Birth after caesarean

How do women make decisions about mode of delivery?

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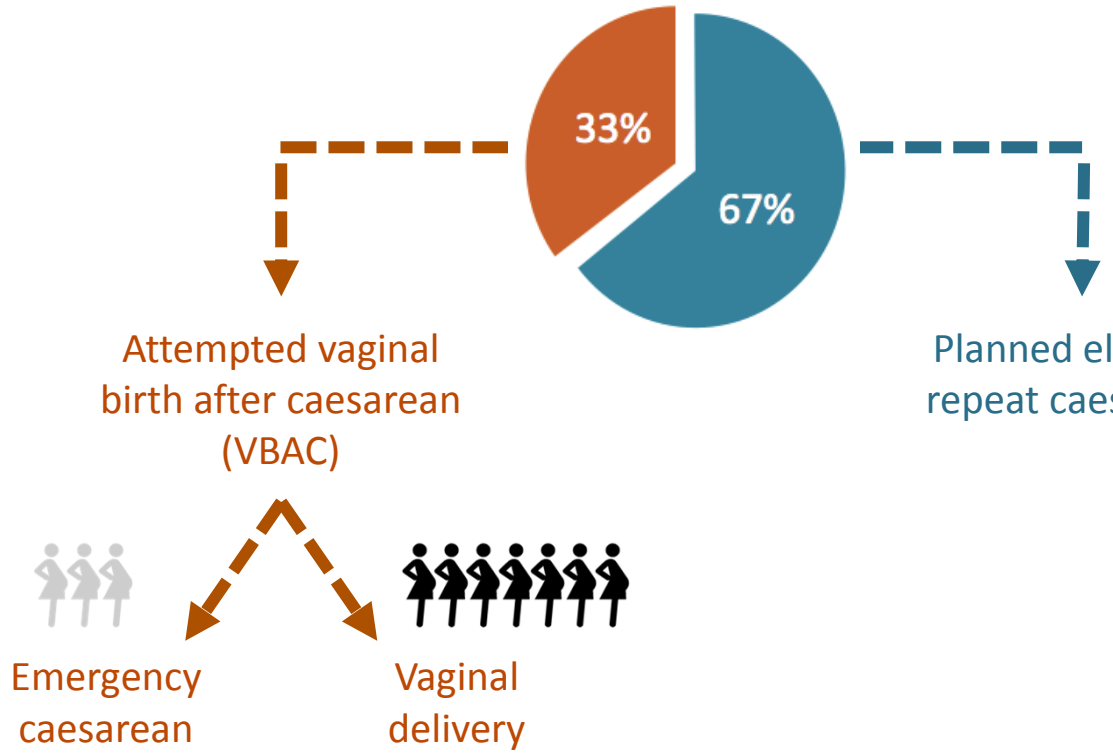
Objectives

1. Understand women's attitudes toward and experiences of decision-making for birth after caesarean in British Columbia.

1. Learn about the role of debriefing and patient decision aids to support informed shared decision-making.

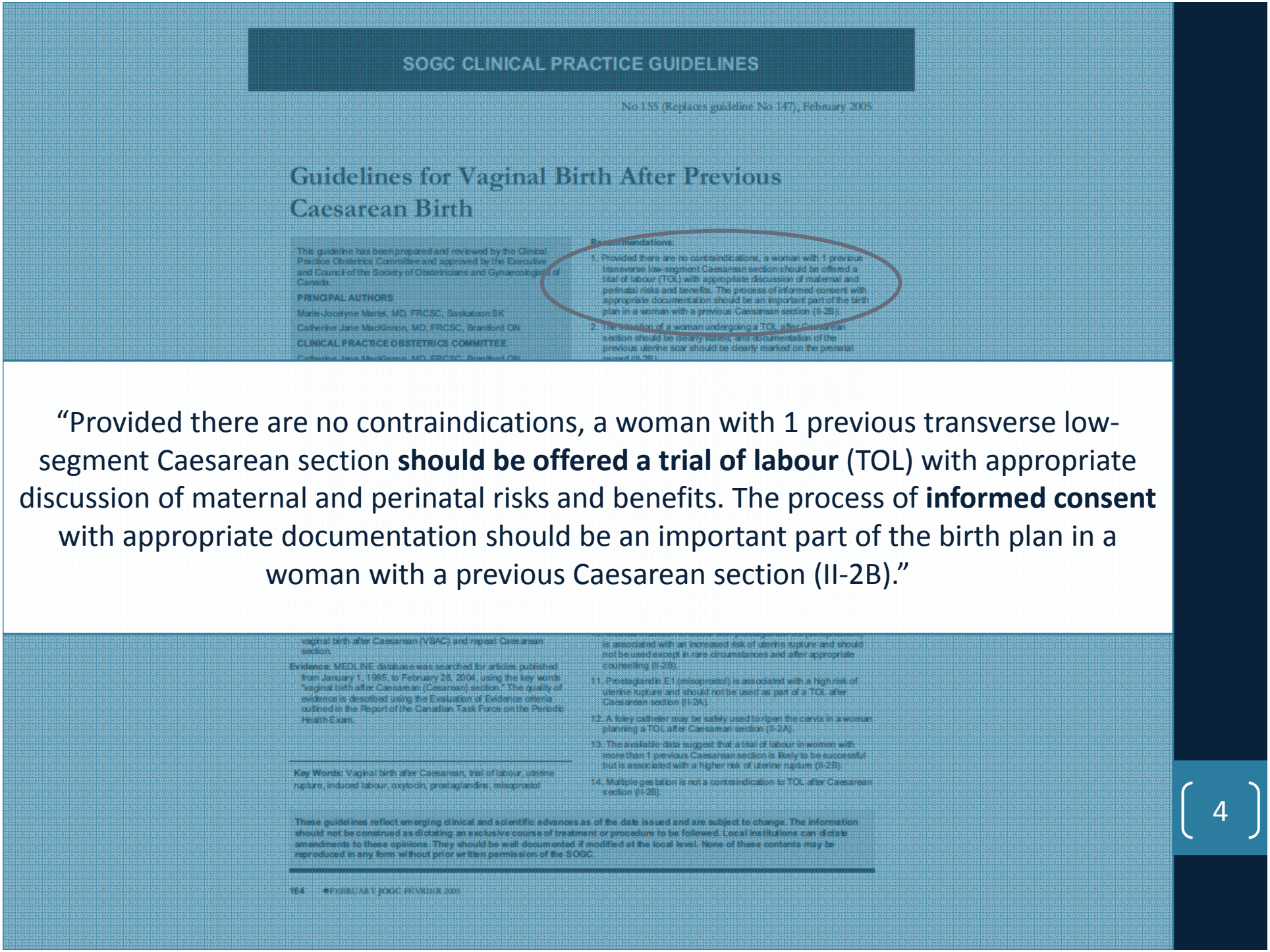
The Problem

82.4% of women are eligible for VBAC



7 out of 10 women will have a VBAC as planned

Perinatal Services BC, 2014


SOGC CLINICAL PRACTICE GUIDELINES

No 155 (Replaces guideline No. 147), February 2005

Guidelines for Vaginal Birth After Previous Caesarean Birth

This guideline has been prepared and reviewed by the Clinical Practice Obstetrics Committee and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

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CLINICAL PRACTICE OBSTETRICS COMMITTEE

Recommendations

1. Provided there are no contraindications, a woman with 1 previous transverse low-segment Caesarean section should be offered a trial of labour (TOL) with appropriate discussion of maternal and perinatal risks and benefits. The process of informed consent with appropriate documentation should be an important part of the birth plan in a woman with a previous Caesarean section (II-2B).

2. The [illegible] of a woman undergoing a TOL after Caesarean section should be clearly stated, and documentation of the previous uterine scar should be clearly marked on the perinatal record (II-2B).

"Provided there are no contraindications, a woman with 1 previous transverse low-segment Caesarean section **should be offered a trial of labour** (TOL) with appropriate discussion of maternal and perinatal risks and benefits. The process of **informed consent** with appropriate documentation should be an important part of the birth plan in a woman with a previous Caesarean section (II-2B)."

vaginal birth after Caesarean (VBAC) and repeat Caesarean section.

Evidence: MEDLINE database was searched for articles published from January 1, 1985, to February 28, 2004, using the key words "vaginal birth after Caesarean (Caesarean) section." The quality of evidence is described using the Evaluation of Evidence criteria outlined in the Report of the Canadian Task Force on the Periodic Health Exam.

[illegible] is associated with an increased risk of uterine rupture and should not be used except in rare circumstances and after appropriate counselling (II-2B).

11. Prostaglandin E1 (misoprostol) is associated with a high risk of uterine rupture and should not be used as part of a TOL after Caesarean section (II-2A).

12. A foley catheter may be safely used to ripen the cervix in a woman planning a TOL after Caesarean section (II-2A).

13. The available data suggest that a trial of labour in women with more than 1 previous Caesarean section is likely to be successful but is associated with a higher risk of uterine rupture (II-2B).

14. Multiple gestation is not a contraindication to TOL after Caesarean section (II-2B).

Key Words: Vaginal birth after Caesarean, trial of labour, uterine rupture, induced labour, oxytocin, prostaglandins, misoprostol

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The Problem

Evidence suggests existing interventions to support optimal birth after previous caesarean are ineffective.

Patient decision support

Audit and feedback vs. opinion leaders

Clinical practice guidelines

Non-clinical factors influence decision-making

- Attitudes and beliefs of care providers and their hospitals
- Malpractice concerns
- Access to the necessary surgical resources

Lundgren et al. Clinician-centred interventions to increase VBAC. *BMC Pregnancy and Childbirth* (2015)

What are the factors that influence women's decision-making for birth after caesarean?

Study Design

Phase 1

- **Qualitative design informed by grounded theory**
- **In-depth, semi-structured interviews**
- **Integrated knowledge translation approach**

Phase 2

- Develop behaviour change interventions at the patient, practitioner, and policy levels to support women to make informed choices for birth after caesarean

Phase 3 (2017)

- Implement and evaluate the interventions

Study Design

Participants	N=57
Women	**23**
Practitioners	**22**
Midwives	4
Obstetricians	4
Nurses	7
GPs	3
GP Surgeons	3
Anesthetist	1
Decision makers	**13**
Hospital	5
Regional	4
Provincial	4

Interviews were conducted between April-August 2015

Summary of Key Findings

Women lacked quality information on options for birth after caesarean

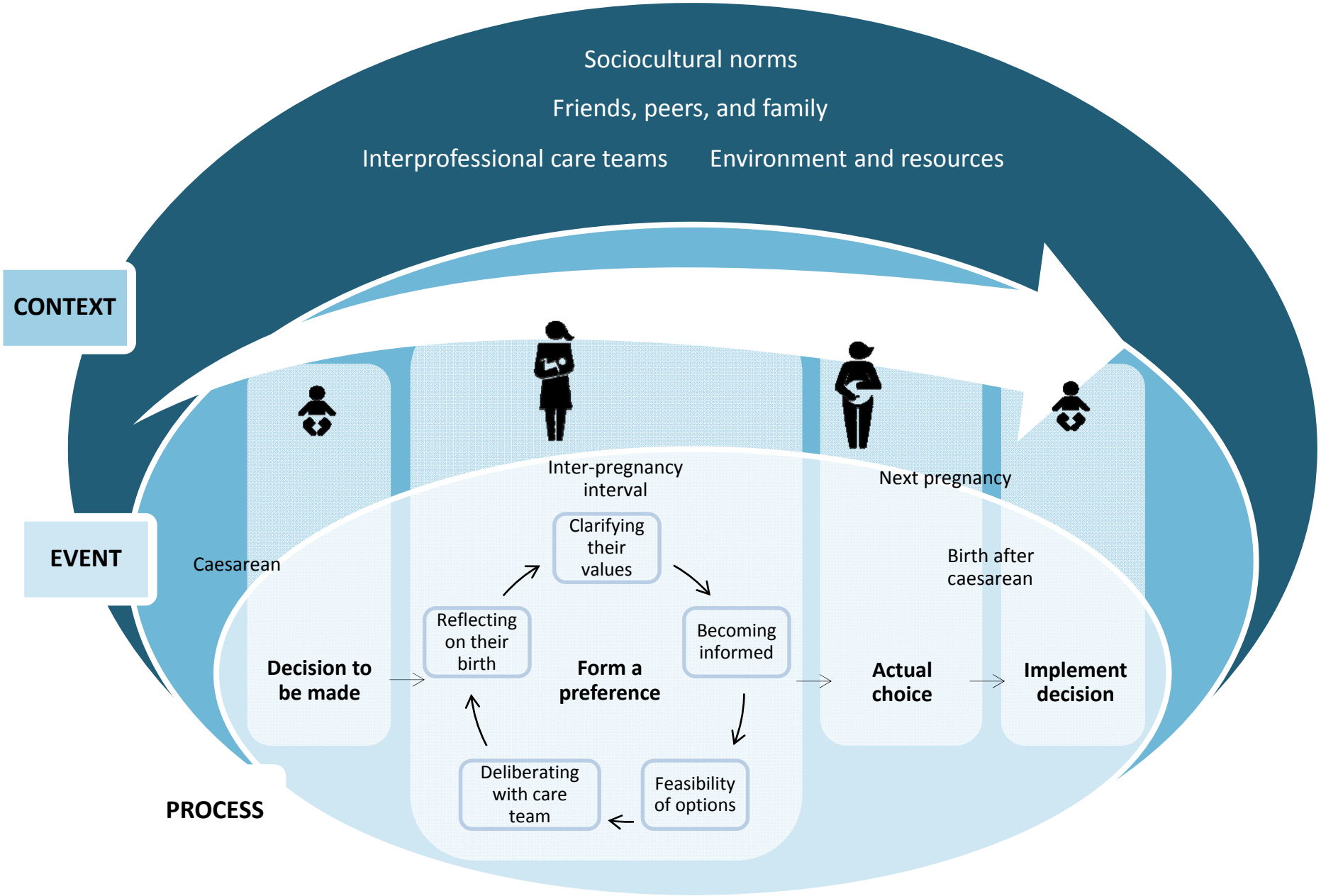
Having a healthy baby is of utmost importance, but it is not the only thing that matters to women

Unplanned caesarean and separation from baby caused trauma for some women

Care providers influenced women's choices

<u>Women consider their options for birth after caesarean in the period between pregnancies</u>

<u>Debriefing a woman's first birth experience may have a positive impact on their decision-making for future births</u>



Adapted from Légaré et al (2010) model of Interprofessional Shared Decision-Making

Women's experiences

Case example: "Emily"

1. Primary caesarean

- After 3 days of labour she had a caesarean for dystocia (general anaesthesia)
- Baby was high and transverse
- Emily and baby are separated
- She felt "powerless," "ignored," and "dismissed"

"It was a really traumatic experience emotionally. The physical recovery was easy … I actually had trouble bonding with my son. I remember staring at him in the hospital going like, '*really, you're my baby*,' and not feeling like that overwhelming surge of love that I thought I was going to experience. And even though I desperately wanted him close to me, I remember feeling like, *'I thought this was supposed to feel different*.'"

Women's experiences

Case example: "Emily"

2. Interpregnancy interval

- Emily feels "rushed" in appointments and alone
- 6 week check-up with GP
  - Emily asks about VBAC
  - No discussion of emotional experience
- Emily goes online to read other women's birth stories for comfort

3. Next pregnancy after caesarean

- Emily is motivated to plan VBAC and has a supportive GP
- Emily mentions her "traumatic birth"
- *"They were just focused on the physical and not the emotional"*
- She gets all of her information online

Women's experiences

Case example: "Emily"

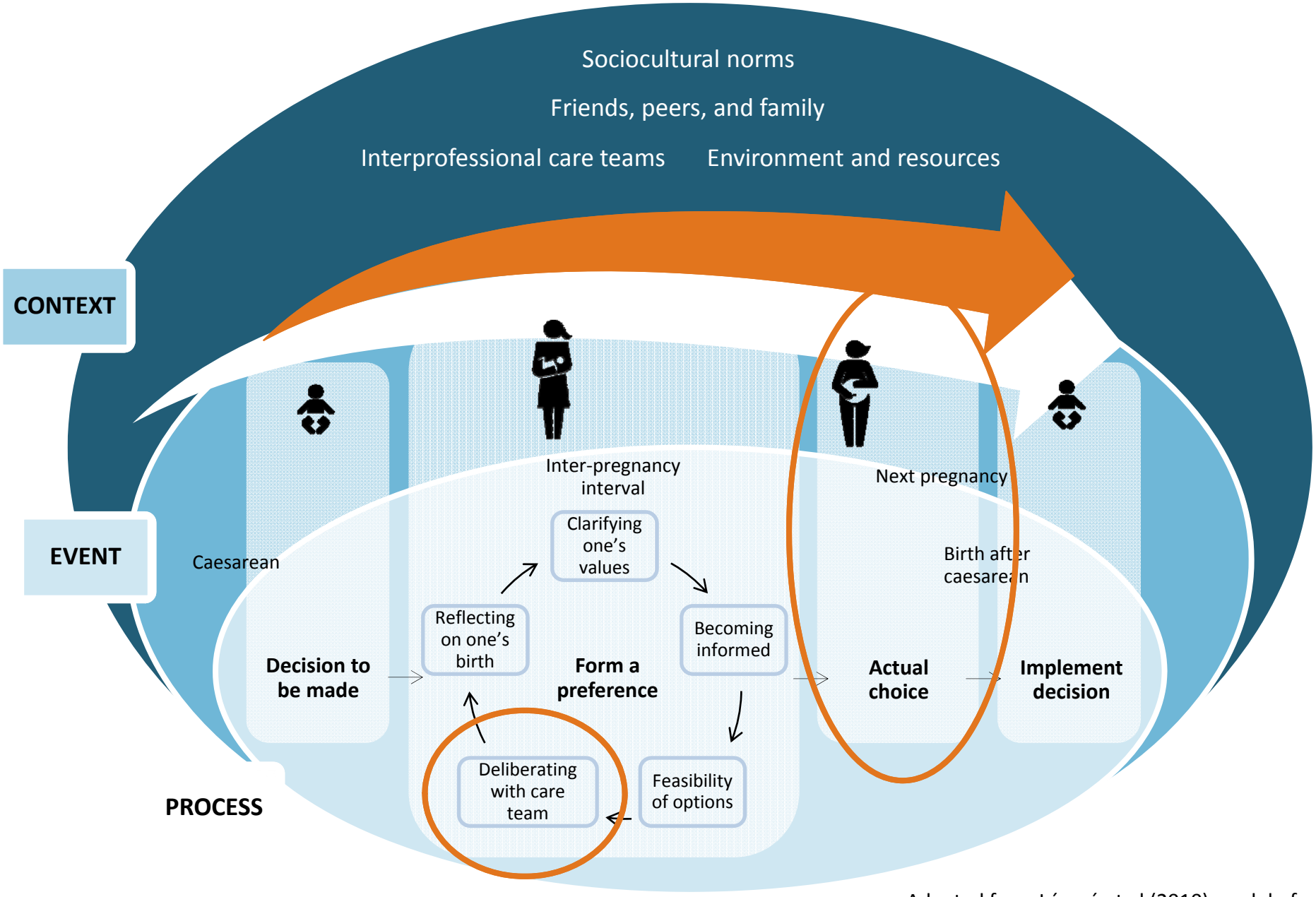
4. Birth after caesarean

- #1 priority was "*being able to hold my body and bond with her right away*"
- Fear of repeat caesarean → 4th degree tear
- GP asks jokingly if she would attempt VBAC again

"His jaw dropped … he had been doing births for 15 years and he said I was in his top 3 of tears that he had ever seen. He said, '*I am really surprised by that. With your severity of tear I would definitely recommend for you to have a c-section again.*' And I said, '*No.*' And he's like, '*Well why?*' And … I said, '*my first was so traumatic emotionally that I would trade it in a second for this one.*' And he actually apologized to me and said, '*I am sorry. I didn't realize it was that bad.*' [Crying] And he said, '*If I had known we would have been giving you more support.*'"

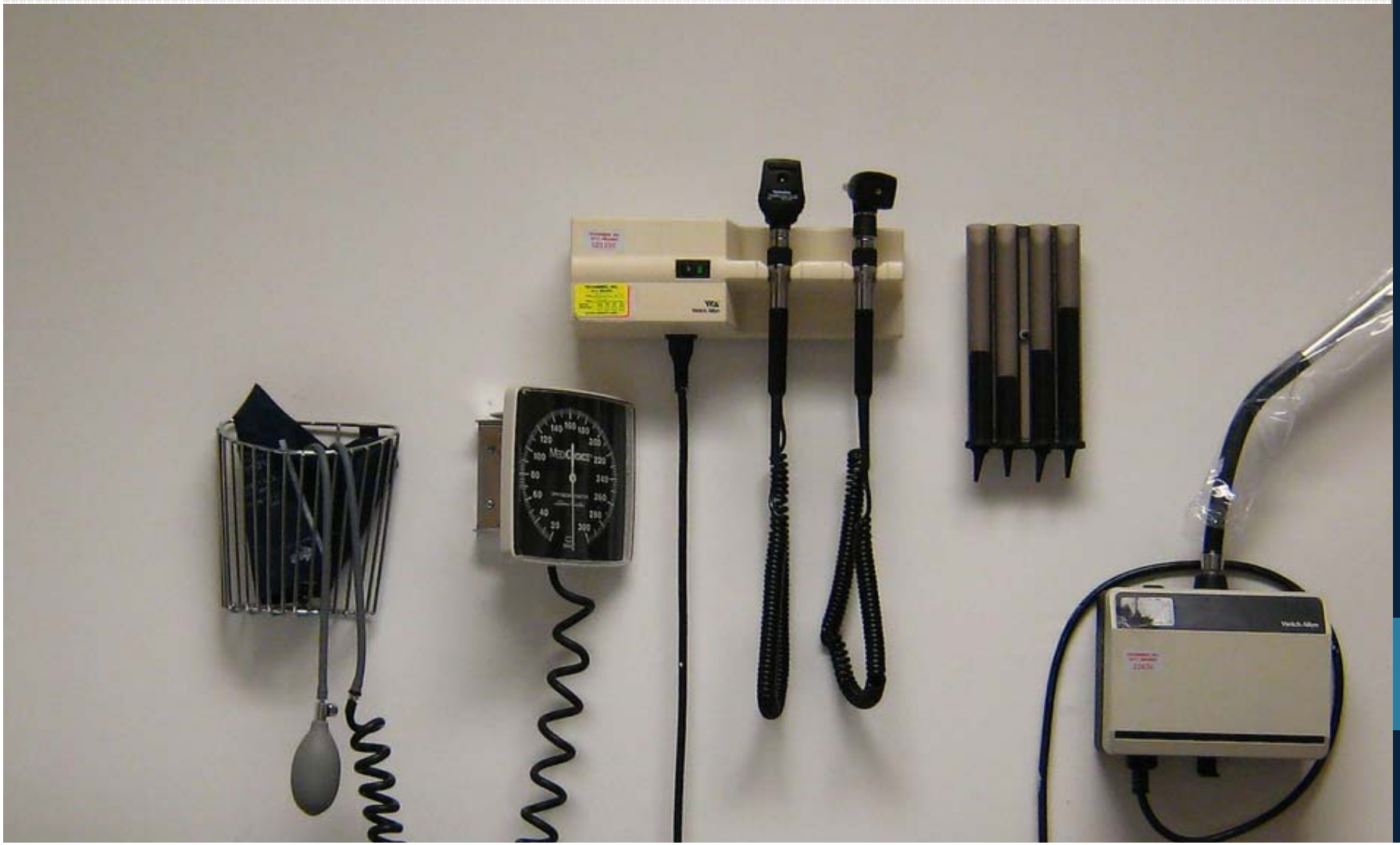
Interpreting Emily's Story

Megan Taylor Photography



Adapted from Légaré et al (2010) model of Interprofessional Shared Decision-Making

How can debriefing and patient decision aids support informed shared decision-making?



Shared Decision-Making (SDM)

Shared decision-making is the cornerstone of patient-centred care.

1. **Choice Talk**
   - Explain that she has a choice for mode of birth after caesarean
   - Explore the role that she wants to play in the decision

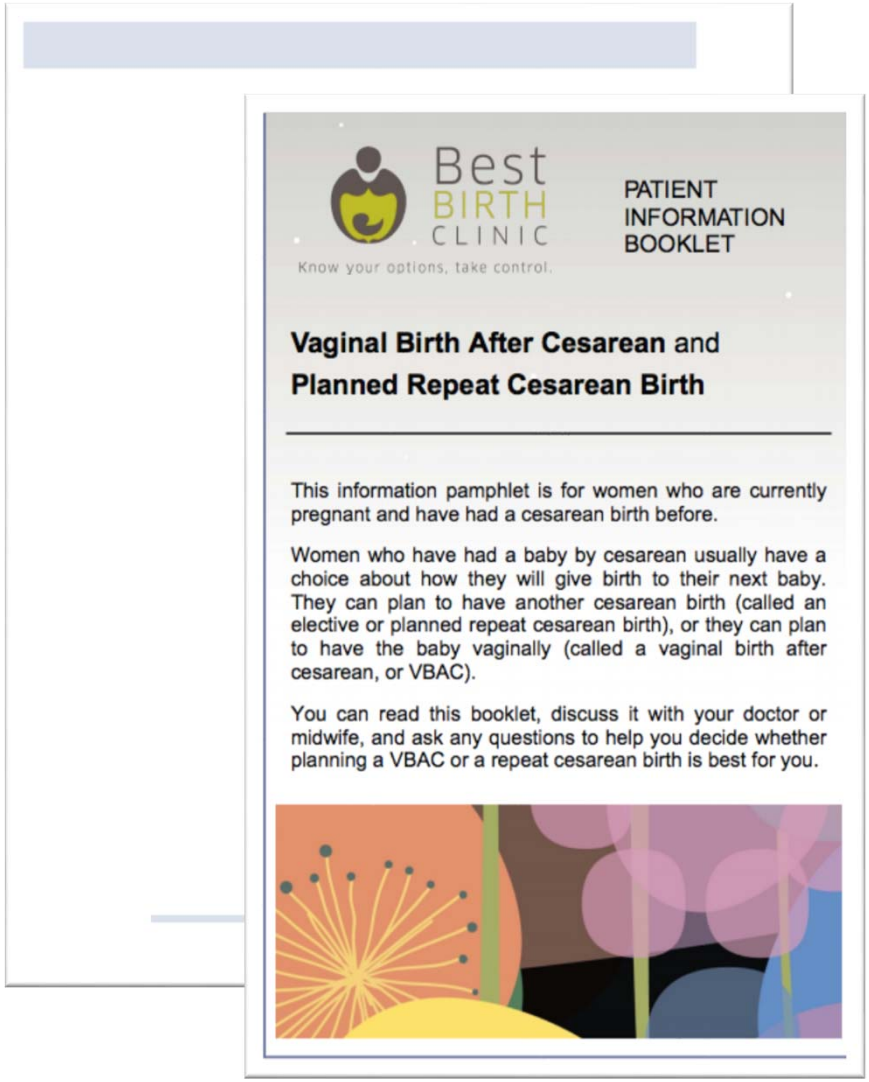
2. **Option Talk**
   - Inform her about the options and their consequences
   - Explore her previous birth, values, and preferences
   - Explore the underlying motives for her preferences
   - Deliberate with her and her significant other(s) over multiple visits

3. **Decision Talk**
   - Make a decision together and stress that she can change her mind
   - Safeguard her sense of autonomy and clarity over the decision
   - Communicate the reasons for the decision to other members of the care team

Adapted from Elwyn et al, *J Gen Intern Med* (2012)

Health system support for SDM

- Debrief at 6 weeks
- Consider “recommending” rather than offering VBAC for eligible women
- Provide women a patient decision aid
- Discuss decision aid “preference report” in iterative discussions
- Decision aid strengthens informed consent, which may reduce malpractice concerns



Durand et al, *BMC Health Serv Res* (2015)

Summary

1. A woman's first caesarean influences their preference for mode of delivery.
2. Some women experience trauma after an unplanned caesarean.
3. Women begin forming a preference for mode of delivery during their interpregnancy interval.
4. Debriefing and shared decision-making (SDM) with patient decision aids can help women make better choices.
5. Look **upstream** to clinician, resource, and policy barriers and address them through regional and provincial strategies.

Thank you!

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