

PREVIOUS CESAREAN IN FLORIDA: HEALTHCARE PROVIDERS'  
DECISION-MAKING ABOUT MODE OF DELIVERY

By

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To my sons: Sky Wells, Tyler Ploch, and Saul Ploch

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High rates of cesarean section and low rates of vaginal birth after cesarean in Florida indicate limited options for women with a previous cesarean section. These trends represent high costs to the healthcare system that have not been shown to produce better outcomes for mothers and babies. Florida also has the distinction of having a high number of malpractice suits. This ethnographic study explored the views of Florida obstetricians, Certified Nurse-Midwives, and Licensed Midwives on the factors influencing their decision-making regarding mode of delivery, and aimed to discover how sociocultural, political, and economic forces impacted the process.

The data consisted of interviews with healthcare providers and key informants, observational field notes, Florida vital statistics, and perusal of relevant documents, such as professional guidelines and state statutes. While a majority of providers viewed vaginal birth after cesarean as a safe birth option, many were deterred from offering it due to fear of malpractice liability. Restrictive hospital policies and professional guidelines were also a major obstacle, particularly in rural and community hospitals. In terms of decision-making, both obstetricians and midwives placed a high value on women's autonomy and the "right to choose" the mode of birth. In order to lower their risk threshold for suit and retain women in their practices, however, most obstetricians steered women towards repeat cesarean birth. Although

midwives were generally supportive of vaginal birth after cesarean, few were able to provide care to women with a previous cesarean due to hospital, employer, and legal constraints.

A few providers have continued to offer vaginal birth after cesarean in limited areas of the state, but they are often inaccessible to women desiring a trial of labor. As a result, many women who desire vaginal birth after cesarean are either consenting to repeat cesarean in order to receive care near their homes, or seeking out-of-hospital midwives for assistance.

## CHAPTER 1 INTRODUCTION

Florida has high cesarean section (CS) rates as well as a high number of obstetrical malpractice lawsuits (Wilson & Strunk, 2006). Not surprisingly, the state also has one of the lowest vaginal birth after cesarean rate (VBAC) rates in the nation (Martin et al., 2008). Many obstetricians and midwives in the state have become unable or unwilling to offer the option of VBAC due to concerns over medicolegal liability and restrictive hospital policies. As a result, many women desiring to attempt a VBAC in Florida are either unable to find a provider who offers the option or forced to travel a long distance from their home in order to be accommodated. Moreover, some women are choosing to deliver in an out-of-hospital setting in order to avoid a repeat cesarean section (RCS). Taken together, these trends represent high costs to the healthcare system without corresponding evidence of benefit to mothers and babies (MacDorman, Menacker, & Declercq, 2008; Resnik, 2006; Sakala & Corry, 2008).

For more than a decade, various authors have speculated that sociocultural, political, and economic trends are driving the changes in obstetric practice that have resulted in increased CS rates and decreased VBAC rates (Burns, Geller, & Wholey, 1995; Hankins, MacLennan, Speer, Strunk, & Nelson, 2006; Roberts, Deutchman, King, Fryer, & Miyoshi, 2007; Stalnaker et al., 1997; Tussing & Wojtowycz, 1992). Although the risk for poor outcomes with VBAC is low in appropriate settings, many physicians and hospitals have opted to curtail their liability by avoiding VBAC altogether (Block, 2007; Roberts et al., 2007). Furthermore, the requirement of being "immediately available" during the entire course of labor with a VBAC is often unfeasible for providers in community or rural hospitals (Roberts et al., 2007).

Declining access to VBAC, however, raises important questions about patient autonomy and "consumer choice" in healthcare decision-making. While informed consent and shared

decision-making are widely advocated, there has been little critical analysis of how patient preferences are incorporated into delivery-mode decisions (Little et al., 2008). Moreover, there is a crucial need for support at the policy level to work toward solutions that will address the needs of both groups of stakeholders (MacDorman, Menacker, & Declercq, 2008; Mander, 2007; Sakala & Corry, 2008).

### **Historical Trends and Practice Changes**

For much of the twentieth century, the dictum of "once a cesarean, always a cesarean" dominated American obstetrics (Flamm, 1997). In the late 1980s, however, women's and physicians' interest in VBAC, coupled with pressures to contain costs, fueled encouragement of the practice (Flamm, 1997; Roberts et al., 2007). Enthusiasm for VBAC peaked in the mid-1990s. Some institutions and insurance companies even required a women with a previous CS to attempt a trial of labor (TOL), regardless of her previous history or personal preferences (Block, 2007; Little et al., 2008). By the new millennium, however, reports of increased rates of uterine rupture and accompanying neonatal morbidity began to appear in the literature (Lydon-Rochelle, Holt, Easterling, & Martin, 2001; McMahon, Luther, Bowes, & Olshan, 1996). The American College of Obstetricians and Gynecologists (ACOG) responded by issuing a practice bulletin that offered a revised set of guidelines for the selection of VBAC candidates and the management of their labors (ACOG, 1999). The bulletin specifically stated that women with one previous CS and a low transverse scar should be counseled about VBAC and offered a TOL; however, the most influential recommendation was that a surgeon capable of performing a CS, an anesthesiologist, and support personnel for surgery should be "immediately available throughout active labor." (ACOG, 1999, p. 198; Block, 2007; Roberts et al., 2007). While ACOG later clarified that the operational definition of "immediately available" was subject to interpretation

by the local institution, the guidelines resulted in a precipitous decline in VBAC availability (ACOG, 1999; Roberts et al., 2007).

There are several features of the highly influential 1999 ACOG Practice Bulletin that should be noted. The first is that the "immediately available" recommendation was based primarily on consensus and expert opinion, while the recommendation to counsel about VBAC and offer a TOL was based on "good and consistent scientific evidence" (ACOG, 1999, p.201). Thus, it appears in retrospect that a significant policy change was promulgated largely on expert opinion rather than scientific evidence (Block, 2007; Little et al., 2008). Another important recommendation, which was accompanied by an algorithm for decision-making, was that the decision for mode of delivery "should be made by the patient and her physician" (ACOG, 1999, p.201). A decade later, the introduction of patient choice in the decision-making process has served those women desiring a RCS; however, it appears to have had the opposite effect for those women desiring a VBAC (Little et al., 2008).

Although ACOG issued a new practice bulletin for VBAC in 2004, the basic recommendations remained unchanged. The bulletin offers the following guidance to providers: "After thorough counseling that weighs the individual benefits and risks of VBAC, the ultimate decision to attempt this procedure or undergo a repeat cesarean delivery should be made by the patient and her physician. This discussion should be documented in the medical record" (ACOG, 2004, p. 208).

### **Knowledge Gaps**

Today, VBAC is largely unavailable in the state of Florida. Considering that professional guidelines still recommend offering VBAC as an option, questions remain about the quantity and quality of the information women receive during prenatal care. How do providers present the information? If they do not offer VBAC, where can a woman go to get one? Who actually

provides the counseling: obstetricians, midwives, or nurses? Are women told about the risks of RCS or the risks to their baby?

While there is a vast scientific literature on risk factors for RCS and VBAC, there is a dearth of research on counseling women about mode of delivery. Most of the existing research on decision-making has focused on women rather than healthcare providers, although a few studies from the United Kingdom (U.K.) and Australia are available (Bryant, Porter, Tracy, & Sullivan, 2007; Kamal, Dixon-Woods, Kurinczuk, Oppenheimer, Squire, & Waugh, 2005). Given the considerable differences between the market-driven American system and the socialized systems of the U.K. and Australia, however, these studies explored a very different context. Moreover, midwives in the United States have considerably less autonomy in terms of VBAC counseling and care than do their British and Australian counterparts (American College of Nurse-Midwives (ACNM), 2003; Bryant et al., 2007; Kamal et al., 2005). Thus, my research study supported the need for a broad, qualitative approach that included the perspectives of both obstetricians and midwives on decision-making for mode of delivery in the context of a populous American state.

### **Purpose, Aims, and Study Design**

The purpose of the study was to explore the perspectives of Florida obstetricians and midwives on the factors that influence their decision-making for mode of delivery and to discover how sociocultural, political, and economic forces impacted the process. The aim was to gain new knowledge of how obstetricians and midwives are counseling patients in a state where VBAC is widely unavailable. Ethnography was a useful research method for this purpose as it requires a few knowledgeable and articulate informants rather than a large unbiased sample of people (Patton, 2002). These issues were explored qualitatively by allowing obstetricians and midwives to share their views on the counseling process, and to tell their stories about

negotiating decision-making with women, healthcare organizations, and regulatory bodies. Through the analysis of in-depth interviews, observations, relevant documents and media, I was able to identify sociocultural, political, and economic influences that are impacting providers' ability and willingness to offer VBAC in the current landscape. Deficits in counseling practices were identified as well. This information is useful in informing policy and practice at several levels.

### **Research Questions**

In order to meet the purposes and aims of the study, the following research questions were addressed: 1) What factors influence how obstetricians and midwives counsel women for RCS or VBAC? 2) What strategies are used to negotiate decision-making with women? 3) How are conflicts with women and organizational forces handled? 4) What happens to women who request VBAC and are told by the provider that it is not offered? Appendixes A, B, and C contain the interview guides that were used in the study.

### **Research Framework: Critical Medical Anthropology**

Although critical medical anthropology (CMA) draws upon neo-Marxian, critical, and world systems theoretical perspectives, the framework has evolved to include medical ecology and postmodernism. Given CMA's emphasis on the political economy of health, it is a useful framework for studying who controls biomedicine and what the implications are of such control (Baer, Singer, and Susser, 2003). CMA seeks to understand health issues "within the context of encompassing political and economic forces that shape social behaviors, pattern human relationships, condition collective experiences, situate clinical meaning, and reorder local ecologies" (Baer, Singer, and Susser, 2003, p. 38).

This multi-level view of the health system is relevant to the research questions proposed in this study. At the macro-level, the profit-making orientation of most Florida health systems tends

to favor high-technology, high-profit cesarean birth over low-intervention, lower-cost VBAC. State regulatory boards, professional organizations, malpractice insurance companies, and hospital risk management boards exert considerable influence over obstetricians' and midwives' practice by setting policy. These agencies also interact with the legal system to enforce control of professional standards, and to discipline "negligent" providers. At the intermediate, or social level, obstetricians, nurse-midwives, and to some extent, licensed midwives, must interact with the community health system. While an obstetrician or nurse-midwife may *want* to provide the VBAC option to women in her practice, she may be constrained by the need to retain hospital privileges, malpractice insurance coverage, or employment. Similarly, a licensed midwife may be controlled by needing to maintain a relationship with a sponsoring physician in order to be in compliance with the state practice act. As a result, these providers may experience internal conflict between their personal views about VBAC and the position they are required to maintain. Thus, as individuals, providers may have little or no power.

Childbearing women may also have little power as individuals. If they are young or poor, they may have few, if any, choices over who their healthcare provider will be. Women of racial and ethnic minorities often have the least power in terms of choices and decision-making. Transportation, health insurance, employment, and other constraints may limit access to alternative providers for a woman who actively seeks a VBAC.

While CMA seeks to understand macro-level forces, it intends to explore the implications of these forces at the micro-level of individual experience and behavior. The micro-level primarily refers to the provider-patient relationship. As CMA views the body as being socially and culturally constructed, it seeks to understand the social forces outside the office that mediate this relationship (Baer, Singer, and Susser, 2003). Faith in technology, discourses of risk,

neoliberal consumerism, fetocentrism, and media influences are but a few examples of these social forces.

CMA acknowledges, however, that not all individuals are constrained by social forces. Some individuals engage in resistance, and even in open rebellion (Baer, Singer, and Susser, 2003). From this perspective, women do have some power to negotiate what their birth experience will be, even those who are culturally and socially marginalized. Resistance in this study is characterized in several ways. Women who insist on being given the opportunity to VBAC, who arrive at the hospital crowning to avoid RCS, or who chose to deliver in an out-of-hospital setting attended by a midwife represent one level of resistance. Obstetricians and nurse-midwives may engage in resistance as well, by offering VBAC to women in opposition to their colleagues and/or hospital policy, or by choosing VBAC for their own birth. By offering out-of-hospital VBAC, with or without the sanction of the state, licensed midwives also engage in resistance. Consequently, CMA acknowledges the concept of agency as a force within the clinical encounter, and anticipates, that in some cases, the patient may be the power-broker.

Through the lens of CMA, I explored and analyzed the views of Florida obstetricians and midwives on decision-making about mode of delivery. I also investigated the context of VBAC availability within the state, as well as the modes of resistance some providers and women are engaging in to change the policy landscape. CMA's utility in explaining the findings is revisited throughout the following chapters.

## **Conclusion**

In this chapter, I provided an overview of the problem and outlined the purpose of exploring it qualitatively. Chapter 2 provides an in-depth analysis of the current literature on health care system factors, safety concerns, decision-making models, and decision-making processes of women and healthcare providers. Chapter 3 presents the details of the research

design and methods used in the study. Chapter 4 outlines the Florida context, and chapter 5 discusses the results of the interviews, observations, and analysis of relevant documents and media. The final chapter concludes with a discussion of the findings and links them to the broader social context through the lens of CMA.

## CHAPTER 2 REVIEW OF LITERATURE

This chapter contains a review of both classic and recent literature that is relevant to the questions addressed in this study. The review begins with an overview of current healthcare system factors that influence mode of delivery decision-making. This is followed by a discussion of the evidence base on individual safety and risk factors that providers should include in their counseling. Next, there is a summary of healthcare decision-making models and informed consent, followed by a discussion of the literature on women's and healthcare providers' decision-making processes. The review concludes with a summarization of the pertinent issues and knowledge gaps.

### **Healthcare System Factors**

#### **Medicolegal Issues**

Over the past decade, concerns about exposure to medical malpractice litigation have affected obstetrical practice patterns (Flamm, 2001; Hankins et al., 2006). VBAC has been identified as a "high risk" practice, (Clark, Belfort, Dildy, & Myers, 2008; Dauphinee, 2004; Flamm, 2001) particularly in Florida, which has been designated as a "Red Alert" state by ACOG (2002). According to Stalnaker et al., (1997) uterine rupture during labor with a previous cesarean section led to compensation by the Neurologic Injury Compensation Association Fund (NICA) in a total of nine patients. Labor induction was particularly problematic, as seven of these mothers had their labors induced with oxytocin because of an unfavorable cervix (Stalnaker et al., 1997). Consequently, many obstetricians have opted to avoid the risk of VBAC altogether by doing RCS (Resnik, 2006; Flamm, 2001).

Data from the 2006 American College of Obstetricians and Gynecologists (ACOG) Survey on Professional Liability indicated that almost 76% of obstetricians in District IV made

changes to their practice as a result of the affordability/availability of professional liability insurance, and nearly 85% had at least one claim filed against them during their professional careers (ACOG, 2006). As a result, 32% of obstetricians increased the number of cesarean deliveries, and 26% stopped offering VBACs (ACOG, 2006). Fear of litigation was also driving these changes. In response to the question of increased risk or fear of litigation, over 39% of obstetricians in District IV increased the number of cesarean deliveries and 31% reported that they have stopped offering/performing VBACs (ACOG, 2006).

### **Birth Setting and Care Provider**

The dissemination of the 1999 ACOG VBAC Practice Bulletin resulted in a re-examination of birth settings and care providers. Tertiary medical centers, with a full complement of in-house obstetrical residents, anesthesiologists, blood banking, and 24 hour surgical staff capabilities, were not generally affected by the guidelines, and most continued to offer VBAC (Flamm, 2001; Lavin, DiPasquale, Crane, & Stewart, 2002; Roberts et al., 2007). Since ACOG left it up to the institution to define "immediately available," however, community and rural hospitals varied in their ability to initiate a prompt emergency CS in the event of a uterine rupture (Lavin et al., 2002; Roberts et al., 2007). In a statewide survey of Ohio hospitals, only 15.6% of Level I and 62.9% of Level II hospitals had a complete complement of physicians and surgical personnel immediately available in the hospital during a TOL, and some hospitals had stopped providing VBAC altogether (Lavin et al., 2002). In a similar survey study, Roberts et al. (2007) found that 3 out of 10 hospitals had discontinued VBAC services, and that 70% of hospitals had changed their policy to require that a surgeon and anesthetist be in-house when a woman attempting VBAC was in labor. Moreover, 19% required that an obstetrician, rather than a midwife or family practice physician, be in attendance (Roberts et al., 2007). Interestingly, however, the authors of a retrospective cohort study of 25,065 women attempting VBAC found

that outcomes were similar between tertiary care and community hospitals. Although uterine rupture rates in community hospitals were significantly higher, the absolute risk remained low. (DeFranco et al., 2007).

Midwife involvement in VBAC care has been affected substantially by the ACOG guidelines, both in hospitals and birth centers. In a 2000 survey, nurse-midwives were experiencing increased restrictions upon their ability to provide care for women attempting VBAC (Carr, Burkhardt, & Avery, 2002). Although a retrospective study of 649 women found that midwifery care during VBAC resulted in similar outcomes to physician care, midwife involvement in VBAC care has continued to decline (Avery, Carr, & Burkhardt, 2004; Lieberman, Ernst, Rooks, Stapleton, & Flamm, 2004).

VBAC care in birth centers has been similarly affected, largely due to the publication of a large national study by Lieberman et al. in 2004. Although the uterine rupture rate was 0.4% and the neonatal death rate was 0.2% for the 1,453 women who presented to birth centers in labor, the authors concluded that care in a birth center was not consistent with the recommended ACOG guidelines (Lieberman et al., 2004). Noted midwifery researcher Leah Albers (2005), however, took issue with these findings and claimed that the conclusions overstated the absolute risks of VBAC. Arguing that the small risk of untoward events was as likely in a low-intervention birth center as it was in a hospital, Albers (2005) predicted that access to both VBAC and midwifery care would diminish as a result of the study's publication.

### **Individual Safety and Risk Factors**

In his widely cited commentary, "Once a Cesarean, Always a Controversy" obstetrician and researcher Bruce Flamm asked, "Where do we draw the line?" (Flamm, 1997, p. 315). A decade later, the answer to that question remains elusive. While there is broad consensus that the risk of adverse outcomes by either mode of delivery is low, the debate among professionals

centers around what level of medical risk is acceptable (Flamm, 1997; Resnik, 2006). The potential for uterine rupture is the chief concern over the safety of VBAC, particularly since the publication of the 1999 ACOG Guidelines, wherein uterine rupture was described as having the potential to be "catastrophic." Ultimately, once the uterus has been scarred by a primary CS, the risk of all subsequent pregnancies is increased, regardless of the mode of delivery (Flamm, 2001). In recent years, however, concerns over the risks of multiple CS are challenging the view that repeat CS is safer than VBAC (Getahun, Oyelese, Salihu, & Ananth, 2006; Silver et al., 2006; Wu, Kocherginsky, & Hibbard, 2005). Furthermore, new research is bringing to light the decreased incidence of uterine rupture in women who have experienced spontaneous labor (Algert, Morris, Simpson, Ford, & Roberts, 2008; Mercer et al., 2008). These issues are beginning to have a significant impact on providers' counseling and decision-making and will be reviewed briefly below.

### **Risk of Uterine Rupture**

Although the risk of uterine rupture after CS has been studied since the 1950s, it was not until the late 1980s that large, multicenter studies confirmed it at approximately 1%. This evidence was in the form of either prospective or retrospective cohort studies, however, as women's strong preferences for or against VBAC discouraged investigators from trying to conduct randomized controlled trials (Flamm, Goings, Yunbao, & Wolde-Tsadik, 1994). In an effort to strengthen the evidence for or against VBAC, Mozurkewich and Hutton (2000) conducted a meta-analysis of the literature from 1989-1999. They identified the absolute risk of uterine rupture as being 0.4% in the trial of labor (TOL) group and 0.2% in the repeat cesarean group, and estimated that symptomatic uterine rupture may be about twice as common with TOL (Mozurkewich & Hutton, 2000).

In another influential study, Mona Lydon-Rochelle and colleagues (2001) used ICD-9 hospital discharge codes in Washington state to determine the effect of induction on uterine rupture rates in women attempting a VBAC. They reported that the use of prostaglandins to induce labor was associated with uterine rupture rates as high as 2.45%, a 15-fold increase (Lydon-Rochelle et al., 2001). Following the publication of this article, and the subsequent release of an ACOG Practice Bulletin discouraging the use of prostaglandins, enthusiasm for VBAC began to plummet (Macones et al., 2005).

In the past several years, new studies of uterine rupture risk are beginning to refine criteria for VBAC candidacy and to encourage the practice in selected women. Cahill et al. (2008) studied the influence of race on uterine rupture, and found that black women who attempt VBAC are 40% less likely to experience a uterine rupture than other racial groups, even after adjusting for potentially confounding variables. In a 2008 Australian study, investigators used longitudinally-linked birth records to follow over 10,160 women from a primary CS to a TOL at their next birth. They found that spontaneous labor before the primary CS significantly decreased the risk of uterine rupture in the study cohort (Algert et al., 2008). The findings of these studies have important implications for counseling women with a previous CS.

### **Maternal Morbidity and Mortality**

Maternal mortality is rare in developed countries and has not been identified as being increased between women attempting a VBAC and those undergoing an elective RCS (Landon et al., 2004; Lydon-Rochelle et al., 2001; Smith et al., 2002). Maternal morbidity is more difficult to determine, however, because labor is a major potential confounding variable (Silver et al., 2006). In their meta-analysis, Mozurkewich and Hutton (2002) found that mothers who attempted a VBAC were less likely to have febrile morbidity, a blood transfusion, or a hysterectomy than mothers having a repeat CS. Conversely, McMahon and colleagues (1996)

reported that major complications were twice as likely for women attempting a VBAC as delivering by repeat CS without labor. This finding suggests that "failed" VBAC is associated with higher morbidity than planned repeat CS (McMahon et al., 1996). In a more recent prospective study, Landon et al. (2004) confirmed McMahon et al.'s finding that failed VBAC and subsequent RCS accounted for a majority of adverse maternal events such as endometritis and blood transfusion.

Due to rising CS rates and the decline of VBAC in recent years, research attention has turned toward evaluating the association between maternal morbidity and multiple cesarean deliveries. In a prospective study at 19 academic centers, Silver and colleagues (2006) found that the risks of placenta accreta, cystotomy, bowel injury, ureteral injury, ileus, hysterectomy, intensive care unit admissions, blood transfusion, and prolonged hospital stay increased progressively with multiple CS. This finding led investigators to recommend that women should be counseled about the number of intended pregnancies when mode of delivery is discussed in order to avoid multiple cesarean deliveries (Silver et al., 2006).

### **Neonatal Morbidity and Mortality**

Studies of neonatal mortality are mixed. While several investigators found no difference between groups (Lydon-Rochelle et al., 2001; McMahon et al., 1996), others have noted a small but significant increase in fetal and neonatal deaths for women attempting a VBAC (Mozurkewich & Hutton, 2000). In a Scottish retrospective, population-based cohort study, Smith et al. (2002) found significantly higher rates of perinatal death associated with a TOL than with a planned RCS. However, it should be noted that the perinatal death rate of 1.3% was similar to other nulliparous women undergoing their first labor (Smith et al., 2002).

In terms of neonatal morbidity, Landon and colleagues (2004) found significantly higher rates of neonatal hypoxic-ischemic encephalopathy in infants whose mothers underwent a TOL;

seven of these cases followed uterine rupture. As a result of these findings, the authors reported that "a trial of labor after prior cesarean delivery is associated with a greater perinatal risk than is elective repeated cesarean deliver without labor, although absolute risks are low" (Landon et al., 2004, p. 2581). They subsequently recommended that women should be counseled accordingly.

Neonatal respiratory morbidity, however, is more closely associated with RCS. Fogelson et al. (2005) found that neonates delivered by RCS without labor were significantly more likely to be diagnosed with transient tachypnea and admitted to advanced care nurseries than those who were delivered vaginally. Other investigators have noted similar findings (Jain & Dudell, 2006). Moreover, there is considerable evidence that "physiologic events in the last few weeks of pregnancy, coupled with the onset of spontaneous labor are accompanied by changes in the hormonal milieu of the fetus and its mother, resulting in rapid maturation and preparation of the fetus for delivery and neonatal transition" (Jain & Eaton, 2006, p.34). Consequently, infants delivered by planned RCS are not as physiologically prepared for birth, particularly those that are a few weeks from term.

Yoder, Gordon, & Barth (2008) confirmed that a "paradigm shift" of increased CS delivery rates, increased proportion of late-preterm births, and decreased median gestational age has occurred in obstetrics. In their study of 705 infants over a nine year period, these authors corroborated the findings of the scientists above and suggested that neonatal respiratory morbidity was increasing as a result of high rates of CS (Yoder, Gordon, & Barth, 2008).

### **Women with Previous Vaginal Delivery and Previous Cesarean Section**

It has been well-documented that previous vaginal delivery is the most significant predictor of VBAC delivery success (Landon et al., 1994). Moreover, ACOG recommends that this subgroup of women be offered a TOL if at all possible (ACOG, 2004). In a recent multicenter study, Cahill and colleagues (2006) reported that there were no significant

differences in uterine rupture or bladder injury between those women undergoing VBAC and those having a planned RCS. Moreover, VBAC was associated with a decreased risk for overall maternal morbidities, including fever and blood transfusion. The authors emphasized that this more favorable risk-benefit ratio for this sub-population of women should be made explicit when counseling (Cahill et al., 2006).

Another multicenter study has similarly concluded that women with prior successful VBAC attempts are at low risk for maternal and neonatal complications during subsequent VBAC attempts (Mercer et al., 2008). A particularly significant finding was that the rate of uterine rupture decreased after the first successful VBAC and did not increase thereafter. Uterine dehiscence, neonatal morbidities, and other peripartum complications also declined after the first successful VBAC. Mercer and colleagues (2008) pointed out that these findings are particularly important for women planning repeated pregnancies after a caesarean delivery, as for this subgroup, the risks of VBAC are lower than the risks associated with multiple repeat CS.

### **Placental Risk Factors Associated with Cesarean Delivery**

Due to the increasing rates of CS in many countries, concern has grown regarding the increased incidence of serious placental complications associated with CS (Getahun et al., 2006; Kennare, Tucker, Heard, & Chan, 2007). Wu et al. (2005) undertook a twenty-year analysis of the rate of abnormal placentation and found that the risk of placenta accreta increased 8-fold with 2 or more CS. Moreover, the odds of those with previa increased 51-fold (Wu, Kocherginsky, & Hibbard, 2005) Getahun and colleagues (2006) found that women with a CS first birth were more likely to have an abruption in the second pregnancy. Two consecutive CS were associated with a 30% increased risk of abruption in the third pregnancy, and a second pregnancy within a year of a CS increased the risk of placenta previa and abruption (Getahun et al., 2006).

Considering the combined risks of placental abnormalities and increased morbidity with multiple

CS, Silver et al. (2006) recommended that women planning large families should be counseled regarding the risks of multiple CS.

### **Decision-Making and Informed Consent**

Decision-making for mode of delivery after a previous cesarean is often framed by providers as a discussion of risk factors such as those reviewed above. Research has shown, however, that complex social and emotional factors also affect the preferences and choices of both parties to the decision (Eden, Hashima, Osterweil, Nygren, & Guise, 2004; Kamal et al., 2005; Moffat et al., 2006). While it is well-known that healthcare providers have significant influence on decision-making, women also value their input and report that effective communication can enhance the process (Emmett, Shaw, Montgomery, & Murphy, 2006; Ridley, Davis, Bright, & Sinclair, 2002). Conversely, counseling about mode of delivery can also be inadequate, coercive, or insensitive (Bryant et al., 2007; Declercq, Sakala, Corry, & Applebaum, 2006; Mander, 2007; McClain, 1990).

### **Decision-Making Models**

Although their boundaries are somewhat fluid, three models of medical decision-making are generally described in the literature: paternalism, consumerism, and mutualism (ACOG, 2008; Charles, Gafni, and Whelan, 1999; Lupton, 1997). Their defining characteristics are described below and will be used throughout this dissertation.

**Paternalism.** This model places the provider in a dominant role and assumes that: 1) the provider "knows best;" 2) she will apply this information when selecting options for her patients; 3) due to experience, the provider is in the best position to evaluate the effectiveness of the various options for the individual patient; 4) because of her professional concern for her patient's best interests, the provider has a legitimate interest in the decision (ACOG, 2008; Charles, Gafni, and Whelan, 1999).

**Consumerism or informed.** A consumerist model rests on the following assumptions: 1) informed, discriminating buyers purchase the providers' services and expertise; 2) the providers' obligation is to enable the patient to make an informed decision; 3) the provider bases the information on the highest quality research evidence available; 4) beyond information transfer, the provider has no obligation to the decision 5) the patient deliberates and decides alone (ACOG, 2008; Charles, Gafni, and Whelan, 1999; Lupton, 1997).

**Mutualism or shared.** Shared decision-making assumes the following: 1) the provider informs the woman of all relevant information; 2) the woman informs the provider of her medical history as well as her values, preferences, life-style, beliefs, and knowledge; 3) the provider individualizes her approach to consider the needs and value system of the woman; 4) the provider and the woman interact and engage in a process to arrive at consensus; 5) both parties have an equal investment in the decision (Charles, Gafni, and Whelan, 1999).

### **Informed Consent**

The ultimate goal of decision-making about mode of delivery is to achieve informed consent. Informed consent rests on the principle of autonomy, which is conditioned upon liberty (independence from controlling influences), and agency (capacity for intentional action) (Beauchamp and Childress, 2001). Informed consent exists when an individual autonomously authorizes a physician to perform a medical procedure. An informed consent occurs only if a patient substantially understands the risks and benefits of a procedure and consents to it in the absence of substantial control by others (Beauchamp and Childress 2001).

Autonomy generally grants a negative right to a patient; that is, they may accept or decline a particular therapy or procedure. Williams (2008) argues that in the case of *electing* a CS, it is unclear whether women have a positive right to demand a specific procedure (VBAC or RCS), or if they are basically choosing between two equivalent modes of delivery. Given the ever-

changing evidence base, this is a complex decision. Moreover, the emphasis on autonomy in the U.S. makes some physicians reluctant to give advice to patients (Williams, 2008).

Other ethical principles also enter into decision-making about mode of delivery. Beneficence and non-maleficence (a physician should only offer treatments that promote the health and welfare of the patient) should be weighed in terms of individual needs; however, the benefits and harms of VBAC and RCS are not always clear (ACOG, 2008). Given the significantly higher cost of RCS when compared to VBAC, (DiMaio, Edwards, Euliano, Treloar, & Cruz, 2002), the principle of justice, or allocation of limited resources, may also enter into the decision (ACOG, 2008; Williams, 2008).

### **Fluidity in Decision-Making**

While the mutualistic or "shared" model is often advocated as ideal, the literature on medical decision-making illuminates the complexity inherent in arriving at a truly "shared" decision within the clinical encounter. Charles, Gafni, and Whelan (1999) compared the "informed" (consumerist) and "shared" (mutualistic) models of decision-making in early-stage breast cancer patients and their oncologists. They found that approaches needed to be individualized, even to the point of changing approaches during a consultation. For example, a physician may begin an encounter with an informed approach by providing the patient with detailed information on the risks and benefits of a procedure. However, the physician may need to change to a more shared approach if it appears the patient does not want to make the decision on her own. Furthermore, if the patient's medical condition deteriorates rapidly, such as in an emergency, even paternalistic models of decision-making have a place (Charles, Gafni, & Whelan, 1999).

A number of authors have found that mutual respect, trust, honesty, and "knowing the patient" were critical factors in shared decision-making models (Armstrong, 2002; Charles,

Gafni, & Whelan, 1999; Ford, Schofield, & Hope, 2003). The current emphasis on consumer autonomy and strict adherence to evidence-based practice sometimes undermined the development of trust and respect by putting the onus on health care providers to deliver more information than patients wanted or could comprehend (Armstrong, 2002; Ford, Schofield, & Hope, 2003; Lupton, 1997). Moreover, actual decision-making in medical encounters often included family members, other physicians, midwives, etc. In addition, agency constraints, such as having the time available to discuss treatment options in detail, ask and answer questions, or simply to develop a mutually respectful and trusting relationship were found to be problematic in terms of achieving an ideal of shared decision-making (Charles, Gafni, & Whelan, 1999; Ford, Schofield, & Hope, 2003; Lupton, 1997).

### **Stakeholders in the Decision-Making Process**

#### **Women with a Previous Cesarean**

Women consider a variety of factors when deciding about mode of delivery. Most of the available studies identify the following: desire for involvement and/or control, experiences during the previous delivery, influence of risk factors, practical considerations, acquisition of information, and the influence of the provider and significant others (Declercq et al., 2006; Emmett et al., 2006; Lucas, 2004; McClain, 1990; Moffat et al., 2006). During a qualitative study in the U.K., Moffat et al. (2006) found that decision-making evolved during the course of pregnancy, and that the responsibility of deciding how to deliver was overwhelming for some women. Studies from both the U.K. and U.S. have confirmed that women differ in terms of their desire for involvement in decision-making and their need for information, and that healthcare providers should be cognizant of these differences when counseling (Eden et al., 2004; Graham, Hundley, McCheyne, Hall, Gurney, & Milne, 1999; Lucas, 2004; McClain, 1990).

**Desire for involvement and/or control.** While research has shown that the majority of women want to be involved in the decision-making process, their desire for control over mode of delivery is often influenced by their previous experiences and personal ideologies of childbirth (Bryant et al., 2007; Declercq et al., 2006; Emmett et al., 2006; McClain, 1990; Moffat et al., 2006). The continuum ranges from those who decide definitively prior to becoming pregnant to those who doubt the validity of their choice even after the birth (Emmett et al. 2006). In the Listening to Mothers II (LTM II) study, a U.S. national survey of 1,573 women who gave birth in a hospital in 2005, mothers were asked specifically about who should have control over decision-making for mode of delivery. 85% of mothers thought that a woman should have the "right to choose" a VBAC if she desired one. While 45% of these mothers wanted the option of a VBAC, 57% reported being denied that option by either the healthcare provider (45%) or by hospital policy (23%) (Declercq et al., 2006). The LTM II also questioned black and Hispanic women about the "right to choose" either a CS or a VBAC. A majority of black mothers in the study thought that a woman should have a right to choose either a CS (52%) or a VBAC (81%); however, Hispanic mothers were somewhat less certain, with only 41% supporting the right to choose a CS and 77% agreeing with the right to choose VBAC (Declercq et al., 2006).

**Previous experience of labor.** A woman's previous experience of labor greatly influences her preferences for the next birth (Emmett et al., 2006; Farnworth, Robson, Thomson, Burges Watson, & Murtagh, 2008; Lucas, 2004; McClain, 1990; Moffat et al., 2006). For example, women who have delivered at least one infant vaginally are more likely to want to attempt a VBAC (Declercq et al., 2006; Eden et al., 2004; Selo-Ojeme, Abulhassan, Mandal, Tirlapur, & Selo-Ojeme, 2008). Several investigators found, however, that women varied widely in their experiences and perceptions. While some perceived their CS as an easier, quicker, cleaner, and

more predictable way to give birth, others viewed the procedure as a painful, dehumanizing process that rendered them unable to breastfeed and care for their infant independently after the birth (Emmett et al., 2006; Moffat et al., 2006). Belief that they had an unnecessary CS the first time was also a reason for desiring to attempt VBAC (Farnworth et al., 2008; McClain, 1990). One study found that the certainty of wanting a RCS "was grounded in a fear of vaginal birth...or lack of confidence that a vaginal delivery was possible for them" (Emmett et al., 2006, p. 1440). Conversely, these authors also found that women who wanted vaginal birth were influenced by the shorter recovery time, desire to experience a natural birth, and fear of CS. Concerns over difficulties experienced by their babies after birth seemed to make the decision more difficult for some women (Emmett et al., 2006; Lucas, 2004; McClain, 1990).

In a widely quoted study, McClain (1990) reported that women of racial and ethnic minorities more often chose RCS (46%) and described their prior CS in positive terms (72%). Moreover, many of these respondents described their previous labors as being a "necessary evil" that was "full of pain" (McClain, 1990). A recent study from the U.K., however, found that a majority of Afro-Caribbean (76%) and Asian women (68%) preferred the option of VBAC. Although these women were 3.5 times more likely than their white counterparts to plan a VBAC delivery, they were also 3 times less likely to actually be delivered by that mode (Selo-Ojeme et al., 2008).

**Influence of risk factors.** Studies varied in terms of the weight women placed on the influence of medical risk factors in their decision-making. While some women felt that safety and knowing the level of risk was vitally important (Declercq et al., 2006; Moffat et al., 2006), others placed more importance on previous experience, family obligations, and personal ideologies about motherhood (Eden et al., 2004; Lucas, 2004; McClain, 1990). Although 98% of

mothers in the LTM II said it was necessary to know about "every" (81%) or "most" (17%) complications of a cesarean (Declercq et al., 2006), Eden et al. (2004) noted that patients' perceptions of the safety of their choice was potentially biased by the outcome of their previous delivery. Therefore, women tended to believe that either VBAC or RCS was safest for the infant based on the previous outcome they had experienced rather than their knowledge of probabilities or of actual complication rates (Eden et al., 2004). Similarly, Lucas (2004) found that members of the elective RCS group were principally influenced by past negative experiences of painful labor, and 71% of this group indicated that the medical risks and benefits of an operative delivery were not important to them.

**Practical considerations.** Practical issues were also cited as reasons for decision-making in a variety of studies from both the UK and US (Declercq et al., 2006; Eden et al., 2004; Emmett et al., 2006; Lucas, 2004; Moffat et al., 2006). Reasons for choosing a VBAC over a RCS included shorter recovery time, not being able to drive for several weeks after CS, needing to return to work in 6 weeks, childcare difficulties, and financial obligations (Declercq et al., 2006; Eden et al., 2004; Emmett et al., 2006; Lucas, 2004; Moffat et al., 2006). Women preferring RCS often wanted to be able to schedule delivery, avoid missing important events, and to avoid having to go through labor. Another reason cited for choosing a RCS was the desire to have tubal ligation sterilization concurrently with the RCS (Eden et al., 2004). Partners or family members often had a role in these types of decisions (Moffat et al., 2006). These issues were also influenced by past experience rather than by information, education, or influence of the provider (Declercq et al., 2006; Emmett et al., 2006; Moffat et al., 2006).

**Acquisition of information.** Women acquired information from a variety of sources, including books, pamphlets, the Internet, television programs, childbirth education classes,

friends and relatives, and their doctor or midwife (Declercq et al., 2006; Emmett et al., 2006; Farnworth et al., 2008; Lucas, 2004; Moffat et al., 2006). While some women felt "quite laden down with a lot of information and facts," others reported that they had not received adequate information or that they had to actively seek it (Moffat et al., 2006, p. 90). Moreover, women expressed a need for information to be tailored to their particular circumstances rather than receiving general information about different modes of delivery; however, getting specific and tailored information also involved knowing the right questions to ask and having the confidence to ask them. Information from providers tended to center on procedural aspects of care rather than discussion of health risks and benefits (Emmett et al., 2006).

Some studies have found that women of racial and ethnic minorities were less likely to be aware that VBAC is possible, to attend childbirth classes, or to use the Internet as a source of information (Declercq et al., 2006; Eden et al., 2004). They were more likely, however, to have named doctors as being highly influential in their decision-making (Declercq et al., 2006; McClain, 1990). In contrast, a recent study, found that Spanish-speaking women with a previous cesarean were not significantly different than white women in terms of the amount of information they received regarding TOL (Renner, Eden, Osterweil, Chan, & Guise, 2007).

**Influence of the provider and significant others.** Doctors and midwives exert considerable influence on women's decision-making regarding mode of delivery. In most studies, women reported that the provider's opinion carried more weight than that of partners, friends, family members, and work colleagues (Bryant et al., 2007; Declercq et al., 2006; Eden et al., 2004; Emmett et al., 2006; McClain, 1990; Moffat et al., 2006; Ridley et al., 2002). Women who responded to the *LTM II* reported that most decisions were made before labor either by the provider (56%) or the mother herself (28%). Only 11% of women had a VBAC at all, and 57%

of women who were interested in VBAC were denied the option (Declercq et al., 2006). When providers engaged in shared decision-making and were supportive of a woman's desire for VBAC, however, women reported that their influence was beneficial (Ridley et al., 2002).

### **Obstetricians and Midwives**

Prior to the completion of this study, there were no studies that specifically explored providers' decision-making for mode of delivery after a previous cesarean in the U.S. The two available studies, one from the U.K. (Kamal et al., 2005) and one from Australia (Bryant et al., 2007) are discussed below.

Kamal et al. (2005) conducted semi-structured, in-depth interviews with 12 doctors and 13 midwives in the United Kingdom (U.K.). Participants in this study considered the most important problem as the attempt to apply generalized knowledge to individual cases. Although these professionals cited "evidence" to support their views, they also argued that experience and clinical judgment carried equal weight to research reports in influencing their decision-making for VBAC/RCS (Kamal et al., 2005, p.1059). Often these decisions were not made alone but were shared with patients and other professionals and subject to a wide range of influences. The contingent nature of decisions surrounding RCS and surgical decision-making in general was thought by the authors to have important implications in terms of changing practice. They suggested that in the absence of clear and convincing evidence, protocols and guidelines are unlikely to lead to change. Due to the highly social and political nature of the non-clinical aspects, such as counseling patients and developing trusting relationships with them, the authors suggested that "reflective practice," a process of thinking about and interpreting experience in order to learn from it for future decisions, may provide a more successful approach to improving practice (Kamal et al., 2005).

In a recent Australian study of women and healthcare providers, Bryant et al. (2007) explored the beliefs through which the decision to have a cesarean are made. A total of 12 hospital-based midwives, 6 obstetricians, and 18 women were interviewed. The authors found that the positioning of women as consumers, that is, "self-governing, autonomous subjects with entitlement to the consumption of birthing information and services, as guided by obstetricians" obligated women to assume responsibility for their decision-making (p. 1196). Women's choices, however, were limited by current beliefs among healthcare providers about what constitutes medical circumstances or risks. These choices centered around themes of cesarean birth as "safer" than "messy, unpredictable" vaginal birth. Bryant and colleagues (2007) argued that the presentation by obstetricians of potential risk to the baby through less predictable vaginal birth obligated "good" mothers to choose "safe, ordered" cesareans, thereby contributing to the escalating CS rate.

### **Summary of the Literature**

Decision-making about mode of delivery with a previous CS is a complex endeavor for both stakeholders. As this literature review has demonstrated, women and providers are subject to a broad range of influences. While it is clear that both modes of delivery carry risks to the mother and baby, that level of risk is highly individual for the mother-infant dyad. Obstetricians and midwives have an ethical and legal obligation to inform the mother of the risks and benefits of all of her options in a clear, understandable manner, and to provide their best advice without coercion.

The literature suggests, however, that many providers are practicing "defensive medicine" to avoid medical malpractice exposure. This fear may impact their counseling about mode of delivery for women with a previous cesarean. There is also evidence that women are influenced by a variety of social and economic factors and may have unrealistic expectations

about the safety of various options. Moreover, they may not be being appropriately counseled. While counseling and informed consent are considered to be the "standard of care," it remains unclear exactly how providers counsel women about the risks and benefits of both modes of delivery. It is also unclear how providers negotiate decision-making with women if they do not agree about the choice the woman favors. Furthermore, little is known about how providers approach the situation if a woman desires a VBAC and they do not offer the option.

### **Conclusion**

This research study endeavored to add to the scientific knowledge about decision-making for mode of delivery after a previous cesarean. Through the use of ethnography, this study explored the counseling practices, views, and experiences of healthcare providers. The following chapter will discuss the design and methods that were used in the study.

## CHAPTER 3 DESIGN AND METHODS

As indicated by the literature review, decision-making about mode of delivery is a complex mix of sociocultural, political, and economic factors for both women and their healthcare providers. In order to explore this complexity with healthcare providers, it was vital to employ a method that allowed them to speak openly and freely about their fears, concerns, and experiences. It was also important to investigate the community context in order to understand why VBAC is available in some communities and not in others. The following chapter describes the ethnographic method and perspective, study design, setting and sample, data collection, data analysis, and scientific integrity of the study.

### **Ethnographic Method and Perspective**

The ethnographic method was used to address the research questions in this study. Ethnography is advantageous for this purpose because of its flexibility in defining a problem that is not clear while allowing for exploration and generation of knowledge to understand the problem within a local sociocultural context (Patton, 2002). Using both qualitative and quantitative data, ethnography is an applied method which is simultaneously guided by and generative of theory (Schensul, Schensul, & LeCompte, 1999). Ethnography is a scientific, investigative method that uses the researcher as the primary tool of data collection. This orientation places the researcher *within* the community of interest and is referred to as the "emic" perspective (Wolcott, 1999). An assumption of ethnography as science is that what people actually do and their reasons for doing it need to be discovered before interpretation of their behavior can occur (LeCompte & Schensul, 1999). Through the use of interviews, field observations, and perusal of local documents and statistics that are relevant to the context, ethnographers can identify factors that contribute to the problems under study. This perspective

is often called the "etic," or the "outsider's" view, which is that of the scientist considering intergroup comparison (Wolcott, 1999). Ethnographic research is applied to a local context and applied to a problem that is identified within that population (Schensul, Schensul, & LeCompte, 1999).

Since the Florida healthcare providers in this study shared the same practice laws, malpractice insurance requirements, common language, and clinical lifestyle, this study assumed that they comprised an "obstetrical community" in terms of having similar constraints and practices. Since I am a Certified Nurse-Midwife who practices in Florida, I am also a part of this community and culture. For this reason, it was easy for me to gain entree to the community and to "speak the language" of American obstetrics. My "insider" status also influenced the participants' comfort level in talking with me. Thus, it was not difficult to define the phenomena from the perspective of those being studied. I endeavored, nonetheless, to adopt an "outsider," scientific perspective when considering my questions about counseling and access. This etic perspective enabled me to identify deficiencies in counseling practices and to question how a woman desiring a VBAC could realistically attempt one in many of the settings I encountered. Moreover, after talking with licensed midwives and exploring the blogs on the International Cesarean Awareness Network (ICAN) website, I was also able to appreciate the perspectives of the childbearing women who often found themselves with very limited options.

The ethnographic method was also consistent with the Critical Medical Anthropology (CMA) framework that was utilized in this study. Listening to providers' views about the influence of social, political, and economic forces on their counseling enabled me to analyze the impact of these forces on their interactions with patients.

## Setting

Interviews and observations were conducted at physicians' and midwives' offices, clinics, health centers, hospitals, and birth centers within the state of Florida. A variety of private and public practices were included. Although the research included the entire state, the majority of the interviews and observations were conducted in Northeast and North Central Florida. Due to the busy nature of obstetricians' and midwives' lifestyles, several of the interviews took place at restaurants or in the "doctor's lounge" while the provider ate lunch. As is often the case in ethnographic fieldwork, interruptions were common. During this study, three of the interviews were delayed or interrupted by the arrival of a baby!

## Design

This study was qualitatively driven and used quantitative vital statistics to both inform both sampling and analysis. The study design is illustrated by Figure 3-1 and explained in the "sample" section.

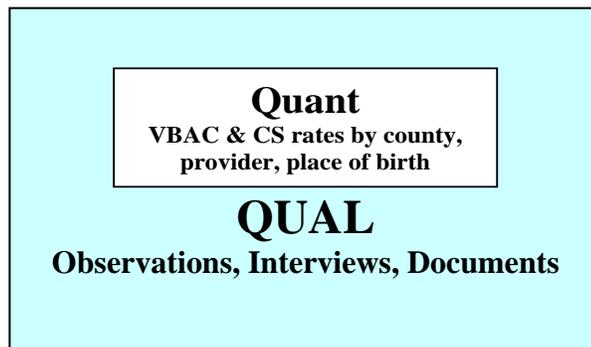


Figure 3-1. Concurrent nested design. (Creswell, 2003)

## Sample

Sampling in an ethnographic study is guided by the central research questions the study is attempting to answer, as well as by the geographic boundaries of the community of interest (Schensul, Schensul, & LeCompte, 1999). Because it was important to know how providers

counseled women about the option of VBAC, it was vital to interview obstetricians and midwives who offered this service, as well as those who did not. Since the overall rate of VBAC is very low in the state (> 1% in 2006), I needed to target specific locations in order to find providers who offered the option of VBAC. This information was "nested" quantitatively in the form of vital statistics from the Florida Birth Query System Reports (2008) and the Agency for Health Care Administration (ACHA, 2008) websites. By perusing these statistics, I was able to locate areas of the state where VBAC was still occurring. I found that Northeast and North Central Florida had the lowest rates of CS and highest number of VBACs. I also discovered that South Florida had the highest numbers of out-of-hospital VBACs, and, not surprisingly, the highest rates of CS.

Due to the sensitive nature of some of the interview questions, it was essential to be able to assure provider anonymity in order to recruit a sufficient number of participants. In order to reduce this barrier, a Waiver of Documentation of Informed Consent was obtained during the Institutional Review Board (IRB) approval process. At the time of recruitment, participants were given an IRB-approved letter describing the study and their rights as a research subject. They read the letter and verbally agreed to participate, but they were not required to sign a consent form. This facilitated the recruitment process considerably.

Purposive snowball sampling was used to recruit subjects. Several types of providers and healthcare settings were sought in order to explore a broad range of views and services and to help assure anonymity of the participants. The sampling process began with locating providers known to me who were likely to be knowledgeable about the subject. These key informants subsequently led me to other potential participants. Study subjects were selected based on the following criteria: age 21-70, fluent in English, currently licensed to practice in Florida, and

willing to participate in the study. Obstetricians and nurse-midwives had to have current hospital delivery privileges, and licensed midwives were required to be currently providing out-of-hospital birth in either home or birth center settings. Administrators had to meet the general criteria as well as have primary oversight of a licensed, hospital-based Labor and Delivery unit or freestanding birth center. The final sample included 11 Obstetrician/Gynecologists (MDs), 8 Certified Nurse-Midwives (CNMs), 4 Licensed Midwives (LMs), and 1 ARNP (Advanced Registered Nurse Practitioner), for a total of 24 participants (N = 24). One MD, two CNMs, one ARNP, and one LM (N = 4) also met the criteria for administrators. Recruitment ended when saturation, or the point at which no more new data emerged, was reached.

### **Data Collection**

Data was largely qualitative and obtained primarily through individual and small group interviews, field notes of observations, and perusal of relevant documents such as informed consent forms, institutional protocols, and professional guidelines. Additional qualitative data was also obtained from the International Cesarean Awareness Network (ICAN) website. ICAN is a consumer advocacy group that was formed over 25 years ago to "support women in their journey towards understanding the risks of cesarean section and with the purpose of helping them have healthy births and healthy lives after undergoing the surgery that changed them" (ICAN, 2008). Quantitative data included demographics of the study participants and relevant vital statistics. Each facet of data collection is considered separately below.

### **Participant Observation and Field Notes**

A key feature of ethnography is to learn "what is going on" in the community being studied; thus, participant observation is often the starting point of an ethnographic study (Richards & Morse, 2006). Moreover, the process of participant observation allows for enhancement and interpretation of the quality of the data. An important aspect of participant

observation "includes a kind of self-observation, both of the way in which the investigator experiences the setting as a participant, and the particular biases she/he brings to the setting..." (DeWalt & DeWalt, 2002, p. 68). As a practicing CNM in Florida, it was important for me to be able to see "old events with new eyes" in the process of this research (DeWalt & DeWalt, 2002, p.74). This was accomplished, in large part, by "hanging around" in the various settings where I conducted interviews from June to December of 2008. Assuming the role of "professional stranger," I waited in office waiting rooms, hospitals, clinics, and birth centers for my participants to finish seeing patients, deliver a baby, answer calls, or whatever task they had to complete that took precedence over their interview with me. This kind of engaged waiting allowed me to observe and take note of myriad aspects of the various healthcare environments from the perspective of an "outside" researcher rather than an "inside" clinician. During these periods, I listened to the informal conversations around me, read informational materials in lobbies and at reception desks, observed the facility's decor (or lack thereof), noted the public presentation of the practice and providers, all the while taking field notes about my impressions and thoughts. Above all, the experience of having to wait in the waiting room for the provider until the "gatekeeper" escorted me in was quite humbling.

In the original study protocol, I had planned to include an observation of the counseling process for mode of delivery at two different clinical sites. This proved to be unfeasible for several reasons. Although I was able to obtain participant approval to conduct the observation at the first site, the process of obtaining the federal-wide assurance required by the IRB turned out to be impractical. At the second site, the provider who initially agreed to be observed decided against it, although he did consent to an individual interview. While this can be interpreted as a

limitation of the study, I did attempt to compensate for it by engaging in the observations discussed above.

### **Individual and Small Group Interviews**

I conducted all of the face-to-face individual and small group interviews. Groups consisted of two or three providers who practiced together. As previously mentioned, the interviews took place in a variety of settings. Care was taken to maintain privacy to a level that the participant considered acceptable. The interviews were semi-structured, ranged from 20-50 minutes in length, and were audio-recorded using a digital recorder. I also recorded field notes about the interview. Interview guides (Appendix A, B, and C) were used to maintain focus during the interview process. While I followed the interview guides closely in the beginning, I began to focus the questions more specifically to the provider's particular situation as data collection and analysis progressed. For example, in one of the later interviews, much of the discussion centered around a recent change in hospital policy that prevented the providers from continuing to offer VBAC. A large majority of the providers were quite articulate and vocal in expressing their thoughts and opinions, and in general, needed very little prompting.

Following the interview, the audio-recording was transcribed verbatim by either myself or a professional transcriber. After the interviews were transcribed, I verified the content by listening to the recording and simultaneously viewing the transcript and correcting any initial errors. Analysis was begun as an iterative process and proceeded as described in detail below. The interviews continued until saturation, or the point at which no new information emerged from the data, was reached.

### **Perusal of Relevant Documents**

Throughout the study, I collected and reviewed a variety of documents that were relevant to the research questions. Prior to beginning the interviews, I reviewed and conducted a

preliminary analysis of the published practice guidelines of both the ACOG (1999; 2004) and the ACNM (2003). This proved to be useful, as the ACOG guidelines were referred to in every interview. During the course of the interviews, I also requested any written teaching materials, pamphlets, informed consent forms, or practice protocols that providers were using to educate their patients or to document informed consent. Surprisingly few of the providers gave any kind of written information on CS, RCS, or VBAC to women. Some of them mentioned informational consumer websites, such as International Cesarean Awareness Network (2009), and the Childbirth Connection (2009), which I subsequently reviewed for relevant information. Only one large group practice had their own consent forms, although the majority of them were able to provide me with an institutional form that was supplied by the hospital. In addition, I also collected relevant news reports on policy, cost, access, and insurance changes related to CS and VBAC. The findings are discussed in Chapters 4 and 6.

### **Data Analysis**

In qualitative research, data analysis proceeds throughout the data collection process (Patton, 2002; Richards & Morse, 2006). Analysis in this study was accomplished using the thematic coding strategy described by Schensul, Schensul, and LeCompte (1999). Data were categorized or "coded" into hierarchies, beginning with domains and proceeding to factors, subfactors, and associated codes. As the interviews proceeded and as the factors emerged with greater clarity, the questions were honed to increase the power of representation of the themes. During this process, I kept an ongoing memo and audit trail of substantive and methodological decisions. The raw data, as well as any decisions, were reviewed periodically by my supervisory chair. The data were also presented to members of the Qualitative Data Analysis Group at the University of Florida for comment at various points in the process. Two members of my supervisory committee, Drs. Simpson and Lutz, were also members of this group. In addition, I

validated the findings with participants as the data collection proceeded, and subsequently incorporated them into more refined questions. This process continued until saturation was reached. NVivo 7 software was used to manage the data and to build a framework of the domains and factors affecting providers' counseling and decision-making for mode of delivery. The final analysis was validated with a few key informants in the study.

I also used supporting quantitative data to enhance validity of the interview and observational data. This included demographic data collected at the interviews, such as age, sex, certification, years in practice, number of deliveries, exposure to a lawsuit, CS rate, sovereign immunity, and whether or not they carried malpractice insurance. SPSS 14.0 software was used to analyze this data and to generate descriptive statistics. I also revisited my earlier perusal of the vital statistics, particularly the CS rates in Florida hospitals, to validate what providers told me about their individual CS and VBAC rates.

### **Scientific Integrity**

#### **Bias**

In ethnographic research, the researcher is the primary tool of data collection (Patton, 2002; Wolcott, 1999). One of the challenges in conducting an ethnographic study is to avoid the error of systematic bias during the study design, question development, recording of the observations, and interpretation of data. Although bias cannot be completely eliminated from any study, be it quantitative or qualitative, adhering to rigorous research principles can reduce the potential for it (Schensul, Schensul, & LeCompte, 1999; Wolcott, 1999). In this study, I attempted to minimize the risk of systematic bias by carefully designing the study and by formulating the interview questions to capture the perspectives of the participants. Scientific integrity was also ensured by ongoing oversight from members of my supervisory committee.

Researchers can also avoid bias by being aware of the assumptions they bring to the

study, and by preventing these assumptions from pervading the study design or explanatory framework (Richards & Morse, 2006). This process is referred to as "reflexivity" (Patton, 2002). The technique of "memoing" helped me to engage in self-reflection throughout the research process. Although my bias toward VBAC as a safe alternative did not change during the study, my assumptions about the position of obstetricians changed significantly. The interpretation of this process is discussed in depth in Chapter 6.

### **Validity**

Guba & Lincoln (1989) have established criteria with which to address threats to both internal and external validity in qualitative research. Internal validity, or "credibility," is established through prolonged engagement in the field, persistent observation, progressive subjectivity, and member checks. In this study, I was actually engaged in the field for over a year. The process began in the fall of 2007, when I initially developed the proposal and began to informally assess providers' interest in participating in the research. During data collection, I reduced threats to credibility by purposive sampling, obtaining verbatim accounts from participants, verifying observations with key informants and others on the research team, and by engaging in reflexivity (Schensul, Schensul, and LeCompte, 1999).

External validity, or applicability, is primarily enhanced through rich description and member validation (Guba & Lincoln, 1989). Every effort was made during this study to provide careful description, operationalization of terms, and tracking of methodological and substantive decisions in order to render the findings useful to other researchers in the future.

### **Reliability**

Reliability in qualitative research is defined as "consistency" in the collection of data (Guba & Lincoln, 1989). While duplication of results is not the desired outcome of exploratory research, careful conduct of interviews, rigorous notes, clarifying methods, and documenting

thoughts regarding changes to the structure of questions to be used can ensure that other researchers will be able to approximate the research process (Schensul, Schensul, and LeCompte, 1999). The use of other data to confirm the results is another way to enhance reliability in qualitative research. I conducted all of the interviews, kept careful field notes, and documented all changes in methodology in order to enhance consistency in this study. In addition, consistency of the results was ensured by combining the analyses of relevant documents, demographic and vital birth statistics, field observations, and interview data.

### **Ethical Considerations**

The sensitive nature of some of the information required a high degree of ethical rigor. In order to reduce discomfort with questioning, all participants were told initially that they were free to answer only those questions that they felt comfortable with and that the interview could be stopped at any time for any reason. Although none of the participants stopped the interview, several either opted not to continue a line of discussion or requested that their response to a particular question not be recorded. These requests were honored without further difficulty.

Confidentiality was maintained throughout all phases of the study. In order to protect individuals' identity, documentation of informed consent was waived by the IRB, as described previously in the Sampling section of this Chapter. I also safeguarded the identity of the participants by not disclosing the participation of any provider to another. In some cases, however, members of a group practice opted to be interviewed together. All participants were assigned pseudonyms. Audio recordings, transcripts, journals and memos were de-identified and kept in either locked files in my home office or in my password-protected computer. All guidelines set by the University of Florida Institutional Review Board and the Health Insurance Portability and Accountability Act were adhered to throughout the study.

## **Strengths and Limitations**

A major strength of this research design was the ability to generate rich and meaningful data about the factors influencing providers' decision-making, and about the landscape of VBAC availability in the state. This information can be useful for informing policy in Florida, particularly in the area of improving the informed consent process for mode of delivery. Furthermore, providers and practices that are offering VBAC successfully can be used as a model for other practices in order to increase access to VBAC in the state.

One weakness of the study was the lack of generalizability due to the relatively small sample size. Another possible weakness is that the circumstances may be unique to Florida; thus, the findings may only be reflective of this sample and not of the larger national or international population.

As this is a relatively unexplored area of research, the information obtained adds to the body of knowledge on healthcare providers' decision-making about mode of delivery as well as VBAC access. Factors that were identified during the research may also be developed into a survey and used to test hypotheses in a larger, state-wide or national survey.

## **Conclusion**

In this study, I used ethnographic research methods to acquire information about healthcare providers' decision-making about mode of delivery and the context in which that decision-making took place. These methods included prolonged engagement in the field, in-depth interviews with healthcare providers, and perusal of relevant documents, vital statistics, and current web-based information. Data analysis was an iterative process, beginning with the statistical targeting of the sample and concluding with validation of the findings by key participants. Ethnography was consistent with the CMA framework, which intends to explore the implications of social, political, and economic forces on the individual level of the provider-

patient relationship. In the next chapter, the findings concerning the Florida healthcare context are discussed in depth.

## CHAPTER 4

### RESULTS PART 1: THE LANDSCAPE OF PRACTICE IN FLORIDA

Ethnographic research takes place in a particular context (Wolcott, 1999). Since the focus of this study was on political, economic, and sociocultural aspects of decision-making in Florida, it was essential for me to explore the structural aspects of obstetrical care that are unique to this context. This chapter is organized into two sections. The first section provides a demographic profile of the individuals in the study, along with supporting tables. The second section describes the "obstetrical landscape" of the state, and includes relevant vital statistics, observations, documents, statutory regulations, and interview data from the in-depth interviews.

#### **Profile of the Participants**

The participants in this study included 11 obstetricians (all MD), 8 Certified Nurse-Midwives, 4 Licensed Midwives, and 1 ARNP administrator of a large obstetrical complex (Table 4-1). Overall, obstetricians were younger than the CNMs and LMs, with 4 out of the 11 MDs being younger than 40 years of age. Mean ages of male (58 yrs) and female (40 yrs) MDs in this study, however, were similar to those in a recent statewide survey (Physician Annual Workforce Report, 2008). While an effort was made to locate providers of both genders from varied racial and ethnic groups, the final sample was 92% white and 83% female. The skew towards white females can be explained in several ways. Over 50% of the sample consisted of either CNMs or LMs, who are predominantly white females. Since I am a white female, it is also possible that other white females were more comfortable talking with me, and therefore, more willing to be interviewed than were men or members of other racial and ethnic groups.

As expected, the providers in this study were a highly educated group. One MD and two CNMs also had a PhD in addition to their professional terminal degree. LMs were the least educated, with only one holding a master's degree. All the participants had been certified by their

governing board, except for the younger obstetricians (n=4) who were still in "board-eligible" status. There was a broad range of practice experience across all three groups, spanning 1-37 years. CNMs had been in practice the longest (M=19 yrs). Although one LM who had worked internationally reported attending 12,000 births, obstetricians had the highest mean number of deliveries (M=3145), followed by CNMs (M=1200), and LMs (M=490).

Data on practice characteristics is available in Table 4-2. While MDs were almost equally divided between public (n=5) and private (n=6) settings, the CNMs and LMs in this study were more likely to work in private or hospital-based practices. MDs (n=9) provided the majority of VBAC care. At the time of the interviews, only 2 CNMs provided VBAC, and one did so only rarely. By the time the study was completed, however, the other CNM had stopped doing VBACs due to a change in her hospital's policy. The sole LM who attended VBACs did so in an area in which VBACs are largely unavailable. Although she had a collaborating physician, she also informed me that her provision of VBAC care was rather tenuous.

Of the 11 MDs in the study, 4 had sovereign immunity and the other 7 had no malpractice insurance. This finding was in sharp contrast to the midwife participants, all of whom had malpractice insurance policies with coverage ranging from \$100,00/300,000 to \$1,000,000/3,000,000. None of the CNMs or LMs had sovereign immunity. The participants were equally divided between those who had been sued (n=12) and those who had not (n=12). A higher percentage of physicians (73%) had been sued than CNMs (38%) or LMs (25%).

Table 4-1. Demographic characteristics of the interview sample. (N = 24)

|                                | MD<br>N = 11 | CNM/ARNP <sup>a</sup><br>N = 9 | LM<br>N = 4      |
|--------------------------------|--------------|--------------------------------|------------------|
| Age                            |              |                                |                  |
| Mean (SD)                      | 46 (12.1)    | 54 (5.5)                       | 50 (13.2)        |
| Range                          | 30-60        | 46-61                          | 30-58            |
| Median                         | 49           | 53                             | 56               |
| Ethnicity [N (%)]              |              |                                |                  |
| Black                          | 1 (4)        | 0 (0)                          | 0 (0)            |
| Hispanic                       | 0 (0)        | 1 (4)                          | 0 (0)            |
| White                          | 10 (42)      | 8 (33)                         | 4 (17)           |
| Gender [N (%)]                 |              |                                |                  |
| Female                         | 7 (29)       | 9 (37)                         | 4 (17)           |
| Male                           | 4 (17)       | 0 (0)                          | 0 (0)            |
| Education [N (%)]              |              |                                |                  |
| Professional (MD)              | 11 (46)      | 0 (0)                          | 0 (0)            |
| PhD                            | 1 (4)        | 2 (8)                          | 0 (0)            |
| Masters                        | 1 (4)        | 7 (29)                         | 1 (4)            |
| Board certification<br>[N (%)] |              |                                |                  |
| ACOG <sup>b</sup>              | 7 (29)       | 0 (0)                          | 0 (0)            |
| ACOG <sup>b</sup> Eligible     | 4 (16)       | 0 (0)                          | 0 (0)            |
| AMCB <sup>c</sup>              | 0 (0)        | 8 (33)                         | 0 (0)            |
| NARM <sup>d</sup>              | 0 (0)        | 0 (0)                          | 4 (17)           |
| Years in practice              |              |                                |                  |
| Mean (SD)                      | 15 (11.3)    | 19 (9.7)                       | 18 (14.9)        |
| Range                          | 1-31         | 2-32                           | 5-37             |
| Median                         | 18           | 21                             | 15               |
| Number of deliveries           |              |                                |                  |
| Mean (SD)                      | 3145 (2576)  | 1200 (815)                     | 490 <sup>e</sup> |
| Range                          | 600-7500     | 150-3000                       | 200-12000        |
| Median                         | 3000         | 1200                           | 270              |

<sup>a</sup> ARNP administrator (n=1) was included with the CNM group; percentages may not equal 100%. <sup>b</sup> American College of Obstetricians & Gynecologists. <sup>c</sup> American Midwifery Certification Board. <sup>d</sup> North American Registry of Midwives. <sup>e</sup> One LM was an outlier with 12,000 deliveries and was not included in the calculation of the mean.

Table 4-2. Practice characteristics of the interview sample. (N = 24)<sup>a</sup>

|                       | MD<br>N = 11<br>[N (%)] | CNM/ARNP <sup>a</sup><br>N = 9<br>[N (%)] | LM<br>N = 4<br>[N (%)] |
|-----------------------|-------------------------|---|------------------------|
| Type of practice      |                         |   |                        |
| Public                | 5 (21)                  | 2 (8)                                     | 0 (0)                  |
| Private               | 6 (25)                  | 7 (29)                                    | 4 (17)                 |
| Provides VBAC         |                         |   |                        |
| Yes                   | 9 (38)                  | 2 (8)                                     | 1 (4)                  |
| No                    | 2 (8)                   | 6 (25)                                    | 3 (13)                 |
| Malpractice insurance |                         |   |                        |
| None                  | 7 (29)                  | 1(4) <sup>b</sup>                         | 0 (0)                  |
| Sovereign immunity    | 4 (17)                  | 0 (0)                                     | 0 (0)                  |
| \$100,000/300,000     | 0 (0)                   | 2 (8)                                     | 3 (13)                 |
| \$250,000/750,000     | 0 (0)                   | 4 (17)                                    | 0 (0)                  |
| \$1,000,000/3,000,000 | 0 (0)                   | 2 (8)                                     | 1 (4)                  |
| Malpractice suit      |                         |   |                        |
| Yes                   | 8 (33)                  | 3 (13)                                    | 1(4)                   |
| No                    | 3 (13)                  | 6 (25) <sup>b</sup>                       | 3(13)                  |

<sup>a</sup> Sample includes one ARNP administrator grouped with CNMs. <sup>b</sup> Includes ARNP who does not carry personal malpractice insurance and has not been sued.

## The Obstetrical Landscape

### Cesarean Section and VBAC

In 2007, 37.2% of Florida's 239,120 births were by CS. This percentage represents a total of 88,932 CS annually (Florida Birth Query System (FBQS), 2008). Although 2007 rates for primary and RCS are not yet available, primary rates were 24.3% and RCS rates were 92.9% in 2004 (Agency for Healthcare Administration (AHCA), 2006). CS rates for women of various racial and ethnic groups, however, were remarkably similar in 2007, at 37.3% for white, 37.4% for black, and 35% for "other nonwhite" mothers (FBQS, 2008). VBAC deliveries accounted for only 0.7%, or a total of 1,716 births (FBQS, 2008). Like CS, there was little difference in VBAC rates among the various racial groups, and composite statewide rates were below 1% for all women (Figure 4-1).

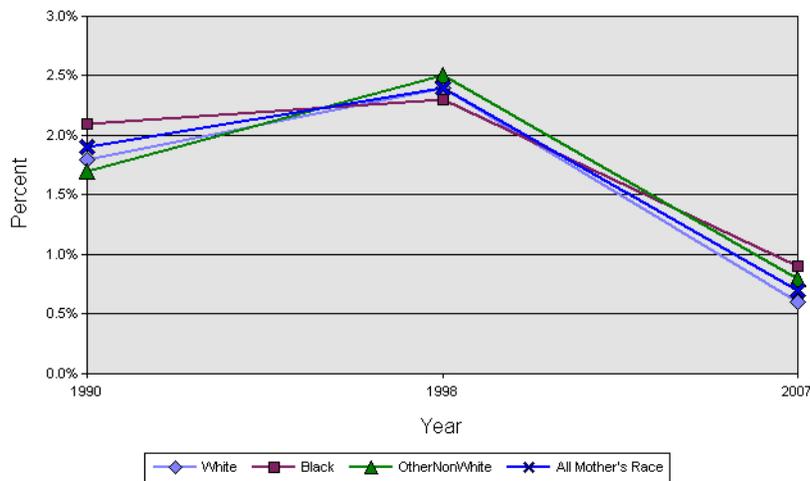


Figure 4-1. VBAC by race in all Florida counties from 1990-2007. Source: FBQS, 2008.

It is interesting to note, however, that there is considerable regional variation in CS and VBAC rates. Although CS rates vary by hospital, South Florida has been consistently higher than North Florida. In 2007, Dade County led the state with a CS rate of 47.7% (FBQS, 2008). Six out of ten hospitals with the highest rates of CS are in Dade County. Two of these hospitals, Kendall Regional Medical Center (67.5%) and South Miami Hospital (59.3%), reported extremely high CS rates in 2007 (Agency for Healthcare Administration (AHCA), 2008). Not surprisingly, VBAC rates in South and Central Florida were correspondingly low at 0.4 - 0.6% (FBQS, 2008).

In Northeast, North Central, and some areas of Northwest Florida, CS rates were closer to the national norm of 31.1%. With a composite CS rate of 31%, the northern regions were 65% lower than South Florida in 2007 (FBQS, 2008). Shands Jacksonville Medical Center (21.6%) in Duval County had the lowest CS rate in the state, followed by North Florida Regional Medical Center (26.2%) in Alachua County (ACHA, 2008). While VBAC rates in these regions (approx. 2.0%) were far lower than the national average (10.2%) (FBQS, 2008), they do indicate that

planned VBACs are continuing to occur, at least in a limited way, in northern areas of Florida (Figure 4-2).

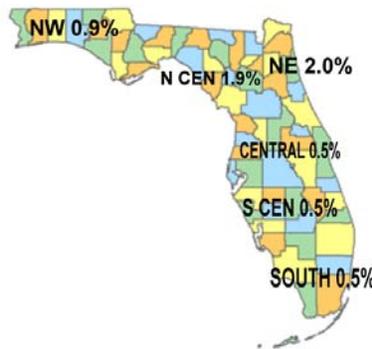


Figure 4-2. Florida VBAC rates by region. Data from FBQS, 2008.

"Dr. Diane" offered her thoughts on regional variation:

Florida is an unfriendly environment for VBACs. Not so much this town, but other parts of Florida...I recently interviewed around Florida, looking for jobs. There are whole cities in the state of Florida that don't allow VBACs. I have a personal friend who could not find providers who would even offer that to her as part of their care. And she went and delivered at a birth center instead.

Vital statistics from Dade County indicate that some women are choosing birth center care, particularly in South Florida, where there are few options to attempt VBAC. The small but definite increase in LM VBAC attendance supports this premise (Figure 4-3).

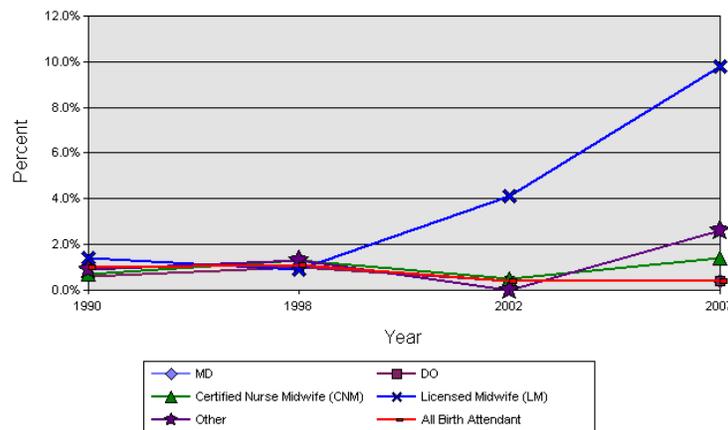


Figure 4-3. Percent of VBACs in Dade County, FL by provider type. Source: FBQS, 2009.

Another participant, "Rosa," described the birth center as the only option for women desiring VBAC in South Florida:

They have to meet with our OB, get approval, it's really not approval, it's simply giving them informed consent...she thinks VBACs should be allowed, but she wishes they could be done in the hospitals, because she thinks that if there was a complication, a hospital is a better place, but currently women have no choice and that's the choice they get.

KC: So there aren't any hospitals who do VBAC in this area?

Rosa: None, zero.

KC: In this city?

Rosa: In this **county** and the one to the north, except for the public hospitals. And even they have gotten, very, very tight on it.

### **Costs and Payment Sources**

It has been well-documented that CS is more costly than vaginal birth, and much of the push for VBAC in the mid-1990s was an effort to reduce this cost (AHCA, 2006). The trend toward higher CS rates, however, has not reduced concern over costs. Researchers at Shands Hospital at the University of Florida, Gainesville, studied the costs of attempted vaginal delivery versus elective RCS in a cohort of 204 mother-infant pairs (DiMaio, Edwards, Euliano, Treloar, & Cruz, 2002). They found that the mean cost of care was significantly higher in the elective RCS group than it was for the attempted vaginal delivery group. This was true across all three groups, including mothers, newborns, and mother-infant pairs (DiMaio et al., 2002).

The state of Florida has also been interested in these trends. Since 1991, hospitals with 30 annual births or more that are paid for by state or federal funds are required by statute to establish practice parameters and a peer review board to evaluate the necessity of every state-funded CS (Provider Hospitals Act, 1991). The Florida Statutes also authorized AHCA to annually assess the CS rate in Florida hospitals (Health Facility & Services Planning Act, 1992). According to the most recent report, CS accounted for over \$1.0 billion, or 49.1% of the total

hospital charges, and average risk-adjusted charges were 92% greater for a CS than for a vaginal delivery (AHCA, 2006). Hospital charges continued to increase in 2007, ranging from \$6,598 - \$10,731 for a vaginal birth to \$12,025 - \$20,762 for a CS delivery (AHCA, 2008). Payment sources for these births included private insurance (44%), the Florida Medicaid Program (43%), and self-pay (13%) (FBQS, 2008).

The high cost of CS has also caused insurance companies to revisit automatic coverage for the procedure. Several companies in Florida have recently changed their policies for those with individual coverage, and are treating previous CS like a pre-existing condition. Blue Cross and Blue Shield of Florida, for example, covers RCS, but increases premiums by 25% for five years unless the woman is sterilized. Golden Rule, owned by United Healthcare, will insure a woman with a CS only if the company could exclude paying for another for a period of three years (Grady, 2008).

While the state and third-party payors have focused on rising costs, the providers in this study were more concerned about the level of reimbursement to themselves. One obstetrician, "Dr. Charles," predicted that the lack of adequate reimbursement, coupled with the high cost of malpractice insurance, would cause a shortage of providers:

I think what's going to happen if the reimbursements for obstetrics don't improve, there's going to be less and less and less people that even do it. I mean, my son is going into OB/GYN... And I told him, if I were you, I would not even do obstetrics. Because the amount of risk you take for getting sued compared to the amount of money that they pay you to do it, it doesn't even make sense. You're losing money.

"Grace," a CNM, echoed the opinion that the cost of malpractice insurance was affecting the business side of obstetrics and making it less profitable:

I feel that they've very much had to tailor their practice to the malpractice climate. Because I think they're a big business...and it makes business sense probably. I think a lot of decisions are made on what makes business sense.

## **The Birthing Environment**

The vast majority of Florida births (99%) occur in hospitals. The remaining 1% take place in freestanding birth centers or in the mother's home (FBQS, 2008). Hospital and birth center services are defined by statute and are closely regulated by the Agency for Health Care Administration (AHCA, 2008). Most hospitals, birth centers, and healthcare providers are located in suburban or urban areas. Birth centers serve only low-risk mothers, and very few offer VBAC. Hospitals that provide obstetrical services are functionally divided into levels of specialization and service intensity, following the national model of perinatal regionalization. Historically, Florida's initiation of perinatal regionalization followed a national trend toward specialist-dominated health planning in the late 1960s (Perkins, 2004). This agenda was widely promoted in state health departments in the 1970s, and was later enforced through statutory regulation in Florida in 1976 as the Regional Perinatal Intensive Care Centers (RPICC) Program. Although the RPICC program was initially adopted to serve ill/low-birthweight newborns, high-risk obstetrical services were added in 1977. Currently, the program provides medical services to women with high-risk pregnancies at 11 designated hospitals and 12 satellite clinics in Florida (RPICC Annual Report, 2008).

All 11 RPICCs in Florida are located in urban areas and are designated as tertiary care, or Level III hospitals. RPICCs offer both high-risk obstetrical care and sophisticated neonatal intensive-care units (NICUs), and are staffed with subspecialists certified in neonatology and maternal-fetal medicine, specialist obstetricians, and in-house anesthesia, blood-banking, and surgical personnel. Most tertiary care centers have residency training programs and are associated with medical schools, such as Shands Hospital at the University of Florida, Gainesville (RPICC Annual Report, 2008). Tertiary centers without residency programs, such as Lee Memorial HealthPark Medical Center in Fort Myers, often have CNMs on staff to handle the

large number of deliveries. VBAC is not an option there, however, as there is no designated in-house obstetrician (Cindy Stewart, personal communication, October 4, 2008).

Level II facilities are typically larger urban or suburban community hospitals offering low-to-moderate risk maternity care and an intensive-care nursery. Rural or smaller community hospitals that provide low-to-moderate risk obstetrical and basic newborn nursery care are classified as Level I. Most of the deliveries in Level I and II hospitals are conducted by private obstetricians; however, a number of CNMs also have delivery privileges in these settings. These hospitals vary in their ability to accommodate VBAC. "Dr. Arthur," an obstetrician in a Level I hospital, felt that the resources in his setting were inadequate for safe VBAC:

But here at this Level I facility, there's no way that they can meet the requirements of ACOG's recommendation...it requires that you have anesthesia and a surgery crew in the house 24 hours and that simply is not realistic to expect that a Level 1 facility can do that. You've got to have a blood bank that's available and all of that. So I think there are too many areas that you can't cover trying to do a VBAC, and as a result of that, I have chosen to just deliver all of my previous sections by cesarean section.

"Joan," an experienced CNM who delivers at a Level II hospital, disagreed with the need to be in-house, and felt that she and her back-up obstetrician were still able to provide safe care:

It's become a hot item in our hospital because we do not have an in-house anesthesia or in-house OB. They are close by, but they are not in-house all the time while someone is laboring...and as far as we can tell from looking at the history, we have not found that there has been a lot of problems with VBACs or any bad outcomes.

Like Joan, "Dr. Fay," who delivers at a Level II hospital, felt that being "close by" was sufficient during a patient's labor:

...the hospital requires you to be immediately available. Immediately available in their definition is within 10 minutes from the unit. So our office is 3 blocks away, my house is within the 10 minute window. I basically, unless there's a concern for a strip or someone's falling off the curve, I basically am doing what I would do normally on call, which is not be more than 10 minutes away from the hospital anyway. It doesn't really change the time factor.

Although "Dr. Angela" practices in a teaching hospital and does VBAC, she shares Dr. Arthur's perspective on the necessity of being in-house:

I think you have to practice medicine based on what your community standards are. And I have the luxury of being in a teaching hospital where we always have in-house anesthesia, in-house faculty, 24-7. So I can let my patients VBAC if they want and know there's somebody there 24-7, God forbid there's a problem. If you're in a community where you don't, where you take call from home, where there's concern about any complications from the VBAC, more so than complications from cesarean, I think the rate of VBAC falls and there's some communities where VBAC's not done.

These comparisons illustrate the differences in providers' tolerance for risk and how it translates into their willingness to offer VBAC within their given environment.

### **Professional Regulation and Provider Relationships**

The practice of medicine, nursing, and midwifery in Florida falls under the purview of the Department of Health (DOH) by legislative statute. The providers in this study were licensed under Chapter 458 (Medical Practice Act, 1979), Chapter 464 (Part I) (Nurse Practice Act, 1979), and Chapter 467 (Midwifery Practice Act, 1982). The practice acts outline the rules and regulations to which providers are expected to comply or face sanction by the state. Obstetricians are granted considerable autonomy and authority in their practice, both by society and by the state. Several participants in this study were quick to point out that **they** had the ultimate say in medical decision-making, not their employers, hospital administrators, or other physicians:

"Dr Hanna:" If we said we don't ever want to do a VBAC again, the [employer] wouldn't say anything about that. They don't dictate how we practice medicine.

"Dr. Charles:" The administrator cannot dictate medical care to you. They just can't. They just don't have the authority to do that.

"Dr Angela:" There are various opinions about what somebody else's tolerance will be within my group...So there is definitely a lot of "wiggle

room" and comfort zones of different people that I work with. I have one partner who won't VBAC anybody ever.

"Dr Brian:" When it all came out [ACOG Guidelines], there was a big discussion in the meetings...some were saying we should make it uniform. And I said, NO, we don't make it uniform, and I don't necessarily agree that it has to be done, and the other group said, no, we don't either. So basically...it's a personal preference. I can't tell the other guys...that you should do VBACs. And you can't look at us and say we shouldn't do VBACs, as long as it's done appropriately and followed the steps that ACOG's laid out...then it can be done.

CNMs have considerably less control over their practice than obstetricians. According to law, CNMs are required to practice within the framework of an established protocol that is under the supervision of a licensed physician (Nurse Practice Act, 1979). Moreover, not all obstetricians are supportive of CNMs; in fact, some obstetricians view nurse-midwifery as a legal and economic threat (Perkins, 2004). For obstetricians that do work with CNMs, however, the amount of actual "supervision" is highly variable, and often depends upon the practice arrangement and experience levels of both parties. CNMs who own their own practices, for example, often have more latitude than those who are employees of obstetricians. "Joan," a CNM who owns her own practice and has a collaborative practice agreement with an obstetrician, described her procedure for a woman with a previous CS:

We have to go through a process where our back-up agrees that we can do a VBAC with that person, a trial of labor, and if he agrees, even for CPD or some other reason, then we'll go ahead.

Many CNMs, however, are not able to attend VBACs because their obstetrician employer will not allow it. "Grace" described her situation when she was employed by a physician group practice:

We worked with a big group of doctors and we were doing VBACs with no problem in the hospital, and then for whatever reason, which I know it to be a medical-legal kind of thing, we weren't able to do VBACs. The midwives were not able to do VBACs, even in the hospital, even with the doctors there.

"Barbara" is not even allowed to do prenatal care for women with a previous CS; however, she says that the "rules" tend to be fluid:

...the doctors won't let us even do prenatal care for previous c-sections...even if the person wants the midwives to be doing the prenatal care. But then of course, the day that one of the VBACs is in labor, I come in to help with a c-section, and then I get told, well, there's a woman in labor that you might need to break scrub and come deliver. And she was a VBAC. So it's a hard and fast rule until they need us to do it.

Economics also played a role in CNM restriction from VBAC in "Barbara's" previous practice:

...then the ACOG shift happened where they decided the OB had to be in house, and [obstetrician] decided, he's not going to be there in the house and not get the money for the birth. So we had to stop doing them.

Some CNMs and obstetricians do work collaboratively around VBACs, however, particularly if the woman has a strong relationship with the midwife. "Dr. Brian" described how he supported CNM "Louisa" to do the delivery if the woman wanted her to:

Because I have to be there if something happens. I've got to be able to get them back to that OR, and if I'm sitting at home, that's a delay, and when it happens, (snaps fingers) it happens. So I'm the one who's in the hospital with them in labor. Well, I do that with all mine, anyway. So it made no big difference for me being there. The only difference is...I was on labor and delivery when she did the delivery.

While LMs have more autonomy than CNMs in some ways, they are generally more marginalized due to their status in the healthcare system (Simonds, Rothman, & Norman, 2007). Most LMs do not have conventional educational backgrounds in nursing, and are often referred to as "lay" midwives by obstetricians and CNMs, even though they must document their training and pass a series of examinations in order to be licensed in Florida (Denmark, 2006). Several LMs shared their perspectives on their status in the medical community:

"Rosa:" I can probably sum it up in just a four letter word. Hate would be a good one...I think most of the doctors really hate midwives down here. They would like to see all of us out. It's like a stated thing from the health

department that their goal is to end midwifery in this state.. I always like it when doctors refer to me as, oh, you're a **lay** midwife!

"Christine:" [they think]...that we don't carry **oxygen** or just completely off the wall things, like that we deliver babies in the nude, you know.

By law, LMs are not required to have a protocol or physician supervision to attend births in homes or freestanding birth centers; however, in order to legally attend VBACs, they are required to have both (Midwifery Practice Act, 1982). Several of the LMs in this study described their status:

"Jennifer:" Our backup physician...his hospital requires him to be present as well as anesthesiologist to be present the whole time a primary VBAC is in labor, so he's not able to make that time commitment. So he's not doing VBACs; thus, he's not signing us off for doing VBACs.

"Sylvia:" So as licensed midwives in the State of Florida...we **have** to have them signed up by an obstetrician with hospital privileges as likely to have a normal labor and birth and postpartum period. We actually have a form that they have to be signed up by an obstetrician in order for us to accept them as clients. So we may not even do prenatal care on somebody in that situation without having a consultation with an obstetrician and a signed collaborative management agreement. So our hands are tied in that sense that we need someone signed off by a physician and our backup is unable to do that.

### **Professional Liability**

The state also requires that obstetricians, nurse-midwives, and licensed midwives carry malpractice insurance unless they serve as an officer, employee, or agent of the state or Federal Government, a condition referred to as "sovereign immunity" (Health Professions & Occupations, 1993). Obstetricians have several options to meet this requirement. According to law, they may establish an escrow account, obtain professional liability coverage, maintain an unexpired, irrevocable letter of credit, or be self-insured under a group trust fund. Any physician that opts not to carry malpractice insurance, however, must post a sign in their office(s) stating that they do not carry malpractice insurance (Medical Practice Act, 1979). This is referred to as

"going bare." As previously mentioned, none of the obstetricians in this study were currently carrying malpractice insurance. "Betty," an administrator, was concerned about how "going bare" would affect VBAC births at her hospital:

...most of our physicians went bare [of malpractice insurance] last Fall. So they have no coverage at all. One physician and the nurse-midwives have coverage. And so, we will see if that decision decreased the number of VBACs at all just because they were more concerned.

Although they did not offer any information to me about how they were otherwise meeting the state's requirement, two of the obstetricians in this study discussed their reasons for not carrying malpractice insurance:

"Dr. Arthur:" My malpractice carrier said...we think this case is defensible and winnable, but ...we would just prefer to settle this and not have to take it to the court...what about poor Dr. Arthur, who will end up in the Data Bank? Oh, too bad! So that is when I decided that I didn't need to be paying anymore malpractice insurance. If they were going to have that attitude, it was better for me to just defend myself.

"Dr. Charles:" The amount of malpractice insurance, if you're going to buy insurance, that's why I quit carrying it, because if I carry insurance, I would basically be working for nothing. The other group here does not carry medical malpractice insurance either...they buy medical malpractice defense, and they protect their assets, and they're going to stonewall any suit.

All of the CNMs and LMs in this study carried malpractice insurance, although their level of coverage varied (Table 4-2). CNMs and LMs are required by law to carry a policy of not less than \$100,000 per claim and \$300,000 in the aggregate at a minimum, or demonstrate proof of their ability to cover a claim to that extent (Health Professions & Occupations, 1993). Most CNMs and LMs, however, do not have the personal assets to cover a large claim, and are forced to carry malpractice insurance unless they are eligible for sovereign immunity. In the case of employed CNMs, however, the cost of malpractice insurance is usually covered by their employer (ACNM, 2007).

Four of the obstetricians in this study were protected under sovereign immunity. The doctrine of sovereign immunity is rooted in common law and is based on the adage, "the king can do no wrong" (Committee on Health Regulation, 2007). In modern common law, sovereign immunity protects the public treasury from unwarranted encroachment and exploitation from citizens or branches of government. Section 768.28 of the Florida Statutes (2008) waives tort liability for the state and its agencies and subdivisions and imposes a \$100,000 limit on the state's liability to a single person. For multiple claims from a single incident, the limit is \$200,000. Individuals involved in a claim for medical negligence are not named in the suit, and the liability action is instituted instead against the state entity (Committee on Health Regulation, 2007). Therefore, health care providers that are officials, employees, or agents of the state are granted sovereign immunity. This includes employees of AHCA, the DOH, and faculty of universities who practice as part of their teaching duties in an accredited school or in its main teaching hospitals. In addition, a person who provides uncompensated care to medically indigent persons under contract of the DOH may qualify for sovereign immunity (Committee on Health Regulation, 2007).

Several of the participants spoke about the influence of sovereign immunity on their ability to offer VBAC. Their views about its impact on decision-making varied however. "Dr. Hanna" felt that her decisions were primarily based on the level of evidenced-based risk to the patient rather than the protection of sovereign immunity:

We would never do a procedure that put a patient at an increased risk, simply because we have sovereign immunity...we've got guidelines that say, it's a low risk, less than 1 percent, so, we wouldn't change our practice based on sovereign immunity.

"Dr. David," however, felt that having sovereign immunity was influential in how he and his colleagues practiced:

I think the attitude towards VBACs is very positive and may be even more than 75%...and that may reflect the fact that we've got sovereign immunity. I mean a VBAC is a lot easier than a c-section as far as the practitioner's responsibility.

Some of the private providers agreed with "Dr. David," and thought that those with sovereign immunity had more latitude to offer VBAC:

"Grace:" ...at the teaching hospital, you can sue the entity, but they have sovereign immunity...it's not *them*, it's not their business, it's not their money.

"Dr. Charles:" .... at the teaching hospital...they don't have the medical malpractice hanging over them because they have sovereign immunity, so that makes them able to pick the whole realm without worrying so much about that, whereas the corporate and private hospitals are going to try to avoid the lawsuit. And they're going to take a different course because of that. And that's unfortunate, but it's true.

The Florida Birth-Related Neurological Injury Compensation Association (NICA), mentioned briefly in Chapter 2, is another key aspect of the malpractice landscape. NICA was created by the Florida Legislature in 1988 with two goals: 1) providing funding for the care of birth-injured babies; 2) reducing the financial burden of malpractice insurance to physicians practicing obstetrics (OPPAGA, 2004). Revenue for the program is generated by an annual fee assessment to all Florida physicians. Obstetricians and nurse-midwives, however, may choose to participate in the program if they pay an annual fee of \$5,000 and \$2,500 respectively.

The NICA Program has had mixed results in meeting its statutory goals. A 2004 report indicated that NICA had not lowered malpractice premiums for obstetricians (OPPAGA, 2004). On the other hand, the experience of claimants was largely favorable. NICA cases were resolved much more quickly and inexpensively than those that went through the tort system, with the added benefit of nearly eliminating attorney costs (OPPAGA, 2004).

While the participants in this study were not specifically questioned about NICA, it is interesting to note that none of them mentioned it at all during the interviews. A search of NICA providers on the public website revealed, however, that all but one of the obstetricians in the study were enrolled in the program in 2008. There was no listing available for the CNMs, and LMs are not eligible for the program. Since the large majority of obstetricians were enrolled, it seems reasonable to assume that they attach at least **some** value to participation in the NICA program. When questioned about NICA during a member check, however, one participant offered the comment that, "Why wouldn't an obstetrician want to be enrolled? At \$5,000 a year, it's a bargain!"

### **Chapter Summary**

The development of this chapter raised a number of important questions about obstetrical care in Florida. Why have CS rates escalated so significantly in South Florida when North Florida is closer to national norms? Clearly, the small number of VBACs occurring in North Florida are not sufficient to explain this difference. Another important question is why VBAC is unavailable, even in urban, tertiary RPICC centers in South Florida, since these facilities are equipped with the highest level of technology and expertise available? Even more puzzling is why this situation continues to exist when statutory oversight of CS rates in Florida hospitals is mandated by the legislature. Although the provider interviews in the next chapter will provide some insight into these questions, many more remain.

### **Conclusion**

This chapter presented a demographic profile of the study participants and explored the "obstetrical landscape" of Florida. Relevant vital statistics, documents, state government reports, statutory regulations, observations, and interview data were combined to create a picture of this landscape. The data provided insight into how political, economic, and sociocultural forces have

converged historically to adopt and mandate a state-regulated and urban-centered system of perinatal care in the state.

Three important observations emerged from this analysis. The first concerned regional variation in VBAC accessibility. Statistical data indicated that CS rates are highest in South Florida, particularly in the concentrated urban areas of Broward and Dade counties. VBAC rates were correspondingly low in these areas. Coupled with supporting interview data, it appeared that women are having great difficulty finding in-hospital providers for VBAC, and a number are choosing the less-safe option of a birth center.

Another pertinent finding was that many obstetricians in Florida have decided to forego carrying malpractice insurance. While the state requires that they have some way to compensate patients in case of a loss, the lack of malpractice insurance means that tort claims are likely to result in smaller awards, if they are initiated at all. For obstetricians, that may be an advantage. However, given the fact that midwives of both types carry insurance, they are likely to be the "deep pocket" in the event of a suit involving both midwives and obstetricians.

This situation appears to be related to the third observation: the exclusion of midwives from VBAC care. While this may not be the case when both have sovereign immunity, the interview data indicated that midwives in private practice are being excluded for this reason. In Chapters 5 and 6 to follow, this issue and its implications for improving care will be discussed in greater depth.

CHAPTER 5  
RESULTS PART II: HEALTHCARE PROVIDER INTERVIEW DATA

**Overview of the Interview Process**

The obstetricians, Certified Nurse-Midwives, and Licensed Midwives interviewed in this study were chiefly recruited by word of mouth. As described in Chapter 3, key informants and professionals already known to me were contacted in various areas of the state. These contacts led to others, and through this process, the sample "snowballed." Most of the providers who were approached agreed to be interviewed; however, some of these interviews did not take place due to the problem of finding a mutually convenient time.

Providers that deliver babies typically have hectic lifestyles, and this condition was obvious during the observations and interviews. In most cases, I spent considerable time waiting to initiate or complete an interview while the provider attended a delivery, answered phone calls, finished seeing patients, or ate a meal. I was surprised at their candor about the subject. While interview guides (Appendix A, B, and C) were used for focus, the majority of providers talked at length on each question and needed minimal probing. Interviews were fairly short, ranging from 25-50 minutes. I attributed the richness of these dialogues to the necessity of communicating a large amount of complex information to their patients in a minimal amount of time. Some were quite passionate about their point of view, particularly those who had experienced some type of conflict over the issue. As I previously described in Chapter 3, documentation of informed consent for this study was waived by the IRB. This may have helped the providers to feel more secure about talking with me, as it meant that their names could not be linked to the research.

**Influential Factors in Decision-Making**

A principal aim of this study was to identify influential factors in providers' counseling, negotiation, and decision-making for mode of delivery. Invariably, when asked about how they

counseled women about mode of delivery, all the providers began their discussion with a standard description of medical risk factors, such as why the woman had her first CS. As the narratives evolved, however, the factors became more sociocultural and political in nature. They spoke about how cesarean was becoming a "normal" way of birth, and of how women were "choosing" and expecting a repeat CS more frequently. Their counseling was framed by a risk approach which was driven by systemic factors, such as hospital policies. These factors also influenced how decision-making was negotiated with women and with organizational forces. Individual factors, such as educational background, personal experiences, and fears about malpractice liability also played a role. Although there was much individual variation among providers, their responses centered around six broad themes that were categorized into three levels of analysis. The conceptual model is depicted in Figure 5-1.

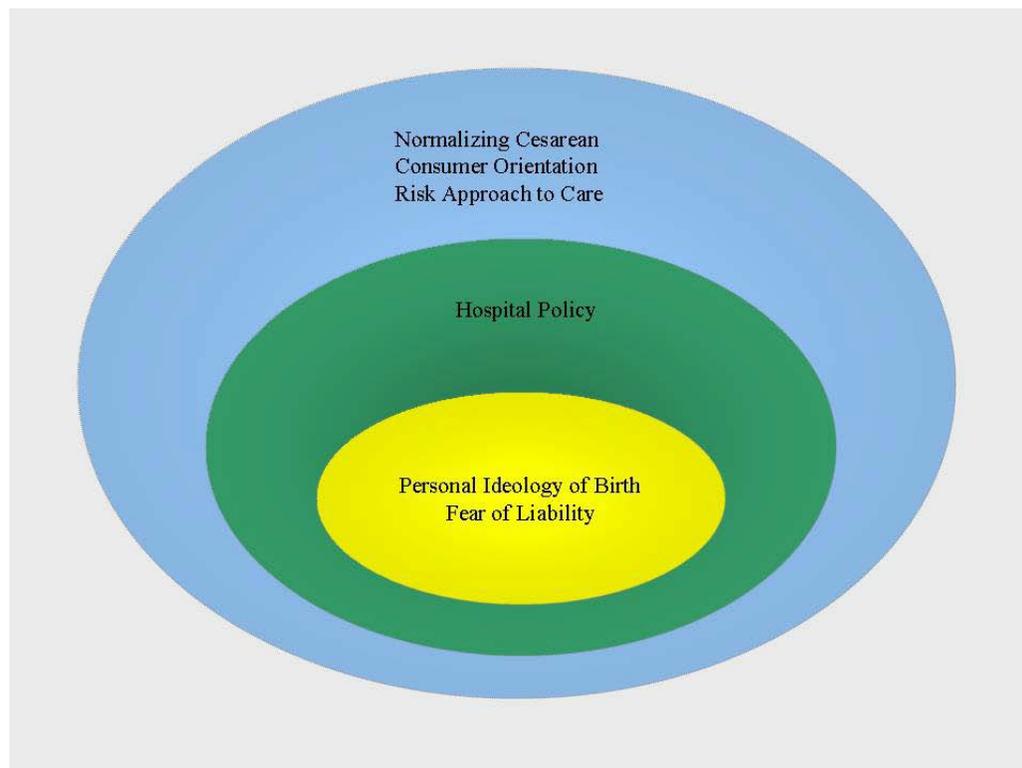


Figure 5-1. Factors influencing healthcare providers' decision-making

In the discussion that follows, each factor is explored in detail and supported with quotations from the interview data. The model represents circles of influence and is non-hierarchical. The blue zone encompasses the sociocultural level; the green zone portrays the systems level; and, the yellow center represents the individual level. Each of these levels interact dynamically during the decision-making process. These factors represent broad categories of influence, and should not be construed as representing all the possibilities within this sample of healthcare providers. In this section, each factor is discussed in detail and is supported with quotations from the interview data.

### **Normalizing Cesarean**

There was much discussion in the interviews about how CS has become widely accepted as a common mode of birth. Some women have been requesting primary CS in recent years, and this trend has not been ignored by women with a previous CS. According to CNM "Louisa," "the majority **expect** to have a c-section once they've had one c-section." Dr. "Patricia" extended this notion to VBACs: "I just think that more people hear that less VBACs are being done so it must be normal to have a c-section. It's normalizing."

The idea that CS is the "normal" way was also reinforced by the idea that there were few risks associated with the surgery:

CNM "Barbara:" They happen so often these days that people feel like they're risk free. I mean it's such a common surgery, that it's almost like people think it's not surgery any more!

When I asked about why they thought this was so, the participants offered a variety of explanations. Some of these reasons were centered around the realities of modern life, both for their patients and for themselves. Many of the providers indicated that the convenience of being able to plan a RCS made it an attractive alternative for many women. Although "Dr. Brian" offered VBAC, he found that few women were actually interested in the option: "...convenience

is probably number one. Because if I tell them, this is the day you'll do it, they'll go OK! That's what I want!" "Dr. Arthur" also voiced this sentiment, saying that most of his patients are "fine with the repeat section" and are "thrilled" that he is able to give them a firm delivery date a week before they are due.

Obstetricians often appreciated the convenience of RCS for themselves as well. Even obstetricians who provided VBAC, such as "Dr. Hanna," were candid about the relative ease of RCS:

It's certainly not as convenient for us as physicians to have a VBAC, because we have to be immediately available...and it's much easier for us to schedule a c-section, but if it's something that the patient wants, then we certainly give them that opportunity.

Nurse-midwives were also pragmatic about the convenience of RCS. Although "Linda" wished that she was able to offer VBAC to her patients, she appreciated not having to come to the hospital in the middle of the night for the delivery:

I'll admit this readily, in some ways it's just one less person you have to come in the middle of the night for...I feel badly for the ones who feel strongly that they want a VBAC...but in some ways, it's like, well, OK, it's just another c-section, I don't have to worry about that one.

Several obstetricians, however, felt that the desire for convenience and control was motivated by a deeper need to plan around the demands of employment and the realities of arranging family assistance during and after the birth.

"Dr. Diane:"...there definitely is a certain mentality that you can plan the birth of your children...get induced on Thursday and then you have a baby and then you can go back to scheduling your life again...If they had a c-section before, OK, I'm gonna have my repeat c-section on Thursday at 3 so I can work up until the day before... I can plan.

"Dr. Ellen," also attributed this need to a general lack of support for motherhood:

I have patients who have no leave at all, and they are struggling to get back to work 2, 3, 4 weeks after vaginal births and c-sections...your job can be on the line if you don't...now extend that workforce-related problem to her family. Her mother frequently works in another city, airline ticket guidelines are very rigid...and so these women feel really locked into, I've got to have my baby by such and such a date.

"Katherine," a CNM with 32 years of experience, lamented that women want a CS because they are intolerant of the unpredictability of waiting for labor to begin and of "letting nature take its course:"

...we live in an instantaneous society right now...things that we used to allow time to be patient for, we don't...why have patients become so intolerant of letting nature take its course?... And once they find out what sex the baby is, the pregnancy's over as far as they're concerned. It's like birth in the ultrasound room!

Women's fears of labor and of possible pelvic floor damage were also cited as a reason for the broad acceptance of CS. Dr. "Ellen" thought that "...a lot more often than not it is pelvic floor function, they don't want everything falling out at a later date." Several obstetricians also mentioned the phenomenon of female obstetricians who chose to avoid labor altogether and opt for a primary CS. Dr. "David" pointed out that such an obstetrician would also be unlikely to attempt a VBAC herself:

...you certainly have a growing number of female obstetricians who are getting primary sections and have no desire to labor whatsoever. Now that's an interesting **change** and how's that going to influence what we do? Because certainly somebody who gets a primary c-section is not going to VBAC, probably not.

### **Consumer Orientation**

While not all the providers subscribed to the consumerist model of decision-making, the ubiquitous nature of consumerism in American society had an impact on their practice and on their relationship with patients. The primary features of the consumerist model were reviewed in Chapter 2. In a consumerist model, the provider functions mainly as an information source for

the discriminating "buyers" of her services. Beyond information transfer, the provider has no obligation to the decision. Thus, the patient deliberates about her options, and then makes an autonomous choice. Although some of the providers in this study identified their personal approach as shared, rather than consumerist, virtually all of them acknowledged a belief in patient autonomy and the right to choose mode of birth.

Dr. "Hanna:" I think the patient has the ultimate decision-making in every aspect of medicine, where we can just guide them and give them the facts that we know.

Some providers said that a number of women did their own research on mode of delivery prior to seeking care. In "Dr Angela's" view, some women were even "quite personally aggressive about their own health care management," especially those who were wealthier and more educated. She described her experience with the women in her practice:

All of them come in with their list and what they've learned...on the web and what they've seen on TV. I think they come in knowing more of what they personally want, rather than seeking advice. The vast majority of my patients who are prior cesarean section want a repeat cesarean section, and if that's what they want, I'm OK with that.

"Dr. Hanna" echoed this position, saying that "patients usually know right away what they want to do. They'll say, oh, I definitely want another c-section, so we never talk about it again until it's time to schedule a c-section." "Louisa," a CNM, also said that "If the patient doesn't specifically say,...we don't really go all out and say, 'Would you be interested in having a VBAC?' I'll have to say it comes from the patient."

As long as the woman was "adequately informed," most providers felt that the decision was ultimately the woman's responsibility. Dr. "Brian" was adamant that the woman should be the one to make the decision:

They are the only one that are truly responsible for the decision... Look, I can tell you, have a c-section, we run into a complication, maybe I should have done it vaginal. I tell you to have a VBAC,

you rupture your uterus, the baby dies or the baby is quadriplegic, I can't make that decision. Only you can decide what I do to your body. I can tell you what is **available**, and what the odds are, and how we'll approach it. But she's the ultimate. And that's who has to make the decision. I do not. I tell them I **will** not make that decision, that's not something I can do.

Midwives had similar views to obstetricians. "Joan," a CNM, felt that "when you give people good information without a lot of bias, they **do** make the best decision for themselves." LMs also agreed with this posture; "Christine" clearly framed the decision as the woman's "right to choose:"

Because it's her body,...and she's taking the risk to have a c-section...I'll even go as far [as saying] I think the woman has the right to say 'I want a c-section' instead of delivering vaginally. I don't agree with them, but I think they have the right to choose how they birth.

In contrast to the majority, a few obstetricians felt uncomfortable with the consumerist orientation. Dr. "Charles" thought that his job was to "give a firm, unequivocal recommendation" about the VBAC/RCS decision rather than accommodating whatever the woman's choice might be. He described the consumer approach as being problematic:

KC: So you don't think of the patient as being a consumer?

Dr. "Charles:" Well, they are! They pay the bill and they can walk with their feet if they don't like what you have to tell them...I don't practice smorgasbord medicine. It's my job to tell people what the best thing to do is, based on my knowledge, education, and experience...if they don't like it, they can leave, and I don't have any hard feelings, it's their opinion.

Dr. "Ellen," agreed with Dr. "Charles," insofar as her greater level of knowledge obligated her to do more than to simply offer information and let the patient choose. Citing her own personal experience as a VBAC mother, "Ellen" took the position that the consequences of the decision were such that the obstetrician's perspective on what was best for the patient should hold more sway:

...one of the goals of our college [ACOG] is to promote patient autonomy, so you really want to help them come to their own best decision...but in terms of the degree to which society holds OB/GYNs responsible...I'm the one with the greater knowledge of what can happen and so...I need to bear that responsibility and make decisions that help my patient to the best outcome...she doesn't have that wealth of obstetric knowledge.

### **Risk Approach to Care**

Much of the providers' counseling for mode of delivery revolved around risks. How these risks were perceived by both providers and women emerged during the counseling process, and was negotiated between them. Although the probability of neurologic damage to the baby is very low, even with uterine rupture, this complication is the most dramatic and legally devastating complication of VBAC. Thus, for many providers, counseling for mode of delivery was heavily weighted towards this risk. Some even presented a RCS as being "safer for the baby" than VBAC. For example, Dr. "Patricia's" "usual speech involves risks...the first thing I tell them is the safest way to deliver your baby and the safest thing for your baby is a repeat cesarean section." Several other obstetricians, however, thought that the public's perception was that CS was safer for the baby, regardless how the provider presented the risks during counseling. According to Dr. "Diane," "in their mind, the small risk of something happening to her baby outweighs any bad effects of having a c-section." In a similar vein, Dr. "Megan," worried that "people think if you didn't do a c-section, you caused this bad thing to happen to a baby."

CNM "Katherine," and her partner "Barbara," claimed that the obstetricians they worked with geared their counseling toward doing a RCS. "It is biased. It is absolutely biased. No question about it." Furthermore, "Katherine" said that when they (the midwives) used to do VBACs, she had to prepare her patients ahead of time for their counseling session with the obstetrician:

When we were doing them, they still had to have an appointment with the doctor to talk about a VBAC versus a repeat c-section. I would tell them, 'You are going to come out of there given information and you are going to feel like you will be a bad mother if you choose to deliver by VBAC.'

Even providers who felt they were presenting a balanced approach found that patients' fears about the vaginal birth process were deeply embedded. Thus, it was difficult to effectively describe the risks in detail without making patients fearful. Dr. "Brian" and CNM "Louisa," described a typical counseling session:

"Brian:" There's risks involved with both cases. The CS, you have a risk of infection, bleeding, injuring bowel or bladder...you can have a dehiscence infection afterward. More of those risks are maternal risks versus fetal risks. Then I turn around and say...you can also have a VBAC...if you start adding things that increase contractility of the uterus, you're going to rip that scar...most of the risk there will be a fetal risk, and some maternal, because if you rip, you will drop oxygenation to the baby, if we can't get the baby out fast enough, then the baby could be born with some neurologic deficit. If you rip the blood vessel, you could bleed, and we could have to do a transfusion or have to take the uterus out if we can't stop it, so there are some risks involved there.

"Louisa:" That's when they say, "I'll have a c-section."

"Brian:" That's about the time they do!

Some providers mentioned, however, that the risks of multiple CSs were an under-addressed concern. CNM "Barbara" felt that the physicians in her practice did not sufficiently represent the longer-term risks of multiple CS to the mother:

...they don't counsel women very vigorously as far as the risk to the patient who has more than 2 c-sections...they don't go into that in as much depth and realism as they need to.

Communicating the risks for future pregnancies could be difficult, however. Dr. "Arthur" voiced his concerns about counseling women on the risks of multiple CS:

But I can tell you clearly that over the last couple of years, we've had more people having 4 and 5 c-sections...And I think that's going to be problematic...the last lady, who I did a couple weeks

ago had 3 previous c-sections, this was her fourth...and I really had to convince her that she didn't need to go down this road again.

It was interesting to note that the providers in this study did not mention concern over the neonatal risks from CS, such as iatrogenic prematurity from incorrect dating. Respiratory risks, such as transient tachypnea of the newborn, were similarly ignored, at least when providers were discussing their counseling with me. This point will be pursued further in Chapter 6.

### **Hospital Policy**

Systemic factors, such as hospital policies, played a pivotal role in providers' decision-making for mode of delivery. First and foremost, hospital policy often dictated whether or not a provider could offer VBAC as an option. All of the hospitals in my sample utilized the ACOG Practice Bulletins (1999; 2004), as the defining standard of care, so formation of policy was directly dependent on the availability of an obstetrician, an anesthetist, and surgical staff. In Level III hospitals, which had a full compendium of 24-hour services, VBAC availability depended more on the "tone of the department" and the "comfort zone" of the attendings:

Dr. "David:" There's no uniform policy. I think the maternal-fetal medicine people set the tone for the department and then the residents parrot that tone. And most of the attendings will pretty much fall in line with what's currently being practiced within the scope of their comfort zone... the other advantage that's very important is...in-house anesthesia, excellent nursing, blood banking, OR is in L&D and allows us to move very quickly if something goes south. So it's a combination of the practice itself, my colleagues who are promoting VBAC, and also the facilities that allow this.

In Level I and II hospitals, however, VBAC availability depended upon obstetricians' negotiation with peers and the cooperation of the anesthesia department. Dr. "Brian" described the situation at his Level I facility:

Hospital doesn't care what we do...what we've worked out [among the medical staff] is...if you're doing them, you HAVE to be on campus...If I have a VBAC...anesthesia's in-house.

Intra- and interdepartmental politics within a hospital had the potential to limit VBAC availability as well. Dr. "Megan" described how the dynamics in her hospital ended up making VBACs unavailable:

Current hospital policy is that we're not able to offer a VBAC and so that sort of came about after much discussion between the obstetric groups as well as the anesthesia group in reviewing the ACOG criteria for offering VBAC. Our issue has been our anesthesia group does not have a dedicated anesthesia provider for L&D...and there were some obstetrics groups that also supported that, they weren't offering VBAC and didn't have any desire...to consider offering that service.

Corporate mandates against VBAC for risk management were also in place in some private hospitals. In one hospital, however, medical staff negotiated to continue offering VBAC by presenting their excellent outcome statistics. "Betty" an administrator in a Level II corporate hospital, described how they negotiated this process:

We do offer VBAC as an option whereas a lot of policies within the corporation are certainly not allowing it as an option anymore. Corporate is very concerned about VBACs and they're trying to standardize...clearly the decisions of how risky we want to be with not following a corporate mandate is based on the administrator...we've reviewed our risk data, and we don't feel at this time that we need to comply with that...generally with clinical issues, we get some flexibility in making those decisions.

The ability to offer VBAC was also influenced by the commitment on the part of the obstetricians as a group to follow the policy. Dr. "Patricia," offered her perspective on why her hospital was able to maintain the option of VBAC while many others had stopped offering it:

And the reason, we think, is that we require ourselves to be in house. We have a very strange rule here that does not exist in any other hospital...if we have Pitocin or an epidural running, the provider has to be in the hospital with the patient. We cannot leave the facility. There's no perineal obstetrics...we are here.

Professional guidelines and hospital policies, therefore, set the stage for how providers counseled women. For those that provided VBAC, this counseling often included negotiating

with the patient about institutional rules, such as fetal monitoring. Dr. "Patricia" offers VBACs in her practice, but counsels women that monitoring is a "requirement:"

Dr. "Patricia:" If they say something totally off the wall, like 'I'm not going to have any monitoring'...we talk about monitoring, but in our hands, that's a requirement. And if that's a deal breaker for them, they can leave the practice. And I'm OK with that.

KC: Now do you have people who do that?

Dr. "Patricia": Almost no one. There aren't very many people who will do VBACs.

"Joan," the only CNM who was doing VBACs, also spoke about the necessity of fetal monitoring. Although her personal feeling was that some women probably didn't really need continuous monitoring during a trial of labor, she opted to make it a requirement:

If they're going to be in our practice, they're going to be monitored...they can be monitored and still be out of bed, they can still deliver on their hands and knees...but that's the compromise we've had to make in order to continue to do VBACs at this hospital...You have to keep them on monitors.

Guidelines and policies also affected the level of intervention that providers were willing to utilize during a trial of labor. Most providers counseled women that they would not induce them, and most were reluctant to augment them either. Dr. "Angela's" strategy was to "avoid medications, avoid Pitocin, avoid induction." Dr. "Brian," however, was much more specific:

I tell them there's a higher incidence of rupturing with VBAC, really high if you start inducing or if you are augmenting...there are risks, and I have certain requirements. I will not induce you, and I will very leeryly augment your labor. If it stalls, I'm not going to augment you, I'm going to section you.

Dr. "Charles" provided a counseling script that was nearly identical:

I'm NOT going to use Pitocin, so you have to go into labor on your own. And if you don't make adequate progress, I'm going to tell you that you need a repeat c-section. And that's up-front.

For those who did not offer VBAC, counseling mostly consisted of explaining why VBAC was not done at that hospital, and where a woman could potentially go to attempt one. "Linda," a

CNM in a Level II community hospital, described what she told patients about their options in terms of hospital policy:

I tell them that we don't do VBACs at our facility,...they have to have a cesarean section at 39 weeks...if they feel really strongly about having a VBAC, they can...have a VBAC through the teaching hospital. I tell them all about the reasons why, the studies, the 1 percent risk,...the hospital has to be manned 24 hours a day with an obstetrician, anesthesia,...

### **Personal Ideology of Birth**

At the individual level, providers often indicated that their education and experiences influenced the way that they thought about birth. This evolved over time into a personal ideology that influenced their perspective on providing VBAC, as well as how they counseled women about their options. Dr. "Hanna," newly out of residency, compared her own perspectives to that of her fellow obstetricians in the community:

I think you'll find that they're more anti-VBAC and we're more OK with it because we are newly out of residency...So we're coming out of a residency where VBAC was very common, whereas the guys out now...they've watched litigation occur, and so I think they're probably more gun shy on VBAC. They just don't want that risk.

Experienced obstetricians who continued to offer VBAC, however, moved beyond being "gun shy" about it to assuming a pragmatic optimism about their ability to handle and anticipate potential complications. Although Dr. "Angela," has had "plenty of negative experiences with VBAC...that doesn't mean I'll stop doing it, but it means I do approach it with caution, like I would anything else." Dr. "David" agreed, saying that he "feels very comfortable laboring somebody, even though I've seen uterine rupture on a previous c-section and it's something to be **respected**..." Dr. "Charles" also tried to balance his experience with his perspective about the risks of VBAC. Even though he has never had a bad experience with a VBAC, "other than it may not work," "Charles" argued that :

...you can't let your anecdotal experience influence what you say the risks are because you usually don't have enough experience anecdotally to make yourself a case for setting the standard...after 31 years and a lot of deliveries, maybe I can and maybe I can't.

Having personally experienced VBAC as a mother had considerable influence on some provider's counseling practices, both pro and con. Dr. "Ellen," who considered herself "pretty pro-VBAC," said she encouraged women who know they want 3 or 4 children to really think about a VBAC:

And I know I'm biased from my own experience, but I felt that coming home to my first baby after a 31 hour labor and a c-section, ...I was preoccupied with my own discomfort and not able to attend to my newborn as well as I wanted to. I share that stuff with patients.

CNM "Polly," on the other hand, sustained a uterine rupture during a trial of labor with her second child, and found it hard to be supportive of VBAC. She would share her experience with patients, however, only if they were undecided about whether or not to attempt a VBAC:

I'd say, yes, it happened to me. And then a lot of the time, you know, when people saw a living, breathing person that it happened to, it did change their mind. And they said, wow, you know you hear about it, but to actually to talk to somebody that it happened to...

### **Fear of Liability**

Over and over, the providers in this study told me that fear of liability was their biggest impediment to offering VBAC. As a result, providers, and particularly obstetricians, tended to steer women towards RCS rather than VBAC. According to Dr. "Diane," "obstetricians are in a constant **fear** of being sued, so they're taking a path of least resistance."

Providers that practiced in smaller Level I or II hospitals were particularly concerned about liability, given that a potential delay in response time could result in a bad outcome. Dr. "Arthur" felt that this situation was not defensible in a subsequent lawsuit:

...if you have a problem...you are going to get no sympathy from the medico-legal community...they are going to be all over you, and if you end up with a ruptured uterus, you are going to be lucky if you get a viable newborn and you don't have a lot of problems with the mother. And nobody is going to be sympathetic for any unusual pattern on the monitor.

"Stacy," a CNM who practiced in a community hospital, was relieved that she was no longer doing VBACs because of her experiences with delays during emergencies:

I was somewhat saddened when we stopped doing them because I think in our practice we had a very good success rate for delivering previous c-sections...But one time it took over 15 minutes for somebody from anesthesia to get there...And when you're sitting there and the baby is going bad...it was a difficult position to be in. So I finally made peace with it.

A number of providers felt that the risks of liability with VBAC were high enough to justify offering it only to the most motivated and adamant women. If women did not express a "strong" desire, Dr. "Patricia" did not feel comfortable encouraging them towards VBAC:

...they really do need to express an interest in it, and I do feel really hampered by being in the state of Florida with no professional liability insurance. So the safest thing for the **baby** is a repeat c-section. I will never get hammered on that in the court of law. I will get hammered in a court of law allowing a VBAC to occur.

Dr. "Brian" agreed with this position, and also said that he will immediately go with a RCS if a patient changes their mind during the pregnancy: "Of course, I never tell them, 'No,' because if you say no and they happen to be the one that ruptures, they'll look at you and say, 'I didn't want this!'"

The birth center LM, "Rosa," took a very different approach to liability management than the physicians. Her approach was to spell out the conditions under which she could offer VBAC, and then let the woman decide if she wanted to assume the risk. In "Rosa's" view, her role was to assist the woman's much-desired attempt at a vaginal birth. If the woman ended up deciding to deliver with her outside a hospital, however, "Rosa" made no guarantees about the outcome:

So when I counsel women, I explain to them, we have an OB on call, we are 7 minutes from the hospital, I cannot guarantee you one thing on **any** birth...there's no guarantees in life. I'm a person who's absolutely convinced that God is in control of this stuff, and I certainly am not...I'm not in control. I'm there to assist you and if this is a decision you'll make...if you're a VBAC, before you deliver I'm going to really make sure that you're in the best shape I can before we deliver this baby. And I don't want you to have an elephant in there!

### **Dealing with Conflict**

Conflict between opposing points of view is inherent in the decision-making process, particularly when the decision is a controversial one such as VBAC. While providers generally tried to avoid conflict with women, problems sometimes arose when the providers' limitations around VBAC did not match the woman's desires or expectations. Providers in teaching hospitals had the greatest challenges in this respect, as they often were the "last bus stop" as far as the option of VBAC was concerned.

Disagreements within group practices and amongst peers in the hospital were not uncommon. Corporate mandates and hospital policies caused conflict as well, for some providers perceived them as being restrictive and problematic. In the following section, I describe how providers avoided, negotiated, acquiesced, and resisted the various conflicts that arose around VBAC.

### **Dealing with Women**

Providers in private practice who did not allow VBAC avoided conflict simply by providing only one option. If RCS was the only choice, the woman either accepted it or went elsewhere for care. Although providers lost some patients this way, the wide acceptance of RCS seemed to still keep them in business. In many instances, even patients who initially wanted VBAC ended up staying with the provider and having a RCS rather than finding a new provider or having to travel a distance to find care.

For providers who did provide VBAC, negotiating differences of opinion was more subtle and complex. Dr. "Patricia," who had been in practice for 19 years, said she had learned to engage in "the sport of listening" rather than argue with a patient who had a divergent point of view:

KC: Some women who've had a horrible experience the first time are the most adamant to try VBAC...

Dr. "Patricia:" "...that's the "nuts and berries" patient...because they had the epidural, they had the c-section and so this time, by God, they're not going to have an epidural! I wish I could convince them of that, but I don't even argue with them.

KC: So what do you do when you get one of those patients?

Dr. "Patricia:" I just try to keep them safe. I can't really direct their points of view very much. I found through the years that it's better to just listen, the 'sport of listening'...Yep, ummhhhmm...

Sometimes, disagreement escalated to the point that the provider suggested that the woman seek a "second opinion" or find another care provider. In others, the woman was actively discharged or "fired" from the practice via a formal registered letter. Although Dr. "Hanna" did not share the outcome of the situation below with me, I suspect that this woman received both a name **and** a letter:

Dr. "Hanna:" My partner recently had a patient who had two previous c-sections who wanted a VBAC...we don't do that here...and she hadn't had a previous vaginal delivery and she really wanted to try VBAC and we said no, and she was very angry.

KC: Now what would you do in that type of situation?

Dr. "Hanna:" If a patient is not happy with me, I always say you can go...you can go get a second opinion. That doesn't hurt my feelings...I know what that opinion will be...

KC: Have you ever suggested that they go to another practice or pointed them in the direction of somebody who might be favorable to that?

Dr. "Hanna:" We have. There is one doctor who is very granola-y around here...if that's what you want, here's the name of somebody who does that sort of thing.

Providers found it hardest to deal with women who had "unreasonable" demands. Dr. "Fay" felt that if a woman "wants to make a choice that I don't agree with, then it is not my responsibility to support that choice...she needs to find another physician who will agree with her decision." Sometimes, however, women were not able to find a physician under these circumstances, and their only option left was the teaching hospital. This presented a challenge to teaching hospital obstetricians, for often these women had no other option for care:

Dr. "Angela:" We have a number of patients who have very specific demands that would be better fit in a home midwifery setting...yet they want to deliver at the tertiary care teaching hospital...because they won't be accepted by the midwives because of extenuating medical circumstances...we try to accommodate to the best of our patient's desire...But the patients have to understand that we have certain limitations on what we are able to accommodate.

Dr. "David," who also practiced in a teaching hospital, felt that providers in private practiced often "dumped" their most difficult patients on them, including women who wanted VBAC, because they didn't want to accept the risk themselves:

Well, they've [providers in private practice] got an out and we're it. We're the last bus stop...what do you do with the occasional nut that's got severe fetal distress and refuses a cesarean section? Other than begging, there's not a whole lot you can do except a court order, and that's what happens at the last bus stop!

Out-of-hospital midwives also encountered women who had unrealistic expectations about VBAC. Although "Rosa" told this woman she was not a candidate for her practice, she said that the woman was persistent in her efforts to persuade "Rosa" to attend her:

This woman just called me yesterday, she's had 3 cesareans...I said...the statistics are there, after 2 there's a change...The fact is I'd like you to be alive to see 4 kids...it's not legal in the state of Florida, and I'm not going to lose my birth center license over it. And last but not least, you've never even dilated to 2. I don't know what makes you think suddenly, they've given you 2 trials of labor, that you're going to now!

## Dealing with Peers and Organizations

Conflict with peers was not uncommon. Most problems around VBAC arose when opinions and management styles differed in members of a call-sharing group. On occasion, this could result in one obstetrician promising a patient that they could attempt a VBAC and the other partner not feeling comfortable with it when they came on call. Dr. "Angela described such a situation:

There are various opinions about what somebody else's tolerance will be within my group...one faculty would induce patients who only had a prior cesarean section, and a patient who wanted a VBAC who was 38 weeks and diabetic. I was not comfortable with that situation...

In contrast, Dr. "Patricia" described how her large group practice has "worked fairly hard on not changing the patient's labor plan based on changing the physician." Citing patient satisfaction as her main goal for the group, Dr. "Patricia" talked about how they attempted to work together to avoid conflict over VBAC:

So if a patient has talked with...one physician and decided on a VBAC, another doctor can't come into that labor and say, 'you can't do that...let's just go do your c-section...You can go talk to the **doctor** who was primary for that patient and say, I don't ever think you should have ever allowed this patient to have a VBAC...but someone's talked to this patient and has decided it's a reasonable thing to do...so just live with it and go with it, because someone's already thought it through.

Problems with peers over VBAC also led to intra- and interdepartmental politics. During the course of this study, one of the hospitals I observed initiated a ban on VBACs. The problem stemmed mainly from the inability of the anesthesia department to commit a provider to the labor and delivery unit 24 hours a day. It was Dr. "Megan's" impression, however, that the larger and more established obstetrician group that did not support VBAC had collaborated with the anesthesia department to disallow the practice:

I think there were some obstetrics groups that also supported that. They weren't offering VBAC and didn't have any desire to...have to consider offering that service.

As a result of this action, a number of Dr. "Megan's" patients were forced to either transfer their care elsewhere or accept a RCS. This situation caused considerable frustration among the women, some of whom wrote letters of complaint to the hospital administration. "Megan" and her partners encouraged this action, and thought it ultimately might be helpful.

CNM "Joan" also practices in this hospital, although not with Dr. "Megan's" group. She had similar observations about the origins of the conflict:

The anesthesia is a big issue, because we do not have in-house anesthesia...what's happening right now is that the one big group at our hospital that is no longer doing VBACs...they're the ones that are showing up at the meetings and basically saying that they don't want to have these done anymore...and they're trying to ramrod the policy down our throats.

Dr. "Charles" found it regrettable that "the hospitals are all trying to practice medicine, and to have all these policies about things you can and can't do. Obviously, you can still do what you think is your best medical practice to do, and you're swimming upstream if you go against the policy...but that policy flies in the face of what best medical practice is...and best medical practice says it's still fine to do a VBAC!"

The issue of the policy being incompatible with evidence-based practice was a point of contention for CNM "Joan" as well. According to "Joan," the problem with restrictive policies about VBAC is that they are contrary to what the public wants.

So there is a lot of conflict, but it's still not conflict we can do anything about. And as a midwife, I have very little power. A midwife in Florida, I have very little power. I am close to the bottom as far as power goes in making a decision in this arena. Right there with the patient.

## Modes of Resistance

So what happens to women who want VBAC and find it unavailable? The previous narratives have provided some insight about the possible choices. According to the providers in this study, most women accept RCS as the most feasible option if there are not willing providers in the area. Some women seek out the few VBAC-friendly private obstetricians available, even if they have to travel to find them, or opt for care in a teaching hospital. Although some women look to CNMs to provide VBAC care, they are often unable to find nurse-midwives who can accommodate them. An even fewer number of LMs are actually offering VBAC care legitimately, although some continue to provide it "underground." As Dr. "Diane" has said: "there are whole cities in the state of Florida that don't allow VBACs."

One strategy of resistance in hospitals or areas where VBAC is banned is for the woman to delay arrival at the hospital until she is in very advanced labor. CNMs "Linda" and "Stacy" said they have advised women who were strongly against RCS to do this, particularly if the woman had had a successful VBAC in the past:

"Linda:"...depending up on the patient, and if she's had a couple of VBACs already, I say you could just walk through the door completely dilated...our practice has had two, maybe 3 VBACs...and they've all been women who came in 8 to 9 centimeters ...and the physician gets there and they're really nine or they're complete and he just goes ahead and does the delivery because it's quicker for him. But I wouldn't tell that to just anybody, it had to be somebody I really felt comfortable telling and who's already VBACed...

"Stacy:" I do something very similar...That's my personal opinion, but I do the same thing.

Out-of-hospital VBAC is another small, but growing mode of resistance for those women who found the limited mainstream options for VBAC unacceptable. Although it is difficult to determine how many women are actually having out-of-hospital VBACs, the LMs in this study suggested that this number is increasing:

KC: So how many women do you think approach you about VBAC in a month?

"Jennifer:" 9.

"Sylvia:" I would say we've been getting between 6 and 10 inquiries a month. And that's email and phone.

"Christine:" And that's women who are not choosing home birth as a priority, their priority is they want a VBAC...they've gone ahead and called a bunch of OBs or hospitals and realized the fact that that choice is diminished...and so half of them are probably thinking about a home birth for the first time because they want their VBAC.

This is a concerning trend, however. When asked if they would ever refer a woman to a home or birth center midwife for a VBAC, the majority of the participants in this study felt strongly that out-of-hospital birth was not a good idea. Not surprisingly, obstetricians were the least supportive, although a number of nurse-midwives also opposed out-of-hospital VBAC. Dr.

"Charles" was clear about his position:

...absolutely insane...I think the same thing about out-of-hospital deliveries. I don't care how low-risk you are, you can still have a disaster occur, it's not very common, that just causes you or your baby to be gone...unfathomable to me...

Dr. "David" echoed similar sentiments, and also suggested that birthing outside the hospital was selfish on the part of the mother:

I have a gut problem with home delivery and a lot of it has to do with parenting, because my attitude toward home birth is this is no longer about you, this is about the baby...I have seen enough things happen unexpectedly to warrant being in a hospital...but a VBAC out of the hospital...I would strongly advise that they not.

Another obstetrician, however, thought the decision to attempt VBAC at home was contingent upon the circumstances rather than being universally unacceptable:

Dr. "Ellen:" I don't know if I really think it's a terrible thing...if a woman has had 3 vaginal births, her 4<sup>th</sup> baby was a c-section for breech, and now she wants to VBAC at home. I think there are VBACs and there are VBACs.

Although more nurse-midwives were supportive of home birth in general than were obstetricians, some drew the line at out-of-hospital VBAC. CNM "Louisa" had done home births in the past, but claimed that she "would not do a home birth VBAC, never!" "Joan," who also has attended home births, was just as emphatically opposed: "I think it's horrible. Horrible! They should not be doing out-of-hospital VBACs. VBAC belongs in a hospital setting."

Other CNMs disagreed with this posture. Although "Grace" was not currently doing VBACs at all, she felt that they could be done safely in a birth center setting, as long as the physician back-up was readily available and the birth center was within a few minutes of the hospital. "Katherine" argued that the minimal intervention in a birth center made complications less likely, and, if they did occur, easier to identify:

I think birth center VBACs are safe...The patient who doesn't have pain relief will know. Immediately. The epidural patients, you have to wait for the baby to show signs of distress before you even figure it out.

Licensed midwives were the most supportive of out-of-hospital VBAC, whether they were currently doing them or not. "Sylvia" pointed out what she thought the advantages were from the mother's perspective:

And some VBACs work and some you wind up going in for a repeat section. But at least she has the satisfaction of knowing that she tried....if her first experience was maybe in a hospital and she was in a conventional position...that things were not different with squatting...with no interventions, with whatever it was that she felt with her hospital birth might have been the obstacle.

While safety is an important issue, how to insure it becomes an interesting question when women have been positioned as autonomous consumers who have a "right to choose" their mode of birth. How can they be autonomous decision-makers when they are described as being "insane," or "selfish" for trying to give birth vaginally in a place of their choosing? How much "autonomy" did the woman in "Joan's" story below have to make a decision about her birth?

I had a patient who had 2 vaginal births. Got pregnant with a third and the baby was breech, so he did a section. So the next one comes along and he says, yes, he would give her a trial of labor, and she got all the way through the pregnancy and came into labor at 5 centimeters and he walked in and said, 'Well I've decided not to do VBACs anymore, so you're going to have a section.' And she literally went to the back [the OR] screaming and kicking and they had to restrain her to do a section on this woman who was already 5 to 6 centimeters. When does it become malpractice or when does it become an infringement on freedom to say to a woman, you cannot deliver your baby vaginally?

### **Conclusion**

Social, political, and economic factors played a major role in providers' decision-making about mode of delivery after medical candidacy was established. Sociocultural forces, such as convenience, and the economic necessity of women's employment, have "normalized" cesarean birth and made it the preferred mode of delivery for some providers and patients. The positioning of women as autonomous consumers was also an influential factor. By encouraging women to "choose" the more convenient RCS, many providers felt they were transferring the responsibility for the decision to the woman, thus practicing "defensive medicine." Most steered women toward RCS rather than VBAC by weighting their counseling toward the risks to the baby from uterine rupture rather than the risks to the mother from CS. The providers who did allow VBAC, however, did so on their own terms, and were clear that non-compliant women would be discharged from their care. Providers in teaching hospitals managed to avoid some of the market and liability pressures of private practice; however, they had the additional challenge of accommodating women with high-risk pregnancies and those who had nowhere else to go for care.

Both types of midwives were marginalized. Although most had previously cared for women attempting VBAC, only one CNM and one LM were doing so at the time of the interviews. CNMs were often prohibited by their physician or hospital employers from providing

VBAC care, and were also critical of the way obstetricians were counseling patients. While all of the LMs said that they received frequent requests to attend out-of-hospital VBACs, only one LM had the obstetrician back-up to provide them at her birth center. Providers engaging in out-of-hospital births and/or VBACs were generally scorned by obstetricians and by some CNMs. Most of the obstetricians suggested that the mother's mental stability was in question if she chose out-of-hospital VBAC.

These data suggest that the fear of liability that providers face has re-ordered the obstetrical landscape of Florida. Chapter 6 will address the specific implications of that conclusion, and suggest structural changes in public policy that will help to improve providers' counseling and increase access to VBAC within the state of Florida.

## CHAPTER 6 DISCUSSION AND CONCLUSIONS

### Chapter Overview

The purpose of this study was to explore and describe the sociocultural, political and economic factors influencing providers' decision making about mode of delivery, as well as to critically examine how they negotiated conflict around this decision with women and organizational structures. In this chapter, I will interpret those findings and propose ways to improve the counseling and informed consent process. In addition, I will offer suggestions about how VBAC access could be improved in the state through a consensus meeting process.

This final chapter also identifies key aspects of the political economy that limit options for both providers and childbearing women in Florida. Using the Critical Medical Anthropology (CMA), framework, I will include perspectives from the participants in this research study, my own observations, and insights from social, economic, and public health scientists in order to provide a picture of the current situation in Florida.

### Summary of Key Research Findings

The primary intent of this research was to discover and explore the **non**-medical factors that influence providers' mode of delivery decision-making. In other words, I was specifically interested in how providers were counseling the 60-80% of women with a previous CS who fall into the category of "good candidates" for a trial of labor. I wondered why VBAC seemed to be disappearing when the evidence, as well as the ACOG Guidelines, supported it as a safe birth option. My initial assumption was that providers' counseling was a key factor in the high rates of RCS and low rates of VBAC in Florida. Once the study was completed, however, I found that this was only true in part. What I found was that many practices throughout the state do not offer VBAC at all. Unless the provider actually **offered** the option, and the woman was interested in it,

"counseling" consisted of reviewing the risks of RCS and picking a delivery date! Women who were adamant about VBAC were usually referred to another provider or informally directed to an urban teaching hospital.

Providers who viewed women as consumers thought counseling had little effect on the decision, and said that women knew specifically from the beginning what they wanted. They were also the most concerned that trying to influence the decision could result in a lawsuit. Others disagreed with this posture, and took the position that their status as professionals obligated them to counsel women thoroughly about their options. Although these providers were also concerned about liability, they were more cognizant of the power differential between themselves and the woman, and were more likely to offer VBAC as a birth option.

Evaluation of the counseling data revealed that there were some troublesome patterns in the information women were being given. Some obstetricians were steering women toward RCS by presenting it as being "safer for the baby," although research evidence to that effect is inconclusive. Moreover, the recent widespread concern about late preterm birth had not been incorporated as a risk factor in the majority of providers' counseling. While most providers told me they were concerned about the risks of multiple CS, they admitted they were not conveying the importance of this to women as vigorously as they should.

In the final analysis, it appeared that the decline in VBAC had less to do with women's choices or providers' counseling than it did with concern over malpractice liability. None of the providers I spoke with thought VBAC was an unsafe medical practice; they did, however, feel hampered by the legal and economic repercussions of a bad outcome associated with VBAC. Moreover, many of the restrictions on VBAC emanated from larger organizational structures,

such as malpractice insurers and hospital policy committees that were primarily concerned about the economic impact of suit.

### **Application of the Critical Medical Anthropology Framework**

#### **The Macro-Social Level**

From a CMA perspective, the medical model views birth as pathology and "normalizes" birth interventions through the process of medicalization. Organized around a discourse of risk, the medical model promotes the need for technology, intervention, hospitalization, and medical management in order for birth to be "safe" (Perkins, 2004; Simonds et al., 2007). Acceptance of birth technology is embedded in the dominant belief system of U.S. culture, and reinforced by popular media such as television and the internet (Cartwright & Thomas, 2001; Davis-Floyd, 2006). Birth technology and services are part of the market-driven, capitalist economy, and generate significant profits for both providers and health systems (Perkins, 2004). In order to protect both power and assets, providers, hospitals, and their insurers have a vested interest in controlling obstetrical risks. "Risks" differ from "dangers," insofar as they are defined in terms of measurable standards that providers believe that they can control, usually through the application of technology (Cartwright & Thomas, 2001). Thus, the identification and control of obstetrical risks grants power to both physicians and healthcare agencies in the state. This control is further reinforced at the institutional level by the adoption of professional standards, such as the ACOG Guidelines, conformity to corporate hospital mandates, and the development of bylaws and protocols. By investing in and applying advanced technology to monitor and control obstetrical risks, physicians and hospitals also benefit economically (Perkins, 2004).

This profit-making orientation favors high-technology, high-profit CS over low-technology VBAC. As CNM "Grace" said, "they're a big business...a lot of decisions are made on what makes business sense." Moreover, VBAC is particularly troublesome, for any untoward

outcomes associated with VBAC often result in high-dollar malpractice suits. Since for-profit health systems and community hospitals want to rigorously avoid these suits in order to protect their profit margin, they often develop restrictive policies against VBAC or prohibit it entirely. Dr. "Charles" described this interest as being "driven by money - they don't want to get sued."

### **The Meso-Social Level**

At the systemic, or institutional level, control of providers occurs through the implementation of restrictive and prohibitive VBAC policies. Restrictive policies are mainly a problem in Level I and II hospitals, largely because of the ACOG Guidelines. As I discussed in Chapter 1, the ACOG requirement that an obstetrician, anesthesiologist, and surgical crew be "immediately available" when a woman is attempting VBAC has made it difficult for solo and small-group obstetricians to offer VBAC. First, the need to stay continuously in the hospital is lifestyle-limiting for the obstetrician. Second, the obstetrician must also be able to enlist the cooperation of other departments, such as anesthesia and nursing, to also be immediately available during the course of labor and delivery. Thus, the difficulties involved in having all parties immediately available for many hours discourages obstetricians from offering VBAC. Prohibitive VBAC "bans" in hospitals are even more problematic, for they take the decision out of the context of the doctor-patient relationship, and place it in the hands of hospital administrative authorities. Therefore, in a hospital where VBAC is banned, the obstetrician's only recourse is to refer the woman elsewhere, losing patients as well as profits. Dr. "Megan" described how she "lost some patients because of that...some opted to schedule a repeat c-section, but again, these were...good candidates to attempt a VBAC."

Midwives have been affected by restriction and prohibition as well. Many of the CNMs in my sample were no longer allowed by their physician or hospital employers to care for women with a previous CS, even during the prenatal period. This restriction has been largely driven by

concerns over liability. According to my participants, the central issue is that the CNMs have to carry malpractice insurance, because they cannot afford the options that are available to obstetricians, such as a purchased bond or a line of credit. As I described in Chapter 4, many obstetricians are now exercising these options and no longer carry malpractice insurance. This situation has made midwives the "deep pocket" in lawsuits in comparison to obstetricians. As a result, their obstetrician or hospital employers, as well as their malpractice insurers, are prohibiting them from attending VBACs. These barriers are limiting midwives' market-share, as well as women's access to midwifery care. Obstetricians stand to benefit from these restrictions, however, as they assure that midwifery competition for the birth market is reduced even further.

### **The Individual Level**

Since institutions and providers have the power to decide whether or not they will offer VBAC, the decision may not even come down to the individual level. If VBAC is not offered, a woman must decide whether or not to stay with that provider and accept a RCS, or to look elsewhere for care if she is able. Even if VBAC is offered, providers still have more power than women because of their extensive obstetrical knowledge, and their ability to control the terms and conditions of the birth. Most American women view birth as a medical event, and trust both the medical model and their healthcare providers. Therefore, they are influenced by their providers and generally want to comply with their suggestions (DeVries, Salvesen, Wieggers, & Williams, 2001; Hausman, 2005). Although providers may describe women as consumers, research has shown that mothers most often choose what is available within their local hospitals and communities (DeVries et al., 2001). CNM "Stacy" emphasized the importance of this to mothers: "But that's it, most of the time, they don't want to drive 50 miles up to [the teaching hospital] for prenatal care just to have a VBAC."

Women are also influenced by how providers present the information about risks and benefits during counseling. The use of language is critically important (Mander, 2007). When RCS is presented as being more convenient and less damaging to the pelvic floor, these arguments can be persuasive. LM "Rosa" felt that some of the obstetricians in her community were "selling cesareans:"

...many OBs here will let them pick the date on their **first OB visit** for their elective cesarean. Repeat cesareans are not only OK here, they're promoted. They'll section at 38 weeks, tell them that you won't get those little stretch marks that women get at the end. Their vaginas will stay tighter and their husbands will be happy for it, and they can pick the date, which is very convenient for people to fly in and be with them and things of that sort.

By portraying the risks of VBAC primarily as fetal risks, providers can also be quite influential in convincing the mother that RCS is "safer for the baby." As I discussed in Chapter 2, the literature is contradictory as to whether or not RCS is safer for babies in terms of long-term population health. Although some researchers contend that VBAC is associated with higher neonatal morbidity than RCS (Landon et al., 2004), others argue that long-term neonatal morbidity and maternal mortality with RCS are understated (MacDorman, Menacker, & Declercq, 2008; Yoder, Gordon & Barth, 2008). As Albers (2005) points out, however, the low rates of serious adverse outcomes with VBAC, as with any vaginal birth, make it difficult to predict outcomes and make definitive comparisons between studies. Mander (2007) points out that the focal point has moved over time from the safety of the mother to that of her baby. The "recognized tendency to prioritize the welfare of her baby over her own well-being" is likely to be effective in persuading her to comply with medical advice (Mander, 2007, p. 168). Thus, women may be manipulated into RCS by the suggestion that they are engaging in "risky" behavior or are unconcerned about the baby's welfare (Cartwright & Thomas, 2001). CNM "Katherine" offered the following warning to her patients prior to their counseling session with

the obstetrician: "...you will come out of there feeling...like you will be a bad mother if you choose to deliver by VBAC."

When providers present the options in this way, women with a previous CS are embodied as the site of risk to both their babies and their healthcare providers if they choose to attempt VBAC. Mothers who deliver outside of a hospital are especially scorned, although the evidence does not support the premise that their choice is "unsafe." It is interesting to note, for example, that the perinatal mortality rate of 2/1,000 in the VBAC birth center study (Lieberman et al., 2004) was considerably less than the overall U.S. rate of 7/1,000 births, 99% of which occur in hospitals (NCHS, 2008).

Women of racial and ethnic minorities often have the least power and fewest options at the individual level, particularly those who do not speak English. The providers who worked with these women described numerous social and cultural barriers, such as illiteracy, poor comprehension of risks, transportation, and difficulties with maintaining contraception. Their general feeling was that poorer women preferred VBAC and wealthier women preferred RCS, but there was variation both ways. Since only three of the providers spoke fluent Spanish, counseling through a translator was a major concern. One obstetrician who did this frequently felt that it was "impossible" to provide informed consent using a translator over the telephone. Although the minority providers in this study did not share any of their personal experiences of discrimination with me, one African-American obstetrician was particularly concerned about the potential effects of low educational status, multiple CSs, and inadequate family planning on minority women in his community.

### **Resisting the Status Quo**

While the situation surrounding VBAC can be characterized as nothing short of oppressive for both women and providers, some obstetricians have continued to offer it in the face of

significant barriers. One major teaching hospital in the state remains committed to liberal VBAC policies, and to training and socializing residents to provide VBAC care. Some private obstetricians have continued to offer VBAC as well, even in the face of system-wide corporate prohibition. One group negotiated to continue to do VBACs at their hospital by presenting their excellent outcome statistics, and by adhering to a strict policy of remaining in-house during the labor. VBAC is still available in a few other locations around the state, mainly because of obstetricians' willingness to negotiate with the anesthesia department, and to stay in the hospital during the labor. I also met with one group that is working to reinstate VBAC at their hospital.

Few CNMs are attending VBAC deliveries in Florida, and there is no professional group activism or policy initiative in the state. LMs are the most activist of the three groups, particularly in providing assistance for women who desire to attempt VBAC outside of a hospital. While I attempted to contact some of these LMs for interviews, most refused to participate or did not return my calls. I suspect that the reason they avoided me was that they did not want to be identified as doing "illegal" VBACs.

One LM devised a rather ingenious strategy to continue offering VBACs at her birth center and remain in compliance with the law. Florida law states that LMs can deliver women attempting VBAC in a birth center if they have an obstetrician consultant, and are part of the National Association of Birth Centers (NACC) Study. In actuality, the results of the NACC study were published several years ago (Lieberman et al., 2004), although they continued to collect data through 2007. In 2008, NACC changed its name to the American Association of Birth Centers (AABC) and issued a statement that the organization could no longer continue the study for political and financial reasons. Refusing to let that stop her, the LM raised money to re-open the study, found two researchers who wanted to collect data, and chartered a new organization

using the old NACC name. This strategic move placed her in compliance with the law, so she continued to offer VBAC at her birth center.

### **Medical Malpractice and the Political Economy**

Providers in the U.S. focus much of their concern over VBAC on the fear of malpractice liability. While litigation also occurs in other developed Western countries, fear of liability is less of a concern due to the structure of socialized health care, government limitations on liability claims, and less cultural support for technology in birth than is present in the U.S. (Cartwright & Thomas, 2001). When a catastrophic outcome, such as a brain-damaged infant, occurs in the U.S., the parents must provide a lifetime of medical care, education, and custodial care for that disabled child (Perkins, 2004). This is extremely expensive, and is unlikely to be paid for by the government unless the family is already impoverished. Moreover, the "technological imperative" in the U.S. demands that injury could have been avoided if a CS, instead of a VBAC had occurred (Cartwright & Thomas, 2001). According to Dr. Patricia: "I will never get hammered [for doing a CS] in a court of law. I WILL get hammered in a court of law for allowing a VBAC to occur."

In the social democracies of Sweden and the Netherlands, however, such a situation would be unlikely to ever appear in court (Cartwright & Thomas, 2001; DeVries et al., 2001). Most citizens are insured by the government for their health care, so medical expenses for the infant would not be a problem. Furthermore, in Sweden, patients are compensated for any injuries that occur in a "no-fault" system, and Dutch courts place limits on all liability claims (Cartwright & Thomas, 2001). With these benefits and restraints in place, obstetrical lawsuits are uncommon. DeVries et al. (2001) also point out that state interests in maternity care are much more substantial in Europe than they are in the U.S. Thus, the state intervenes at the policy level in order to control costs, provide better care for the majority of citizens, and so forth. Evidence-

based medicine tends to hold more sway, and the proliferation of birth technology and positioning of women as consumers is less pervasive than in the U.S.

The malpractice climate in the state continues to pose an interesting challenge to the authority of biomedicine in Florida. When obstetricians gained political and economic control of the birth market in the 1970s, they sold themselves and their technology so convincingly that the public believed they could do no harm (LoCicero, 1993; Perkins, 2004). This false sense of infallibility has now come back to haunt them, as women and their families want to hold them accountable when they fail to deliver the "perfect baby" that was promised. Much of this profound sense of betrayal seems to be related to some, but not all, obstetricians' abrogation of responsibility for decision-making. Thus, "doing what the consumer wants" has failed to protect many providers from legal and financial responsibility in the event of a bad outcome.

### **Implications for Providers**

#### **Counseling Practices**

During the course of this research, it was obvious that some providers delivered a more thorough description of the risks and benefits of VBAC and RCS than others. There were major differences between those who offered VBAC and those who did not, for providers indicated that it was not their responsibility to inform a patient about a procedure that they would not be doing themselves. Moreover, some openly admitted that they did not do much additional counseling if a patient requested a RCS early in prenatal care. Group, as well as individual variation was present. For the purpose of organization, strengths and weaknesses in counseling practices will be grouped according to whether or not the provider offered comprehensive counseling for both options or abbreviated counseling for RCS. Since only one CNM and one LM in the sample were actually doing VBACs, specific observations about midwives as a group will be discussed separately within the "abbreviated counseling" group.

## **Comprehensive Counseling for VBAC and RCS**

Not surprisingly, providers who offered both options were more thorough in their discussion of the risks and benefits of VBAC and RCS than those who did not. Most providers began this discussion at either the first prenatal visit or in the first trimester. Once they had discussed the reason for the first CS with the mother and determined that she was a "good" candidate, the issue of family size was usually addressed. Interestingly, female providers brought this up more frequently than males. If the woman indicated that this was her last pregnancy, most obstetricians argued that the risks and benefits of VBAC/RCS were equivocal, and tended to leave it up to the woman to decide mode of birth. Emphasis on the importance of family planning and the risks of multiple CS varied according to whether the provider viewed this as the woman's responsibility, although some offered the option of an accompanying tubal ligation at this point. If the woman indicated that she wanted three or more children, most providers did discuss the risks of multiple CSs and the comparative advantages of VBAC. From there, however, the counseling strategy varied according to the provider's personal experience and biases. Some openly told women that RCS was safer, and only encouraged VBAC if the woman had had a previous vaginal birth and was highly motivated. Others counseled about the risks and benefits of both, but did not attempt to influence her decision either way. Conversely, a few providers felt that it was their job to try to influence the woman's decision. All had a standard "speech" that included the statistical risks of uterine rupture with VBAC, the potential consequences for the baby, and the surgical risks of RCS. However, the less dramatic risks to the baby from RCS, such as iatrogenic prematurity, respiratory difficulties, and jaundice were rarely mentioned.

Several of the obstetricians in this study who felt that provider influence was important outlined remarkably similar strategies. There was an initial discussion in early pregnancy, in which they encouraged the woman to delay the decision until later, even if she initially wanted a

RCS. If she did want a RCS, they would explore her reasons for this during the course of the pregnancy, so they could get to know her and "feel out" her fears. Around 35-36 weeks, they would make an assessment of her likelihood of success with VBAC, and advise her of whether they thought her labor would be "easy, medium, or hard." If they thought VBAC would be "easy," or "medium," they would recommend VBAC. A "hard" assessment was usually accompanied by a recommendation for a RCS. Both said that most women accepted their advice at this point. In the event the woman wanted a RCS anyway, they accommodated her request. If a woman with a "hard" VBAC assessment was still determined to try, they would agree to an attempt if spontaneous labor occurred by 41 weeks. Interestingly, these obstetricians also felt that having midwifery care during labor maximized the woman's chances for a successful VBAC; their role was to "stand by" if a CS was needed. These obstetricians had remarkable records of good outcomes, with no litigation over VBAC in over 20 years of practice.

In light of the complexity of decision-making for mode of delivery, the effective practices of experts can be instructive, as decision aids and predictive models have not been shown to be clinically useful (Macones, 2008). Since "expert judgment" is extremely difficult to quantify and measure, qualitative explorations such as this study can offer insight into those practices which have been shown to be effective over the course of time.

### **Abbreviated Counseling and Referral**

For obstetricians and midwives who did not offer VBAC, counseling practices varied widely and were often inadequate. Few providers felt obligated to give equal weight in counseling to both options so the woman could decide whether to remain in the practice or not. In fact, there was little motivation to do so from an economic standpoint, especially if the woman readily accepted the option of a RCS. The standard narrative for both obstetricians and midwives was to first advise the woman that VBAC was not an option in their practice. This was followed

by a rationale for why the provider or hospital was not allowing VBAC, and included a brief synopsis of the difficulty of insuring safety according to ACOG's recommendation. Women were then told they would be able to schedule their RCS at 38-39 weeks. Evaluation of the woman's candidacy for VBAC was not addressed unless the woman initiated it. If the woman expressed a desire for VBAC or wanted a referral, what happened next was largely dependent on how invested the provider was in that particular woman. Well-known, established patients were more likely to be given a specific referral to a VBAC-friendly physician, if there was one available, rather than simply being "sent to the teaching hospital." Counseling about the risks of RCS usually occurred closer to the time of delivery, and risks to the baby were minimized if they were mentioned at all. Although most of these providers indicated that they were concerned about the long-term effects of multiple CS, they often did not discuss this in counseling.

The CNMs varied widely in their interest in advising women about VBAC. Some referred women to doulas, or to the International Cesarean Awareness Network (ICAN), a consumer research and support organization for women with a previous CS. Two midwife practices had ready-made lists of VBAC-friendly physicians' addresses and phone numbers, as well as other informational resources. Out-of-hospital CNMs provided more referral information than those who were employed. Most CNMs felt that the responsibility for counseling women about the risks of RCS belonged to the obstetrician performing the surgery rather than to them. The few CNMs who provided prenatal care for women with a previous CS sent them to the delivering obstetrician at 34-36 weeks for counseling and scheduling of their RCS. None of these CNMs worked with a physician or hospital that gave women the option of VBAC, so they viewed their role as directing women to the teaching hospital if they were adamant about VBAC. As I

previously mentioned in Chapter 5, some CNMs also advised women who strongly wanted to avoid a RCS to present to the hospital in the late first stage of labor.

Three of the four LMs I interviewed did not offer VBAC. Their methods of dealing with VBAC requests were similar to CNMs in terms of offering referrals and resources. Since these were small, independent practices, the LMs said that they sometimes got involved in listening to women and providing them with emotional support for their frustrations over VBAC access. LM "Christine" described this situation:

And it's **heartbreaking** for these women because they're not realizing after they've had that first c-section that they're going to have an issue the next baby they have. And so for us, it's hard, I was averaging...a couple phone calls a week of people wanting homebirths that can't, because they had a c-section.

### **Use of Teaching Aids and Consent Forms**

The use of teaching aids and consent forms was rare in the practices I observed. Only two providers offered written materials on VBAC/RCS: the CNM and LM who offered VBAC. The rest said that they documented their informed consent process in the progress notes of the prenatal record. Most of the hospitals, and one hospital-based group practice had standardized consent forms. These forms varied widely in their specificity of risks and benefits. Two hospitals used forms that included multiple obstetrical procedures and were not specific to VBAC and RCS. For example, VBAC was combined with "vaginal birth," and RCS with CS, so the lists of risk factors were rather confusing. Moreover, the forms were difficult to read and did not include the benefits of any procedure, including CS.

In contrast, one hospital-based group practice provided a consent form for "women with prior cesarean delivery " that was much more specific and comprehensive. Benefits and risks of both options were clearly worded and at a low literacy level. Interestingly, VBAC was listed first along with its benefits, including the statement: "VBAC is safe for both mother and baby." Risks

included uterine rupture, although this was qualified as being harmless in most cases. Injury and death were also listed as risks. The only advantages listed for "Repeat Cesarean" were that the woman can know the date she will deliver. The list of risks for RCS was quite extensive, and included multiple CS but not future placental abnormalities. There was no mention of risks to the baby from RCS.

### **Improving the Counseling and Referral Process**

Clearly, many women with a previous CS are not receiving comprehensive counseling, particularly when the provider does not offer VBAC. These providers were the most ambivalent about the positive effects of counseling, and often said that women were not interested in VBAC. Informed consent implies, however, that the **provider** has discussed the range of options with the patient in as comprehensive and unbiased a manner as possible. George Macones, an obstetrician and prolific researcher of VBAC issues, wrote in a recent editorial that appropriate counseling should include the potential complications of both RCS and VBAC (Macones, 2008). According to Macones, every provider should be discussing the risks and benefits of both options early in prenatal care. This gives the woman time and opportunity to consider her options and to find another provider if she is interested in VBAC. Based on the most recent evidence, a full discussion should include the following points:

- Benefits of VBAC & RCS
- Success and failure rates of VBAC
- Incidence of uterine rupture
- Maternal outcomes with rupture
- Circumstances that decrease rupture rates when applicable
  - Black race (40% less likely)
  - Prior VBACs or other vaginal births
  - Labor before primary CS
- Neonatal risks of both VBAC and RCS, including late preterm birth
- Short-term risks of RCS
- Risks of multiple CS, including abnormalities of placenta
- Need for reliable family planning and pregnancy spacing

(Algert et al., 2008; Cahill et al., 2008; Macones, 2008; Mercer et al., 2008; NNEPQIN, 2005; Silver et al., 2006; Yoder, Gordon & Barth, 2008). Although these points should be brought up early in prenatal care, it should be emphasized that making a firm decision early is not always in woman's best interest. According to some of the participants in this study, as well as Macones (2008), circumstances may change during pregnancy that make one choice more favorable than the other. Using anticipatory guidance, i.e., adopting a "wait and see" attitude, can encourage more women to attempt a VBAC in the long run. This strategy also has the added benefit of dispelling unrealistic expectations and decreasing disappointment. An in-depth assessment in the last month of pregnancy still leaves time for the woman to plan a RCS if that is the most important value to her.

Providers should also make a concerted effort to refer women to a willing VBAC provider early in the pregnancy if she expresses an interest in VBAC. Simply offering her a vague referral to a teaching hospital, particularly if it is a considerable distance to travel, is not a realistic option. It also does not allow time for the fluid management described above. During the course of this research, I found that some providers had accessible options available that they did not even realize were there. Thus, women who could have had the option for VBAC were resigned to an inevitable, and possibly unnecessary RCS.

Providers should also be cognizant of the words they use to discuss the risks and benefits during counseling, as the terms themselves may cause alarm in women who are weighing the options. Rosemary Mander, a Scottish midwife and researcher, points out that words like 'permitted,' 'trial of labor,' and 'candidate,' coupled with the requirement of a 'high risk' setting, are "sufficient to cause alarm in the woman..." (Mander, 2007, p. 157). Moreover, many women have fears about repeating the experience of the first birth, particularly if it was long and

grueling, or if it was an emergency CS for fetal distress (Mander, 2007). Several providers discussed the reactions of women as: "I don't want to go through that again." Thus, women have legitimate fears about the safety of their baby and their bodily integrity which should be addressed during counseling. Women tend to think anecdotally in terms of what happened to them or to their friends, and have limited knowledge of probabilities or actual complication rates. As CNM "Polly" pointed out, "statistics don't matter when it happens to you!" Therefore, counseling should be tailored to the woman's particular situation rather than simply presenting a "laundry list" of statistical information (Emmett et al., 2006; Moffat et al., 2006). The goal in this case may not be to convince her to have a VBAC, but to assist her in addressing her fears so that she can have a satisfying birth experience, regardless of the actual mode of delivery.

### **Implications for Policy Change**

Improving providers' counseling means little without significant policy change. Without an available choice, the "right to choose" is an empty concept. Women should be able to have access to VBAC at the very least in major hospitals, whether they are teaching facilities or not. It is unacceptable that women with a previous CS are seeking home births solely because there are no alternatives available. Instead of condemning mothers who choose to give birth in out-of-hospital settings, mainstream obstetrics should acknowledge that they have failed women in this regard and work together to provide alternatives instead. Women should not be forced to have a RCS because there are no hospitals that will accommodate them to attempt a VBAC within 100 miles or more. In a state as populous and wealthy as Florida, we can, and should do better. Unfortunately, many of the providers I interviewed and have spoken with have little to no optimism about change in the near future.

There are, however, more serious consequences afoot than insuring women's choices and protecting providers from malpractice risk. According to Dr. Charles Mahan, of the Florida

Pregnancy-Associated Mortality Review (PAMR) panel, maternal and neonatal mortality is likely to increase in Florida as a result of high CS and multiple RCS rates (Charles S. Mahan, M.D., personal communication, January 14, 2009). This situation represents an escalating threat to the health of mothers and babies as well as a significant financial crisis. The cost of CS was over \$1.0 billion in Florida in 2006 (AHCA, 2008). Current estimates indicate that the RCS cost to prevent 1 case of uterine rupture, with a 10% incidence of significant fetal injury, is \$7.5 million (Northern New England Perinatal Quality Improvement Network (NNEPQIN), 2008). Furthermore, insurance companies are highly cognizant of the cost of CS and are beginning raise premiums or refusing to insure women with a previous CS (Grady, 2008).

As I outlined in Chapter 4, there are legislative mechanisms in place within the state of Florida that should be providing supervision of current practices. The Agency for Healthcare Administration (AHCA) has had statutory oversight of the publicly-funded CS rate (> 40%) since 1992. Considering the dramatic escalation of the CS rate in recent years, it is obvious that regulation is lacking. According to one key informant, this is because the obstetricians on the peer review committees within the hospitals are largely ignoring the behavior of their peers, particularly in South Florida.

Most of the current advocacy for VBAC is coming from the volunteer members of ICAN. Composed primarily of mothers who have experienced a CS, ICAN works at many levels to assist mothers with emotional and practical support. Their comprehensive website is replete with research information sources, data on hospital CS rates, VBAC bans, local support groups, blogs, legislative efforts, and even an upcoming national conference. Florida has six local chapters: Orlando, Gainesville, Tampa, Sarasota/Bradenton, Tallahassee, and Southwest (Lee, Charlotte, & Collier counties). Interestingly, however, there is no chapter in Dade and Broward, the

counties with the highest CS rates. Pam Udy (2008), the current president of ICAN, had this to say about the crisis over VBAC:

What does it say about our medical community when our hospitals, which are supposed to be places of comfort and healing, are instead places of coercion and fear? Doctors need to realize and work with us to make hospitals again, a safe and a respectable place to go and have our babies. We need to feel like it's successful there, that it's going to be encouraged and that it is actually an option and that as soon as we step in the door, we're not going to be rushed off to the operating room. And if they want us to deliver there, they're going to have to meet us and make some real changes in the way that VBACs are handled in the hospital.

While most of the providers I spoke with are dissatisfied with the status quo, there is little activism among professionals for change. As discussed in Chapter 5, obstetricians were quick to condemn home birth mothers for attempting out-of-hospital VBAC, but few actually offered any workable solutions to the access problem. In a recent editorial in the trade journal, *OBG Management*, Dr. Robert Barbieri (2008) described home VBAC as "outrageous," but never once proposed that obstetricians could play a positive role by working to improve access to hospital VBAC. Instead, he blamed mothers for their bad choices and advocated for stricter legislation against home birth midwives. Anthropologist-obstetrician Claire Wendland (2007), however, offered a better suggestion. She described the discourses of obstetricians and birth advocates as being at "cross-purposes...preach[ing] only to the converted...neither group creates a world the other recognizes as real. A feminist obstetrics could acknowledge the sometimes perilous unpredictability of birth and simultaneously explore the costs of the desire for the purchased promise of technologically mediated 'safety'" (Wendland, 2007, p. 227).

The most positive effort toward VBAC reform nationally is the work of the Northern New England Perinatal Quality Improvement Network (NNEPQIN, 2009) at Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire. In 2002, concerns over the declining accessibility

of VBAC in small hospitals in Vermont (VT) and New Hampshire (NH) provided the impetus for a meeting of obstetric providers, nurse managers, hospital administrators, anesthesiologists, and pediatric providers from all the hospitals in VT and NH, as well as representatives from medical malpractice insurers, health care insurers, and public health departments. Over the course of five regional meetings, this group developed regional guidelines, patient education materials, and consent forms. The most significant development of these meetings, however, was a risk stratification system that improved access to VBAC considerably in small hospitals. Based on the idea that all VBACs were not equally risky, the guidelines outlined the criteria for the three risk levels (low, medium, and high), and operationally defined "immediately available" based on patient risk status. Each hospital was also required to have a system in place for competency drills and ongoing reviews. Thus, a low-risk VBAC patient was considered to be at the same risk for an untoward event as those women undergoing their first labor, and did not require a continuous 24-hour presence. While medium or high-risk patients were not deemed suitable for all hospitals, a specific referral system was put in place so women could have access to an appropriate facility. Since there was strong regional consensus and oversight of practices, malpractice insurers were unable to penalize individual providers or hospitals for offering VBAC. The provision of thorough and consistent educational materials and consent forms also helped to assure a uniform standard of counseling and informed consent. The director of the project, Dr. Michele Lauria, continues to collect data on the effectiveness of the project while also working with ACOG and JCAHO to develop national policy initiatives. (Michele Lauria, M.D., personal communication, February 8, 2009).

### **Recommendations for Change**

Without question, the non-system in Florida is ripe for change. With the large number of undocumented immigrants in the state and the high fertility rate, Florida needs to address its

VBAC "crisis" immediately. NNEPQIN's model could be very useful for this purpose. Given the hostile environment in South Florida, a regional project in the more VBAC-friendly north would be a feasible first step. Funding for an initial meeting could be raised through the DOH, AHCA, or both. An alternative would be to write a community-based participatory research (CBPR) grant to organize a meeting and begin the policy development process. Successful development of such a project in North Florida would provide the impetus and resources for doing the same in South Florida. An integrated set of educational materials and informed consent forms would better define the standards of care, and help to relieve some of the liability burden for providers.

Non-teaching hospitals could also increase availability of VBAC by employing in-house hospitalists. This should be required by AHCA in RPICC centers where there is no residency program. This measure could also boost the involvement of CNMs in VBAC care, for there would be a readily-available surgeon in the event of a problem. While some hospitals have already begun to utilize hospitalists for obstetrical care, I was not able to obtain an interview with any of them in this study.

Another important improvement would be to include LMs in the policy development process. As Wendland (2007) has said, when groups work at cross-purposes, little change is achieved in the long run. Interestingly, the Midwifery Practice Act (1982) states that physicians and nurse-midwives are not liable if they accept a woman for care that an LM has brought to the emergency room from a home birth. Yet this is the principle complaint about LMs that I heard from obstetricians and nurse-midwives. Although LMs have been licensed in Florida since 1982; it appears that there continues to be widespread ignorance and condemnation of their role, even by providers who vigorously espouse autonomy and independence.

### **Directions for Future Research**

It is common for a qualitative study to generate as many questions as it answered. In addition to the CBPR study proposed earlier, there are a number of possible options for future research. Factors influencing providers' counseling could be developed into a survey for both obstetricians and midwives. Another possible study could compare the influence of counseling on VBAC decision-making in women using two different models: non-directive (consumerist model) and directive (shared model) counseling. Groups could be randomized within a teaching hospital setting, and compared at early pregnancy, late pregnancy, and postpartum data points. An equally interesting study would be to compare the satisfaction and knowledge levels of groups of Spanish-speaking women who were counseled for VBAC and RCS by: 1) a Spanish-speaking, non-Hispanic provider; 2) a Hispanic native speaker serving as translator in person; or 3) a Hispanic native speaker translating over the telephone. Finally, an ethnography specifically focusing on out-of-hospital VBAC mothers and their providers would be fascinating.

### **Strengths and Limitations of the Research**

The greatest strength of this study was the rich data it generated on providers' decision-making and on VBAC access within the state. Through the in-depth interviews, I was able to determine the reasons why the various providers were, or were not, offering VBAC in their practices. The mixed-method design was another strength, for the combination of vital statistics and qualitative data provided an in-depth picture of the Florida obstetrical landscape.

There were limitations to this research as well. Because of the small sample size, the findings are not generalizable to the population at large. Other states or regions could have different problems with access, provider mix, or counseling practices. Because I was unable to observe the provider-patient interaction, I had to accept what providers told me about their counseling as true. It is possible that providers actually gave women less information than they

indicated to me that they did. Moreover, I was also unable to elicit women's input on whether they thought the provider gave a balanced view of the risks and benefits of both options. I also would have liked to include more minority providers in the sample, as well as younger male obstetricians.

### **Summary**

In this chapter, I utilized the CMA framework to demonstrate how providers' decision-making about mode of delivery was impacted by sociocultural, political, and economic factors at various levels of analysis. This analysis revealed a variety of deficiencies in counseling and referral practices in Florida, particularly for providers who did not offer VBAC. These deficiencies were mainly driven by the lack of perceived need to inform women about a procedure (VBAC) that the provider was either unwilling or unable to offer. Providers lacked financial incentive to inform women about VBAC, since engendering an interest in the option might motivate the woman to leave the practice. While it is easy to understand why this is happening, it is a significant deviation from best practice at best, and unethical at worst. I suggested that counseling could be improved by adhering to evidence-based guidelines, and by utilizing a shared, minimally directive model. In the final section, I concluded that policy change will require involvement at the state level, and the development of a consensus process similar to the one currently being utilized in the Northern New England region. Directions for future research, and the strengths and limitations of the study were also discussed.

### **Conclusion**

The principal aim of this research study was to generate new knowledge about, and to provide supportive evidence for, the claim that sociocultural, political, and economic factors are highly influential in providers' decision-making about VBAC and RCS. The data supported my claim that salient features of the political economy are dominating obstetrical practice and

diminishing safe birth options for women. The decision of whether or not to have a VBAC or a RCS in Florida is rarely a medical decision between a woman and her obstetrician or midwife anymore. It has already been decided at political and economic levels by hospitals, malpractice insurers, attorneys, judges, ACOG, and state regulatory boards. Although women and their providers point fingers and blame each other for manipulation over this issue, the real culprit is much more ubiquitous.

The providers in this study think VBAC is a safe option for women; however, they do not believe that it is a safe option for themselves. This fear is driven by a need to control real economic risks to themselves in the form of malpractice lawsuits. The institutions they practice in are motivated to control these risks as well; they do so by imposing restrictions upon providers under the aegis of the ACOG Guidelines. Although these guidelines were promulgated from expert opinion and not evidence-based, they continue to have a profound effect on providers' ability to offer VBAC in Florida.

Providers are expected by the public and by the state to control obstetrical risks and to adhere to professional standards. Controlling risks involves placing a high value on the fetus, since damage to the fetus extracts a high toll in the event of a malpractice suit. Therefore, the mother's interests become rather subordinate to those of the fetus. The mother is embodied as the site of risk in this decision, both to her fetus, and to the provider, particularly if she chooses a VBAC instead of a RCS. In an effort to protect themselves from risk, providers avoid participating in VBAC, particularly if it is banned at the systemic level or is highly inconvenient to their lifestyle. Thus, there is little incentive in most cases for providers to provide a balanced view of the risks and benefits of VBAC. Only the few that practice in large groups or in teaching hospitals and can protect their assets through sovereign immunity or group bonds are willing to

take this chance. Counseling about mode of delivery, then, may be framed as, 'RCS is safer for the baby,' or, 'You can plan your delivery date,' or, "Our hospital does not allow VBACs.' Most women simply accept these restrictions if they are not fortunate enough to be living in an area where VBAC is offered.

Not all women accept this state of affairs, however. Those that argue or engage in resistance are "fired" from practices, sent to the teaching hospital, or worse, seek out-of-hospital birth in an effort to have a VBAC. They are 'outrageous,' selfish,' and a 'little crazy' to be risking their babies' lives, according to most mainstream obstetricians. But according to the ICAN moms (Udy, 2008):

It's very hard to get a VBAC in these hospitals, which is very unfortunate, because it is a huge leap to go from having a caesarean for whatever reason to having a home birth. Like I said, 98% of our population delivers in the hospital. For a mom to feel unsafe enough to turn away from the hospital and turn to home birth is very significant and it says some really bad things about our hospitals.

So who is really to blame and who suffers most? My answer based on my data is that we all lose in a situation like this. There IS a solution, and that solution is to work at the policy level to reinstate VBAC through a system of risk stratification that will meet the needs of most mothers and providers. The changes accomplished in Vermont and New Hampshire provide evidence that a compromise can be reached. If the problem continues to escalate, I fear that the consequences will be more dire than we can comprehend. In closing, I offer a sobering statement by one of the study participants:

We are so rapidly swinging the pendulum back to this notion that no good can come out of a natural, vaginal birth experience...if we aren't doing appropriate counseling, and women wind up having higher order c-sections, we're going to see catastrophic complications, the likes of which we are not familiar with.

APPENDIX A  
INTERVIEW GUIDE FOR OBSTETRICIANS & CERTIFIED NURSE MIDWIVES

1. Tell me about how you counsel women with a previous CS about mode of delivery.  
Probes: When do you bring it up in prenatal care? What do you think about protocols and consents? Do you discuss this issue prior to women becoming pregnant again?
2. Do you try to influence women's decisions if they have a firm idea either way?
3. Who do you think should have the responsibility for the decision and why?
4. Are there restrictions regarding VBAC in your practice or in the hospital where you deliver?  
Probes: If your practice does not allow VBAC, what do you tell women who want to attempt it?
5. How much do you depend on published research to guide your practice?
6. How has your practice changed in the last five years?  
Probes: What caused the change? What are the pros and cons of the change?
7. Tell me about how your views on VBAC compare with your patients, with other physicians, with midwives (CNM or LM)?
8. If conflicts do occur, how do you handle them?
9. What are your thoughts on out-of-hospital VBACs?  
Probes: Have you ever sent a patient to a home birth midwife for a VBAC?
10. How do you think the situation surrounding VBAC/RCS can be resolved?

APPENDIX B  
INTERVIEW GUIDE FOR LICENSED MIDWIVES

1. Tell me about how you counsel women with a previous CS about mode of delivery.  
Probes: When do you bring it up in prenatal care?  
What do you think about protocols and consents?  
Do you discuss this issue prior to women becoming pregnant again?
2. Do you try to influence women's decisions if they have a firm idea either way? How?
3. Who do you think should have the responsibility for the decision and why?
4. Do you refer women immediately to a physician, or do you provide some of the care?  
Probes: Do you collaborate directly with a physician?  
Tell me about your role in counseling and in attending births.
5. How much do you depend on published research to guide your practice?
6. How has your practice changed in the last five years?  
Probes: What caused the change?  
What are the pros and cons of the change?
7. Tell me about how your views on VBAC compare with your patients, with physicians, with CNMS, with other LMs?
8. If conflicts do occur, how do you handle them?
9. How do you think the situation surrounding VBAC/RCS can be resolved?

APPENDIX C  
INTERVIEW GUIDE FOR ADMINISTRATORS

1. What policies are in place regarding VBAC at your hospital/birth center?
2. Talk about the rationale for the policy.  
Probe: How was research used in the development of the policy?
3. Have you had to deal with conflicts over VBAC from physicians, midwives, patients, families?  
Probes: Tell me about how you handled the situation.
4. Which do you think carries more risk for your institution, VBAC or RCS and why?
5. What impact has the situation surrounding VBAC/RCS had in your community? In Florida?
6. How do you think the situation should be resolved?

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## BIOGRAPHICAL SKETCH

Kim J. Cox is a Certified Nurse-Midwife. She received her ASN from Santa Fe Community College, Gainesville, Florida, in 1986. After working as a labor and delivery nurse for several years, she opened the first LDRP unit in Gainesville at North Florida Regional Medical Center. She earned her BSN with Honors from the University of Florida in 1992, and was inducted into Sigma Theta Tau and Phi Kappa Phi. She earned her master's degree in nursing at the University of Florida in 1995, and also became credentialed as a Certified Nurse-Midwife by the American College of Nurse-Midwives. After becoming a midwife, Kim moved to Fort Myers, Florida, where she practiced with the Lee Memorial Midwifery Service and taught in the BSN program at Florida Gulf Coast University. In 2005, she received an Alumni Fellowship from the University of Florida and began doctoral studies. She received her PhD in Nursing Sciences from the University of Florida in May 2009.

Kim is active in midwifery and nursing organizations on the local, state and national levels. She served as Treasurer and Chapter Chair of the Gulf Coast Chapter of the American College of Nurse-Midwives, and has participated in legislative efforts for midwives at the state and national levels.