Sigma's 30th International Nursing Research Congress

The Role of Nurse Advocate in Cesarean Sections on Maternal Request

Julia Imanoff, MN
Cynthia Mannion, PhD
Graham McCaffrey, PhD
Faculty of Nursing, University of Calgary, Calgary, AB, Canada

Background: The trend for women choosing cesarean deliveries is increasing. The polarizing nature of this choice has led to increased media attention and scientific scrutiny. It has challenged maternity care providers to make a choice of whether or not to support these women. There is a lack of clear guidance for maternity care nurses when caring for these women. Clinical guidelines have recently recommended physicians to explore the context of the woman's choice and if comfortable doing so, to support her choice by performing the cesarean delivery or if not to refer to another physician. In Canada, there are no guidelines for how nurses can best to support women in this plan of care. Due to the different values associated with choice and delivery modalities between nurses and patients, nurses may experience ethical distress in providing care for women who choose cesarean deliveries. Further exploration and understanding of women's choice are necessary to improve the care provided by maternity care nurses and to promote positive birth experiences.

Purpose: This qualitative research study aimed to explore women's choice of cesarean delivery and the findings uncovered have clear applications to nursing practice. Namely, in the role of a nurse advocate with potential applications to emerging roles such as a cesarean case manager.

Methods: Four women who had chosen to have their first child by cesarean in the absence of medical indication were interviewed between September 2014 to January 2015. These participants generated data to provide rich new understandings. I used a type of purposive sampling referred to as criterion sampling, where you search for individuals who meet a set of criteria. The main criterion was women who have chosen cesarean deliveries for their first child as they were identified as having had the unique experience of never-before having a child and so previous delivery experiences could not impact their choice for cesarean delivery. Semi-structured interviews lasting 45-90 minutes were used to generate data. The interviews were audio-taped and transcribed. The interpretation followed the qualitative, dialogic approach of Gadamerian Hermeneutics.

Results: The final interpretations revealed 1) the complexities of choice, 2) the impact of allowing choice, and 3) nurses are in the unique role to act as an advocate for women choosing cesarean deliveries to promote positive birth experiences and healthy developmental environments for their newborns. 1) Choice is complex and is influenced by history, society, and the personal values of the individual. Women's rights movements, industrialization, health care commodification, and the medicalization of childbirth have all contributed to the occurrence of choice for cesarean deliveries. Women who choose cesarean deliveries are likely to have the perspective of vaginal birth being inherently risky and are more likely to take on the risks of surgery than attempt a planned vaginal birth. Women who choose cesarean deliveries may have underlying anxiety around the birth of their child and want to have a sense of control, predictability, and safety, which they may feel in a planned surgical delivery. 2) Allowing for choice can promote a positive physiological response in the women and create mental well-being in the post-partum period. Alternatively, feelings of losing control during delivery have been implicated in post-traumatic stress disorder (PTSD) and post-partum depression (PPD). The psychological impact on mothers who experience traumatic deliveries can be detrimental to the child as well. PPD can deprive an infant of essential maternal interactions. Early deprivation is correlated to childhood behavioral disorders. Alternatively, a perceived sense of control can have a positive effect on birth satisfaction. 3) Nurses can act as an advocate to best care for women choosing cesarean deliveries by promoting individualized care, advocating for patient autonomy, and by exploring new ways to serve this population.

Conclusion: Throughout history, women have gained more control to make choices that impact their lives and health; choice in government, choice in parturition, and now, choice in delivery. Women are making a choice to have cesarean deliveries. It is a choice that is situated in broad shifting social contexts and also one that is made by each woman for their individual context. As with other shifts in health care, now maternity care providers are faced with the responsibility of responding to this choice. When caring for women who chose a cesarean delivery, maternity nurses have a unique opportunity to inquire and reflect on the woman's perception of safety and the underlying factors in her choice as well as how they can best care for this woman in order to promote a positive birth experience and healthy developmental environments for their newborns.

Title:
The Role of Nurse Advocate in Cesarean Sections on Maternal Request

Keywords:
cesarean, choice and nurse advocate

References:
American Psychiatric Association (APA). (1994). *Diagnosis and statistical manual of mental disorders. 4th ed. (DSM IV).* Washington DC: American Publishing Inc.

Canadian Institute for Health Information (CIHI). (2017). Health indicators interactive tool: Total Caesarean Section Rate. Retrieved from https://apps.cihi.ca/mstrapp/asp/Main.aspx?Server=apmstrextprd_i&project=Quick%20Stats&uid=pce_pub_en&pwd=&evt=2048001&visualizationMode=0&documentID=029DB170438205AEBCC75B8673CCE822&_ga=2.147533684.2121168267.1542641398-56320519.1527891310

Canadian Nurses Association. (2017). *Code of ethics for registered nurses.* Retrieved from https://www.cna-aiic.ca/html/en/Code-of-Ethics-2017-Edition/files/assets/basic-html/page-1.html

Doucet, S., Denis, C., Letourneau, N., & Robertson Blackmore, E. (2009). Differentiation and clinical implications of postpartum depression and postpartum psychosis. *Journal of Obstetrics, Gynecology and Neonatal Nursing, 38*, 269-279. doi: 10.1111/j.1552.6906.2009.01019x

Fair, C. D., & Morrison, T. E. (2012). The relationship between prenatal control, expectations, experienced control, and birth satisfaction among primiparous women. *Midwifery, 28*(1), 39-44. doi:10.1016/j.midw.2010.10.013

Gallagher, F., Bell, L., Waddell, G., Benoît, A., & Côté, N. (2012). Requesting cesareans without medical indications: An option being considered by young Canadian women. *Birth. 39*(1), 39-47.

Latimer K, Wilson P, Kemp J, Thompson L, Sim F, Gillberg C, … Minnis H. (2012). Disruptive behaviour disorders: a systematic review of environmental antenatal and early years risk factors. *Child Care Health & Development*, *38*(5), 611-28. doi: 10.1111/j.1365-2214.2012.01366.x.

Liu, S., Liston, R.M., Joseph, K.S., He M., Sauve, R., & Kramer, M.S. (2007). Maternal mortality and severe morbidity associated with low-risk planned cesarean delivery versus planned vaginal delivery at term. *Canadian Medical Association Journal. 176*(4), 455-460. doi:10.1503/cmaj.060870

Marmot, M.G., Rose, G., Shipley, M., & Hamilton, P.J. (1978). Employment grade and coronary heart disease in British civil servants. *Journal of Epidemiology and Community Health, 32*(4), 244-249.

National Institute for Health and Care Excellence (NICE). (2013). Caesarean Section. Retrieved from https://www.nice.org.uk/guidance/qs32

Palys, T. (2008). Purposive sampling. In L. M. Given (Ed.) *The Sage Encyclopedia of Qualitative Research Methods*. Vol. 2, (697-698). Sage: Los Angeles.

Rodney, P. A. (2017). What we know about moral distress. *American Journal of Nursing*, *117*(Suppl.), S7-S10. doi:10.1097/01.NAJ.0000512204.85973.04

Saisto, T. & Halmesmaki, E. (2003). Fear of Childbirth: A neglected dilemma. *Acta Obstetricia et Gynecologica Scandinavica.* 2003;*82*(3): 201-208. doi: 10.1034/j.1600-0412.2003.00114.x

Society of Obstetricians and Gynaecologists of Canada (SOGC). (2018). *It Takes Two: Weighing the risks of caesarean deliveries on maternal request.* Retrieved from https://sogc.org/files/medCaesareanDeliveryMaternalRequest_web.pdf

Waters, K.R. & Easton, N. (1999). Individualized care: Is it possible to plan and carry out? *Journal of Advanced Nursing, 29*(1)*,* 79–87.

Abstract Summary:
Women's choice for cesarean delivery is complex. This choice challenges maternity care provider given the difference in values between patients and care providers. The findings of this study suggest that nurses can provide supportive care in the role of an advocate to promote positive birth experiences.

Content Outline:

Introduction

1. In Canada, the cesarean rate has been increasing over the past 2 decades and is now approaching 30% (CIHI, 2015)
2. Women's choice for cesarean deliveries is contributing to the rising rate (Gallagher, Bell, Waddell, Benoît, & Côté, 2012; Liu et al., 2007).

Body

1. **Main Point #1:** Women are choosing cesarean deliveries without medical indication and this is challenging for maternity care providers to know how best to support these women.
    1. Supporting point #1: There is a lack of clear guidance for maternity care nurses when caring for these women.
        1. Clinical guidelines have recently recommended physicians to explore the context of the woman's choice and if comfortable doing so, to support her choice by performing the cesarean delivery or if not to refer to another physician. (NICE, 2013; SOGC, 2018)
        2. In Canada, there are no nursing guidelines to help maternity care nurses caring for women choosing a cesarean delivery.
    2. Supporting point #2: Due to the different values associated with choice and delivery modalities between nurses and patients regarding this issue, nurses may experience ethical distress in providing care to these women.
        1. Ethical or moral distress "arises when nurses are unable to act according to their moral judgment" (Rodney, 2017, s-7). This can occur when nurses have a set of values, morals, and beliefs that may differ from those set by the patients and obstetrician when a plan of care is set for a chosen cesarean. Moral distress can lead to negative consequences such as feelings of anger, frustration and guilt,

yet it can also be a catalyst for self-reflection, growth and advocacy (CNA, 2017 ; Rodney, 2017).
        2. Many nurses support vaginal deliveries for all of the health benefits this natural biological process can offer to both mothers and their babies.
        3. When patient's values are conflicting their own, and they view the patient's choice at detrimental to their well-being, it can be a source of ethical distress.
2. **Main Point #2**: Women's choice for cesarean may be seen as beneficial when taking a broader perspective on choice. This may help to resolve nurses' ethical distress in caring for these women.
    1. Supporting point #1: Choice is complex and is influenced by history, society, and the personal values of the individual.
        1. Choice is situated in the broader historical and social context. Women's rights movements, industrialization, health care commodification, and the medicalization of childbirth have all contributed to the occurrence of choice for cesarean deliveries.
        2. Women who choose cesarean deliveries are likely to have the perspective of vaginal birth being inherently risky and are more likely to take on the risks of surgery than attempt a planned vaginal birth.
        3. Women who choose cesarean deliveries may have underlying anxiety around the birth of their child and want to have a sense of control, predictability, and safety, which they may feel in a planned surgical delivery.
    2. Supporting point #2: Allowing for choice can promote well-being (physiological response to being in control) and create mental well-being in the post-partum period.
        1. Having a sense of control, or choice, creates a physiological and psychological response. The Whitehall II study found that the less control people felt in their job the more adverse health outcomes they would face, including increased blood pressure, back pain, and mental illness (Marmot et al, 1991).
        2. Feelings of losing control during delivery have been implicated in post-traumatic stress disorder (PTSD) and post-partum depression (PPD) (American Psychiatric Association, 1994; Saisto & Halmesmaki, 2003).
3. **Main Point #3**: Nurses can act as an advocate to best care for women choosing cesarean deliveries.
    1. Supporting point #1: Promoting individualized care
        1. Women often felt judged by maternity care providers and did not feel supported in their choice of birth.
        2. By applying the key concepts of individualized care (Waters & Easton, 1999), nurses can better support, care for, and advocate for positive birth experiences. This ultimately will help to promote positive developmental environments for the newborn.
    2. Supporting point #2: The more women make this choice, the greater the need for an intentional response from the healthcare system.
        1. Nurses can act as an advocate for patient autonomy by advocating for a women's right to choose their birth modality. It is important that choice should be advocated for equally between choosing cesarean deliveries and vaginal births (e.g. trial of labor after cesarean or breech presentation) in order to promote positive birth experiences and well-being for all women.
        2. I also suggest a new role of a nurse consultant who could act as a case manager. When women ask their physician for a cesarean birth, they would be referred to the case manage who would provide an initial assessment, health history, psychological assessment, and a screen for fears/anxieties related to childbirth. The nurse would then be able to refer the patient to other services as need (i.e. Obstetrician for cesarean delivery, psychologist/counselor for mental health concerns, social work for support/resources).

III. Conclusion

1. Throughout history, women have gained more control to make choices that impact their lives and health; choice in government, choice in parturition, and now, choice in delivery. Women are making a choice to have cesarean deliveries. It is a choice that is situated in broad shifting social contexts and also one that is made by each woman for their individual context.
2. As the choice for delivery continues, maternity care providers have the opportunity to reflect on the meaning of the choice for each woman, how it is situated in a broader historical context, and how they can promote positive birth experiences within their practice.

First Primary Presenting Author
Primary Presenting Author
Julia Imanoff, MN

University of Calgary
Faculty of Nursing
Nursing Instructor
Professional Faculties
Calgary AB
Canada

Author Summary: Mrs. Julia Imanoff is a Nursing Instructor at the University of Calgary. She has a Bachelor Degree in Science from the University of Waterloo, a Bachelor of Science in Nursing from Ryerson University, and a Masters degree in Nursing from the University of Calgary. Mrs. Imanoff has worked primarily in maternal-child health focusing on high risk obstetrics in the antepartum, intrapartum, and postpartum periods. Her research interests revolve around promoting positive birth experiences.

Second Author
Cynthia Mannion, PhD
University of Calgary
Faculty of Nursing
Associate Professor
Professional Faculties
Calgary AB
Canada

Author Summary: Dr. Mannion's program of research addresses questions pertaining to maternal/child health and dietary intake during pregnancy and breastfeeding. Underlying her research is the premise that dietary intake while meeting physiological needs, is a behaviour that is governed by belief systems.

Third Author
Graham McCaffrey, PhD
University of Calgary
Faculty of Nursing
Associate Professor
Professional Faculties
Calgary AB
Canada

Author Summary: Dr. McCaffrey joined the Faculty in July 2012. His doctoral research was a hermeneutic study of nurses' practices of relational care in mental health, using Buddhist perspectives as a way of opening to new understanding. He is an Assistant Editor for the Journal of Applied Hermeneutics and has presented his work at the Canadian Hermeneutic Institute.