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Vaginal birth after caesarean section (VBAC): exploring women's Perceptions

Aims and objectives. This study was designed to complement local audit data by examining the lived experience of women who elected to attempt a vaginal birth following a previous caesarean delivery. The study sought to determine whether or not women were able to exercise informed choice and to explore how they made decisions about the method of delivery and how they interpreted their experiences following the birth.

Background. The rising operative birth rate in the UK concerns both obstetricians and midwives. Although the popular press has characterized birth by caesarean section as the socialites' choice, in reality, maternal choice is only one factor in determining the method of birth. However, in considering the next delivery following a caesarean section, maternal choice may be a significant indicator. While accepted current UK practice favours vaginal birth after caesarean (VBAC) in line with the research evidence indicating reduced maternal morbidity, lower costs and satisfactory neonatal outcomes, Lavender et al. point out that partnership in choice has emerged as a key factor in the decision-making process over the past few decades. Chung and Jenders explored the issue of choice in an earlier study and concluded that the best method of subsequent delivery, following a caesarean birth, is dependent on a woman's preference.

Design and methodology. Using a phenomenological approach enabled a holistic exploration of women's lived experiences of vaginal birth after the caesarean section.

Results. This was a qualitative study and, as such, the findings are not transferable to women in general. However, the results confirmed the importance of informed choice and raised some interesting issues meriting the further exploration.

Conclusions. Informed choice is the key to effective women-centred care. Women must have access to non-biased evidence-based information in order to engage in a collaborative partnership of equals with midwives and obstetricians.

Relevance to clinical practice. This study is relevant to clinical practice as it highlights the importance of informed choice and reminds practitioners that, for women, psycho-social implications may supersede their physical concerns about birth

Introduction and background

In recent years, there has been a growing concern about the escalating caesarean section rates in the UK (Thomas and Paranjothy 2001). In 2003, 25% of all births were by caesarean section (National Institute of Clinical Excellence 2004) compared with only 12% 10 years ago (Francome & Savage 1993). There is evidence that caesarean section increases a woman's risk of severe morbidity (Waterstone et al. 2001) and inflicts a significant cost burden on the health service (Henderson et al. 2001). In addition, many women who have experienced normal birth believe that the experience confers emotional and spiritual benefits (Wainer 2001).

There are various contributing factors associated with the rising caesarean section rate, for example the use of fetal monitoring (Thacker et al. 2002) and the increasingly litigious culture of health care, particularly with regard to obstetric

complications or congenital injuries (O'Boyle et al. 2002). However, maternal choice has recently become a significant contributing factor (National Institute of Clinical Excellence 2004). While it could be argued that if caesarean section is a valid alternative to vaginal birth, then all women should be offered the choice of an operative delivery, the ethical grounds for such an approach are dubious (Bewley&Cockburn 2002) and largely opposed by the medical profession (FIGO Committee for the Ethical Aspects of Human Reproduction and Womens Health 1999, National Institute of Clinical Excellence 2004).

O'Cathain et al. (2002) examined the issue of maternal choices around the childbirth and found that women's perception of choice was associated with social background. Interestingly, women from non-professional backgrounds felt more able to exercise choice although this may have been partially because of lower expectations around decision making or greater trust placed in health professionals. While in the current study all aspects of choice informed the thinking of the researchers, the sample size did not enable any differentiation by education or social background. Women who have already experienced one caesarean may be in a stronger position to choose this method in subsequent pregnancies. However, routine elective section on the grounds of a previous caesarean birth cannot be recommended because of the excess maternal morbidity and mortality associated with such a policy (Grobman et al. 2000, National Institute of Clinical Excellence 2004) and the increased risk of respiratory problems in the neonate (Hook et al. 1997).

Interestingly, although VBAC has been resisted by some obstetricians because of the theoretical risk of rupture of the uterus, a large case-controlled study of severe maternal morbidity (Waterstone et al. 2001) found that induction of labour and manual removal of the placenta were the only significant predictors of uterine rupture. Nevertheless, routine trial of labour although beneficial for over 70% who can expect to achieve vaginal birth (Lehmann et al. 1999) may lead to increased morbidity (especially maternal and neonatal sepsis) for those who require emergency surgery after several hours of labour (Hook et al. 1997, Hibbard et al. 2001). It is, perhaps, important to note that the term 'trial of labour' medicalizes the birth experience and provides women with negative imagery about their ability to have a successful vaginal birth and therefore midwives should seek to avoid the term in their discussions with women. However, 'trial of labour' remains the standard medical terminology to describe a labour following a previous caesarean birth.

Overall, the evidence suggests that it is vaginal birth that reduces the risk to maternal morbidity rather than caesarean section even after a previous caesarean (National Institute of Clinical Excellence 2004). However, there are issues around choice, especially whether women who have no medical contra-indication (any factor which might make vaginal birth inadvisable) for attempting a vaginal birth should be offered a repeat caesarean section and the reasons why they may choose this mode of delivery. Weaver (2000) undertook a study examining choice and decision making in childbirth. Postnatal women were questioned as to whether they or any health professional had raised the possibility of caesarean section to deliver their infants. The findings of this study suggest that, although women considered vaginal birth as the ideal for themselves, there was a tension between what they perceived as best for themselves and what they believed was safest for the baby. Women participating

in the study considered vaginal birth unpredictable and hazardous, whereas, caesarean section was seen as a safe, routine and controllable operation. Weaver describes a perception of altruism in that, for the sake of their babies, women were prepared to undergo a caesarean birth regardless of the extra risk to themselves. To demonstrate reluctance or refusal was seen as selfish. Weaver concludes that hospitalization and the medicalization of childbirth have created a culture of fear in which women have lost confidence in their ability to give birth safely. In contrast to women's perceptions that vaginal birth is more hazardous for the fetus than caesarean section, evidence suggests that an operative delivery increases the risk of respiratory difficulties in the neonate (Hook et al. 1997). It has also been suggested that maternal pain in labour may have a beneficial effect on the neonate by raising the level of endorphins secreted in colostrum (Zanardo et al. 2001).

Aim

The concept of informed choice is fundamental to a high quality maternity service (Department of Health 1993). More recently informed choice has been linked to the need for evidence-based practice. Women can only exercise valid informed choice if they have access to the current evidence about the implications of different childbirth options. A woman who has already experienced one caesarean section requires evidence-based information to make choices about her subsequent mode of childbirth. Overall, research suggests that attempting vaginal birth after caesarean section offers the most benefits to the health of both mother and child (Hook et al. 1997, Grobman et al. 2000). However, this must be weighed against the increased risk of morbidity if vaginal birth is not achieved. Local audit can help quantify this risk in clinical terms but to facilitate informed choice, health professionals require a holistic understanding of what matters most to women. To address this need, a proposal for a study exploring women's reasons for selecting vaginal birth as a mode of delivery after a previous caesarean section was developed and presented to the local research ethics committee (LREC) at a northern teaching hospital in the UK. The study, designed to run in parallel with a trust-wide audit of VBAC outcomes, was approved by the LREC and supported by Midwifery Managers and Consultant Obstetricians.

Methodological considerations

The underlying philosophical orientation to this study was phenomenology, a research methodology derived from the work of the early 20th century German philosopher, Edmund Husserl. In rejecting scientific positivism as a sterile categorization of supposed facts, Husserl argued that phenomena have no objective reality, but can only be understood through the interpretation of personal experience (Groenewald 2004). Phenomenology can be a successful tool in understanding the experience of others as it is a research method, which seeks to uncover the meaning of a life situation through reflection and interpretation. In this instance, the focus of the research was to develop a deeper understanding of women's experiences of birth following a previous caesarean section.

Data collection

Data were collected through semi-structured interviews utilizing a topic guide as a prompt. This was to ensure that the whole range of the subject was covered, but it also enabled the participants to tell their stories in a narrative or conversational form (Polit et al. 2001). This is an important component in qualitative research, which

enables participants to freely express their own thoughts, beliefs and interpretations in order for the researcher(s) to begin to develop a true understanding of their perspectives. The purpose of the interview schedule was to discover women's lived experiences of previous LSCS (lower segment caesarean section) and their thoughts on the impending childbirth experience, then to discuss their post delivery perspectives in the light of these antenatal expectations. The study aimed to describe, interpret and begin to understand the meanings, which the participants attributed to their childbearing experiences (Cutcliffe & McKenna 1999).

Each interview was tape recorded with the participant's permission. All tape-recorded interviews were then transcribed verbatim, prior to the analysis process. Content analysis of the taped interviews provided a list of repeated themes; these themes were then used to provide structure to the findings and discussion of the research. The research team shared the interpretation of the emerging themes, which provided an opportunity for challenging the robustness of those selected. This method assisted the development of reasoned and complete interpretation of participants' experiences of vaginal birth following the caesarean section. The study therefore used a phenomenological philosophy, which values the creative interpretation that researchers bring to the study (Walters 1995).

Semi-structured interviews were undertaken antenatally and postnatally with the same group of research participants. An antenatal interview took place in the participant's own home after each woman had completed her 34th week of pregnancy. The postnatal interviews were scheduled around six weeks following the childbirth. The timing of the interviews was determined deliberately: antenatally, to facilitate discussion of an imminent event at such time that discussions about childbirth will have been completed and postnatally to allow time for recovery from birth and reflection on the event. Although women were offered a choice of venue for the interviews, all the women elected to be interviewed in their own homes. This was conducive to a relaxed and un-hurried approach to the interview process.

Sampling

The study used a sample of eight women. The only inclusion criteria were that women who had given birth by caesarean section in their last pregnancy planned to have a vaginal birth in their current pregnancy. The participants were recruited via the co-operation of local community midwives, who were asked to approach clients meeting the research criteria, provide them with information about the study and to gain permission for contact by the research team. Limitations are acknowledged with regard to the sampling technique, which placed heavy reliance upon community midwives (who were not stakeholders in the research process) to recruit women to the study. However, because of constraints on maintaining confidentiality and with due regard to the ethics of consent, the research team felt that this was the best available approach. It could be argued that the small number recruited to the study is a direct reflection of the increasing burden that community midwives face in an already over-stretched antenatal schedule.

Qualitative research does not claim to produce universally transferable findings but, rather, to present the lived reality of the research participants. The responsibility to present the findings clearly while developing an honest and credible interpretation of the data lies with the researcher(s). It is the task of the reader to determine

appropriate application of qualitative research findings. Therefore, even within the constraints of a limited study some interesting and unexpected findings emerged, which may serve to inform clinicians during the discussions with women contemplating VBAC. Certainly, they merit further investigation.

Data analysis

In qualitative research, data collection, analysis and interpretation are all part of a fluid process, which seeks to transform raw data into a coherent source of information, which can be used constructively to inform practice. The stages of this process are data reduction, organization and interpretation. Various authors describe slightly different methods of managing data and more recently, a number of computer packages have been developed for qualitative analysis. In this study, because of the small sample size, data analysis was carried out manually, based on Burnard's (1991) 14 stage process. This was chosen both for its clarity and for its familiarity to the researchers. To reduce individual bias, all analyses were carried out collaboratively by two or more researchers, emerging themes and categories were then verified by an experienced researcher who was not involved in the project. Tape recordings of the interviews with the informants were anonymized, then transcribed and used to derive themes. Initially eight working categories were developed, but these were later collapsed down to three major themes. Various issues were explored within each theme.

Findings

The largest theme was 'informed choice'. All of the women participating in the research study discussed the concept of informed choice in different contexts. To many of the women, being given a choice about mode of childbirth was very important and most indicated that trying for a normal birth was their preference. This seemed to be tied in to the desire to experience the normal functioning of the female body, which has been highlighted in previous studies (Eden et al. 2004). As one woman commented:

because the sensation...everybody wants to have a shot at giving birth naturally. I just think, I don't know, maybe it is something within a woman.

Bainbridge (2002) points to research demonstrating the adverse affects of negative emotions associated with birth by caesarean section, arguing that these are much more common than is generally acknowledged by health professionals. Women who are told that they should be grateful for a healthy baby may suppress emotions ranging from a sense of failure to anger or betrayal. One informant who gave birth by caesarean section after a trial of labour was able to express her feelings thus:

...is there no way I could have (had) it naturally?...I felt cheated you know, that I'd gone through that and then had to have a caesarean section.

Most of the women in the study indicated that they felt involved in the decision about planned mode of birth. One informant described a discussion with her midwife as follows:

She said to me, 'look, if you really feel you want to, you could go for a caesarean' but I felt I really did want this opportunity to go for a natural birth.

Interestingly, in contrast to the perceived medical bias towards caesarean (Carr et al. 2002, Young 2002), most informants felt that medical and midwifery advice was weighted towards a trial of labour. One woman indicated that she felt unprepared for labour, which appeared to result from a lack of information:

I don't know what to think really. It's a bit daunting thinking about having a normal birth after a caesarean section. I don't know what to expect.

The importance of adequate education and discussion about VBAC has been discussed by other authors. Eden et al. (2004), in their systematic review on birth preferences following a caesarean section, suggest that the risks and benefits of both vaginal and operative birth should be discussed as early in pregnancy as possible, or ideally, as part of preconception counselling. However, in this study, even women who felt well informed expressed some anxiety about labour, particularly the second stage. In one postnatal interview, a woman spoke of how difficult and tiring the second stage of labour had been. Despite its difficulty, she felt that giving birth naturally was preferable to the supposed ease of a caesarean section.

Another woman, although having had consented to a trial of labour, expressed the opinion that she preferred what she perceived as the predictable nature of an operative delivery:

What I like about a caesarean in a way is that it is planned, you know.

Choice related to more than just mode of delivery with participants discussing informed choice in relation to interventions such as induction of labour or the use of ultrasound to determine fetal position in late pregnancy. This was of particular concern to two women who had previous caesarean sections for undiagnosed breech presentations. Although they both requested a scan to satisfy their own perceived need for confirmation of cephalic presentation during the current pregnancy, only one woman was offered the procedure. Concerning induction of labour, women seemed to be given very little choice, despite the lack of medical consensus of opinion as to whether induction should be attempted following a previous caesarean section.

One clear benefit of feeling involved in choices about childbirth options was the confidence this gave to women. Some women sought out additional information over and above what they received from their midwives or obstetricians:

I've tried to be positive. It's a different pregnancy and I've tried to do a lot of reading.

Other informants expressed the feeling that because they had been given choices, this increased their trust in their carers:

I mean, as long as you feel confident in the people looking after you, which I did, all the way through, then you know that they're going to tell you.

However, the negative side of this could be a reluctance to question any medical decision because of the perception that the professionals 'know best'. This was expressed postnatally by one informant who said:

I'm not really bothered that I had it (LSCS) 'cause I just put myself in their hands and if that was best for the baby, you just go with that.

The second major theme which emerged from the data was: 'differences in recovery from childbirth'. Women compared recovery following the vaginal birth to their experiences after a caesarean. Several different issues were raised within this broad theme. All women who experienced both types of birth felt that a caesarean resulted in a longer, more painful recovery. This was significant with regard to family obligations. Women saw the additional recuperation period following a caesarean and particularly the inability to drive immediately as very prohibitive, as the following comments illustrate:

I'm saying that it would be a lot of hassle after the event, and being in a state with stitches or whatever and being told you can't do this and you can't do that for six weeks...my little boy's at nursery and so it would be difficult if I can't drive to get him to nursery and all that kind of thing.

This agrees with Eden et al. (2004) who found that family obligations were a more significant determining factor in a woman's choice about method of delivery than concerns about either maternal or child health.

The final theme was: 'influences on bonding'. The researchers never suggested the term 'bonding', instead this was a word which almost all the women used and identified as a postnatal experience. Women compared their perception of bonding with their new baby following the vaginal delivery and caesarean section. Some women felt that there was no difference in terms of bonding with either mode of childbirth:

I felt that complete love for both of them as soon as they came out and no, I don't think I felt any differently. Just really joyful.

Other women thought that a caesarean section did affect their ability to bond with their babies. This was particularly related to the type of anaesthetic used:

...it was a general anaesthetic. I never saw him. My husband saw him being lifted out but I think I felt a bit cheated because you don't get any bonding with your baby.

However, another woman reported a decrease in bonding following a vaginal delivery when compared with her previous caesarean. This was also related to the use of analgesia:

I didn't feel as bonded this time as I did...but it did seem to take a bit longer to come round. I don't know if it were with all the gas and air that I had. I don't know, but it just didn't seem to register for a while, you know.

Although most women discussed the relationship between bonding and breastfeeding immediately after delivery, mode of delivery did not seem to influence the establishment of breastfeeding. However, one woman stated the opinion that this had not been true after her previous caesarean section. She felt that method of delivery had made an impact on her ability to breastfeed and she expressed the desire to bond with her baby and establish breastfeeding as a major influence in her choice to have a vaginal birth.

Discussion

The concept of informed choice in the maternity services began with the implementation of changing childbirth (Department of Health 1993). The ethos of informed choice has become an underpinning expectation of care. More recently, the NHS Plan (Department of Health 2000) reiterated the concept of choice. However, without education, choice becomes meaningless. Women require a clear reminder of why a caesarean was performed and need to be provided with evidence-based information regarding the chances of a recurrence of the problem, which resulted in an operative delivery (Bainbridge 2002). Clinicians, both midwives and obstetricians, must ensure that current evidence informs their thinking as it is clear that women are easily influenced by professional beliefs (Hundley et al. 2001). This is especially significant when it can be demonstrated that beliefs widely held by professionals are not always substantiated by the best available research.

The women in this study felt that they had some choice in the mode of delivery although they were all aware that medical and midwifery opinion supported VBAC, which may have influenced their decisions (Hundley et al. 2001). The reasons they gave for wanting a vaginal birth ranged from the desire to experience normal birth, the expectation of increased bonding and easier breastfeeding, reduced pain and length of recovery and the ability to take on family responsibilities quickly, especially the care of their older children. Most of the women described labour as a valuable experience, although one woman who had not experienced labour before was surprised at how painful it was. One interesting finding was that even the two women who had repeat caesarean sections appreciated the opportunity to labour and to try to achieve a normal delivery. The experiences of women who try for, but do not achieve VBAC merits further investigation as anecdotally, health professionals often express the opinion that such women have experienced the worst of both vaginal and operative deliveries. Women may view their experiences differently.

Strengths and limitations

The study design enabled the researchers to explore issues around caesarean section and VBAC with women in some depth. The researchers are all midwives involved in education and therefore had no clinical involvement with the research participants. Their professional knowledge and experience enabled the researchers to gain a quick rapport with the research participants while the fact that they were not involved in clinical care of the women encouraged the frank discussion.

The main limitation of the study was the recruitment procedure, which meant that the research team relinquished any control over sample size or composition. Although qualitative research cannot be generalized, the inclusion of a larger sample may have allowed additional issues to be explored. Recruitment was undertaken by community midwives who were otherwise uninvolved in the project. This was carried out to address ethical concerns, but did mean that an invitation to participate may not have been offered to all eligible women. Indeed, two of the researchers later met eligible women, who had not been informed of the study. The composition of the sample also meant that participants did not accurately reflect the ethnic mix of the community. Although an interpreter was supplied by the Trust to assist in interviewing non-English speaking women of Pakistani or Bangladeshi origin, only one participant was in this category. Other studies, particularly from North America and Australia have looked at the effect of ethnicity on attitudes towards VBAC (Walker et al. 2004). This merits further investigation within the UK.

Conclusion

In addressing concerns about both the health and the cost implications of the well-documented rising caesarean section rate, the issue of repeat caesarean sections is a significant factor which must be considered. This paper set out to present the concerns of women who were hoping to achieve a vaginal birth after a previous caesarean section. Follow up interviews enabled the research team to explore more deeply any issues which arose. The women who chose to participate in the research seemed to value the opportunity to discuss clinical issues with a midwife who was not involved in direct care. This was identified by Webb (1986) in her classic research on women as gynaecology patients and nurses. She too found that women appreciated the researcher as a knowledgeable listener.

During the antenatal and postnatal interviews, women raised a number of issues. Of these, the biggest concern seemed to be around choice. Women who have experienced one operative birth may wish to exercise choice about the method of delivery in subsequent pregnancies. It is important to understand how women's lived experience of childbirth influences choice, especially regarding aspects of birth which are most significant for the women themselves. These may not always tally with the obstetric or midwifery interpretation of events. An example from this study is the importance that women afforded the experience of labour, whether or not it ultimately resulted in a vaginal birth. This was a particularly interesting point as many midwives and obstetricians seem to view labour primarily as a physical process, expressing concern with the increased morbidity resulting from emergency caesareans following the labour. Women, on the other hand view labour almost as a rite of passage (Mander 2000) and express satisfaction with the process, regardless of the outcome.

Bonding, or the establishment of the mother–infant relationship was also raised frequently. Women were concerned about how differing methods of delivery affected this process and their experiences were not all weighted towards the vaginal birth. Instead, mental clarity was perceived as important for the first mother–infant encounter and women expressed less satisfaction when their senses were fogged by analgesia or anaesthesia. This finding may have important implications for practice. The best method of pain control and mode of birth must be considered, as some women may find a planned operative delivery under spinal anaesthetic preferable to a vaginal birth using an opiate analgesia for pain relief.

Finally, recovery from childbirth was considered very significant and most women pointed to the quicker recovery time as an important reason for choosing a vaginal birth. An important consideration for all the mothers in the study was the ability to care for their older children. A particular concern involved the ability to drive so that the routines already established with older children, such as the school run, were disturbed as little as possible. This was perceived as a significant element of family adaptation to the new child. None of the women who had experienced both methods of birth thought that recovery was quicker or less painful with a caesarean birth. The only real benefit to caesarean section was expressed in one woman's antenatal admission that she liked its predictability.

In conclusion, this study demonstrated that VBAC has implications, which have not always been considered by obstetricians and midwives who have tended to focus on the physical aspects of safe birth. For women, there are also psychosocial implications that go beyond the physical process of birth. Midwives and obstetricians need to be aware of these when discussing options for birth with women who have had a previous caesarean section.

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