandall, 2013).

Consistent with other studies, while most women would have preferred a VB, they were 'happy' to follow their clinician's recommendation for a CB, even though many did not entirely understand why this was required (Goodall, McVittie, & Magill, 2009; Kingdon et al., 2009). Women's beliefs that the 'clinician knows best' may divert the power in decision-making in favour of clinician preferences (Faisal, Matinnia, Hejar, & Khodakarami, 2014). The literature suggests that clinician MOB preferences, such as a preference towards CB, influences how they present information to women, to encourage decision-making towards their own preferences (Farnworth, Robson, Thomson, Watson, & Murtagh, 2008; Fenwick, Staff, Gamble, Creedy, & Bayes, 2010; Frost, Shaw, Montgomery, & Murphy, 2009; Shorten, Shorten, & Kennedy, 2014).

While some women reported feeling pressured by clinicians to have CB or VB, others reported that they felt their clinician was very careful not to influence them in fear of pressuring them, such that they appeared to refrain from making recommendations or supporting women to make an evidence-based decision. Women valued the provision of expert guidance to facilitate their MOB decision-making, and did not want their clinicians to take a neutral stance. Instead, they appreciated clinician recommendations, given that clinicians acknowledged the women's priorities and provided evidence-based explanations for these recommendations. Similar findings were yielded by two studies that found that women did not mind that MOB decision was not completely autonomous, and trusted doctors to make the decision on their behalf providing that their health considerations were prioritised (Goodall et al., 2009; Kingdon et al., 2009).

Furthermore, similar to findings by Kennedy et al. (2013), women valued the verbal information and personally-applicable explanations they received from their clinician, in addition to written information.

Implications for Future Practice

Women want clinicians to facilitate SDM by providing them with comprehensive and trusted evidence-based recommendations, yet ultimately want clinicians to respect the woman's autonomy to make her own final MOB decision. While women would ideally like longer consultations for in-depth discussions, providing clinician-endorsed written resources for perusal in their own time may be helpful in ensuring women have access to sufficient supplementary information as required, to support their decisions.

Strengths and Limitations

A key limitation of this study is its inclusion of women who had CB for multiple different reasons, and both primiparous and multiparous women. The information needs and experience of SDM may vary considerably based on the indication of CB or parity.

Future research should investigate women's experiences of care as per their indication, to explore its potential influence, as well as study the experience of first-time mothers separately. Additionally, phone interviews were relatively short as women were caring for their newborn baby, limiting the depth into which women's experiences were explored. Furthermore, this study included women who had CB for multiple different reasons, with a large proportion having had a prior CB or a breech presentation, which may result in variations in their actual experiences of care. This study's strengths include the adaptive semi-structured nature of the interviews and its explorative approach to identify issues in care that were important to women, based on their experiences.

Conclusion

Best-practice guidelines promote the implementation of SDM during pregnancy in order to ensure all CB decisions are informed by evidence-based information and women's preferences. In doing so, it may help ensure that only medically-necessary CB, as agreed upon by both clinicians and women, are undertaken. Although most women voiced that they had positive SDM experiences in preparation for their CB, they were still able to identify several areas of improvement. Specifically, women wanted their clinicians to respect their autonomy to make MOB decisions on their own, by providing medical guidance and evidence-based information to facilitate decision-making. By addressing these specific concerns in their future clinical practice, clinicians can aim to improve SDM and successfully implement woman-centred care.

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Table 1: Mode-of-birth preferences: Reasons for wanting a VB

Theme and subtheme	Supporting quotes
Perceptions of CB as unnatural, 'not actually giving birth'	*It's a lot with the social stigma as well about failure if you can't actually labour naturally […] One particular person told me like 'so when's your operation?' not when are you going to have your baby or when are you expecting your baby.* (Aisha, Repeat CB)
Not wanting to skip the hard work of labour	*When you have a caesarean, it feels like someone else has done all the hard work.* (Nia, Previous CB)
Feeling less of a mother	*I've never got a chance to actually 'give birth' and it sounds stupid but you feel less of a mother in a way?* (Nia, Previous CB)
Perceptions of safety	*I think babies are meant to come that way for a reason, and there's a lot of stuff that happens to them in that birth process and to the mum that's sort of necessary.* (Patricia, Previous Classical CB Scar)
Concerns surrounding breastfeeding and post-partum recovery	*All the people that I've heard of c-sections told me that it's not very easy to recover and you can't enjoy your baby because you'll be in so much of pain and whereas in a normal delivery within a couple of days you can be back.* (Shanthi, Requested Repeat CB)

Table 2: Women's Experiences of Shared Decision-Making

Theme and subtheme	Supporting quotes
Positive experience of shared decision-making	*They explained the procedures and the purpose and they didn't sway me either way they just told me 'these are the options and it's up to you to choose what you want to do'. And I chose the one that was best for me.* (Alexandra, Medically-Indicated Breech) *I think it helped that I'd already been through a caesarean but definitely it was also helpful to have all that information again, because you do forget a lot the second time around.* (Zoe, Amniotic Band Obstruction)
Pressure to have a VB or CB	*As someone who's already leaning towards a natural birth it was okay, but if you were someone who was terrified about having a natural birth, there was a real push to try a natural birth.* (Laila, Requested Repeat CB) *On the actual day of the birth I had doctors saying to me…are you sure you don't want to deliver naturally? [...] Literally I was a matter of hours before going into theatre and people were trying to change my mind about going down a natural route. When they knew what my history was….so that was more*

	upsetting and frustrating. (Sophie, Previous CB & Traumatic VB)
Little guidance from medical staff or access to evidence-based information	*The doctors and midwives are very careful not to force the decision on anyone [...] But sometimes it's nice to have someone trained in the area tell you 'this is what I think is the best based on …' rather than leaving it to me to decide what my risk threshold is.* (Joanne, Previous CB) *I feel like [the doctors] don't feel like they can really make recommendations one way or another. [...] I think I would have really liked for them to outright recommend to me, 'you're low-risk, you should do a vaginal birth but let's put a pain management in place' and etc etc […] I think they can be more open.* (Siobhan, Requested Repeat CB)
Need for more accessible information, as relevant to their unique situation	*I think perhaps there's a tendency to…throw leaflets at people, which I think for some people worked quite well […] but I think for some women that wouldn't necessarily work so well* (Nora, Medically-Indicated Breech) *I'm a second time mum so it was a bit different…if I was a first time mum yes I probably would have appreciated a much more in-depth sort of thing, but not second time around, I was sort of fine with it.* (Susanne, Repeat CB)

	As in you don't have the experience to back it up so not very many women know what to say to stand their ground […] I think that when it's your first baby you just don't know and its very stressful […] Whereas the second time around you know what works the first time and you know what was horrible and what you do not want to do again and you stand your ground more (Laila, Requested Repeat CB)
Rushed medical consultation with insufficient time to ask questions	*I did ask them some things but just the time pressure in public hospital system, you get like a 10 minute session if you're lucky after you've been waiting for three hours, […] I could feel the pressure on them, the time-pressure on them, and I felt like I couldn't really sit there and ask every single thing. (Kim, Medically-Indicated Breech)* *The midwives, depending on which one, but they prompted me more to ask any questions and gave me plenty of time. The doctor didn't really ask if I had any questions, but I just spoke up myself.* (Amirah, Requested Repeat CB)
Communication inhibited by insufficient medical continuity of care	*I would rather prefer the same person because every time we had to tell the whole story and everything again and again, and also it doesn't feel comfortable […] they feel like strangers, and every time you'll have to make a rapport…it's very important thing, especially with women who are pregnant…they go through a lot of stuff, so I personally feel that to ease them and*

	to comfort them, it's important that they have a doctor or a midwife patient rapport. (Halima, Previous Traumatic VB)