Do women have a choice? Nurse's Role in Women's Decision Making Regarding Vaginal Birth after Cesarean

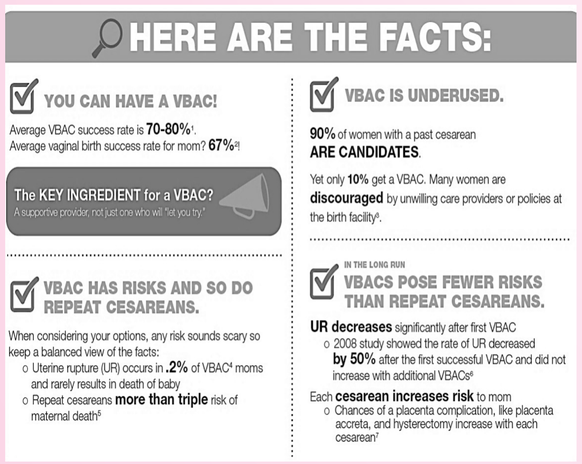
Emilse Sanchez, SN & Dr. Linda McCash, PhD, APRN-BC

Nova Southeastern University

Introduction

- Cesarean section (C-section) rate has increased at a rate of 32.9% in 2009 and stabilized at 32.8% from 2010-2012
- Due to the risk of uterine rupture previously studied in 1996, the American Congress of Obstetricians and Gynecologists (ACOG) published a standard of practice for labor after C-section
- The rate of vaginal birth after cesarean (VBAC) decreased and sparked controversy on the appropriateness of VBAC
- VBAC has been explored through risk and benefits, but there is a need for further research on the rate of the risks
- Nurses can provide advocacy, support and education for women wanting to have VBAC as an option for delivery
- This project includes discussions of current literature and data, and how these relate to real world practice and the need for further research and support

(Van Dis, 2018)



Evidence Based Guideline

- The evidence-based guideline, "Planning for Labor and Vaginal Birth After Cesarean", was authored by the American Academy of Family Physicians (AAFP)
- The guideline presents 9 recommendations that were developed to assist clinicians and women to better understand the risks and benefits of vaginal birth after cesarean (VBAC) compared to a repeat cesarean delivery (RCD)
- It explored factors that influence the chance of having a VBAC

(King et al.,2014)

Review of Literature

Do Women Have A Choice? Care Providers' and Decision Makers' Perspectives on Barriers To Access of Health Services for Birth and Previous Cesarean

- Increase in VBAC is in part due to nonclinical factors, including care provider practice patterns, malpractice concerns, financial incentives and delays in access to surgical and anesthesia services
- Open-ended interviews related to behavior, attitudes, and experiences with delivery after cesarean were conducted for care provider and decision makers as participants
- Analysis of the 35 participants' interviews revealed that their attitudes and experiences were characterized by the theme of supporting women to make their own choice
- Care providers' interviews revealed the characteristics of clinical decision making, while decision makers highlighted the influence of health service resources and policy on the context of that decision-making
- Three additional themes highlighted the barriers and facilitators to care providers' perceived ability to support women to make a choice: being an "information provider," listening to the woman's voice, and "making it work" of limited access to services

(Munro et al., 2017)

Association Between Prior Vaginal Birth After Cesarean and Subsequent Labor Outcome

- Evaluation of the effect of prior successful vaginal birth after cesarean (VBAC) on the rate of uterine rupture and the possible outcomes in delivery
- Purposive sampling included women who do not have any other multivariable that could interfere with the risk of having uterine rupture
- 1,211 women who have had at least one prior VBAC and the control group of 2,045 women with no history of prior VBAC
- Women who have had history of a prior VBAC were associated with a lower rate of uterine rupture and dehiscence than women who have never had a prior VBAC

(Krispin et al., 2018)

Table 2. Delivery characteristics for the study and control groups.

	Prior VBAC $N = 1211$	No prior VBAC $n = 2045$	p value
Uterine disruption	14 (1.2)	59 (2.9)	.001
Uterine rupture	9 (0.7)	33 (1.6)	.036
Uterine dehiscence	5 (0.4)	26 (1.3)	.015
Vaginal delivery[a]	1163 (96)	1737 (84.9)	<.001
Spontaneous vaginal delivery	1104 (91.2)	1362 (66.6)	<.001
Operative vaginal delivery	59 (4.9)	375 (18.3)	<.001
Prolonged second stage	15 (1.2)	128 (6.3)	<.001
NRFHR	42 (3.5)	241 (11.8)	<.001
Other[b]	2 (0.1)	6 (0.2)	
Cesarean delivery	48 (4.0)	308 (15.1)	<.001
Dystocia	12 (25)	121 (39)	<.001
NRFHR	36 (75)	187 (61)	<.001
Revision of uterine cavity	140 (11.6)	433 (21.2)	<.001
PPH	60 (5.0)	164 (8.0)	.001
Neonatal birthweight (g)	3268.2 ± 489.2	3215.5 ± 478.6	.003

NRFHR: non-reassuring fetal heart rate; PPH: post-partum hemorrhage.
Values are presented as median (interquartile range) or n (%).
[a]Vaginal delivery – spontaneous and operative vaginal delivery.
[b]Other – no otherwise specified.

Table 2. Comparison of Knowledge Scores Between Choice for TOLAC and Choice for ERCD

	TOLAC n (%)	ERCD n (%)
High knowledge score (≥7)	11 (55)	6 (24)
Low knowledge score (<7)	9 (45)	19 (76)
Total	20 (100)	25 (100)

The Relationship Between Personal Knowledge and Decision Self Efficacy in Choosing Trial of Labor after Cesarean

- A convenience sample of 45 pregnant women were chosen for meeting the criteria based on the American College of Obstetrics and Gynecologists
- Knowledge of risks and benefits were assessed for both trial of labor after cesarean (TOLAC) and elective repeat cesarean delivery (ERCD) using an exception scale
- "The Decision Self-Efficacy Scale" is an instrument used to measure each woman's self-confidence or belief in personal abilities in decision making for mode of birth and consisted of a score from 0-14 based on 14 items
- Score of 7 or higher for decision of either TOLAC or ERCD were deemed woman who had a lot of knowledge and woman scoring under that were deemed low knowledge

(Scaffidi et al., 2014)

Implications for Nursing Practice

- Advise women to discuss the option of having a VBAC during their prenatal visits with their obstetrician or midwife
- Be a patient advocate and respect the woman's autonomous decision
- Provide support and direct to appropriate healthcare providers willing to accept the option of VBAC
- Ensure appropriate facilities certified and prepared for potential outcomes or risks in the delivery
- Discuss risks and benefits to having a VBAC based on their individualized evaluation of medical history and pregnancy from a professional
- Professionally trained, educated, and certified to support and manage intrapartum situations

(Durrance & Hankins, 2018)

Dissemination of Information

- Pamphlets at women's health clinics that discuss the risk and benefits of VBAC
- Informative posters in waiting rooms of OB/GYN offices
- Healthcare professionals making VBAC a possible option in the discussion of current or future delivery options
- Further education regarding VBAC in schools and healthcare facilities for students and nurses

Implications for Future Research

- What is the hospital's personnel response time needed to guarantee maternal and neonatal safety?
- What are the effects of VBAC on infant development and health?
- What is the extent of medical malpractice liability exposure with VBAC?
- What are factors that affect availability of VBAC? (such as economic status, professional, institutional and cultural)
- What are long term maternal effects of uterine rupture?
- What are outcomes of VBAC with various induction methods?