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Suffragettes for Caesareans: “Every woman should have a choice”

by

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A THESIS

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Abstract

Patient choice for caesarean delivery (CD) is complex. This choice poses a challenge to Health Care Providers (HCPs) in terms of resource allocation, economics, and surgical risks. Yet, women's understanding of choice is poorly understood.

This study answers the question: how HCPs might understand women's choice for CD? Four primiparous women who chose a CD were recruited. Semi-structured interviews were used to generate data. The interpretation followed a hermeneutic approach.

The interpretations emphasized the complexities of choice, HCPs' role in birth experiences, and how the woman in this study understood vaginal deliveries as risky and unpredictable and caesarean deliveries as safe and controlled.

These findings question how HCP's understandings of choice can shape patient care. HCPs have the opportunity to recognize the meaning of the choice for each woman and how it is situated in a broader historical context, and how they can promote positive birth experiences in their practice.

Preface

This thesis is the original work by the author, J. Imanoff. The recruitment and data generation described in Chapters 4 and 5 were approved by the University of Calgary Ethics Board (ID # REB13-1183).

The discussion on fear of adverse outcomes in Chapter 6 includes ideas that are based on a concept analysis that has been published as Imanoff, J.B. & Mannion, C. (2015). The Great Caesarean Debate: The concept of fear of childbirth as a potential indication for caesarean birth. *Proceedings of the 20th World Congress on Controversies in Obstetrics, Gynecology, and Infertility (COGI), France*, 117-123. doi: 10.12894/COGI/201412/16. J. Imanoff was responsible for the concept analysis as well as the manuscript composition. C. Mannion contributed to manuscript edits.

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Dedication

I dedicate this work to all mothers who constantly face the challenge of choosing their own path.

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List of Symbols, Abbreviations, Nomenclatures

BF	Breast Feeding
CARNA	College and Association of Registered Nurses of Alberta
CIHI	Canadian Institute of Health Information
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CD	Caesarean Delivery
HCP	Health Care Provider (Obstetricians and Maternity Registered Nurses)
MES	Maternal Experience Survey
MW	Midwife
NICE	National Institute for Clinical Excellence
Nullip	Nulliparous
OB	Obstetrician
PCCD	Patient Choice Caesarean Delivery
PNOB	Provincial Notice of Birth
PP	Postpartum
PPD	Postpartum Depression
PPH	Postpartum Hemorrhage
Primip	Primiparous
PTSD	Post-Traumatic Stress Disorder
SOGC	Society of Obstetricians and Gynaecologists of Canada
SVD	Spontaneous Vaginal Delivery
VD	Vaginal Delivery
WHO	World Health Organization

Chapter 1: A Brief History of Caesarean Deliveries

1.1 Introduction

The rate of caesarean deliveries (CDs) has increased worldwide over the past two decades and is now approaching 30 percent in Canada (Canadian Institute for Health Information [CIHI], 2015a). This is despite the World Health Organization's (WHO) recommendation that a caesarean rate of greater than 10 percent is "not associated with reductions in maternal and newborn mortality rates" (2015, p.1). Yet, women choosing caesarean deliveries (CD) are becoming more common (Kelly et al., 2013) which is becoming a growing concern for Health Care Providers (HCPs) in Canada (SOGC, 2008a). The phenomenon of patient choice for caesarean delivery (PCCD) is complex. Women's choice for CDs has perplexed HCPs in that the values and beliefs of these women may be different from their own and resulting in a lack of understanding from the clinical perspective. Increased media attention and scientific scrutiny have polarized public and professional opinions about this choice. This has challenged Health Care Providers (HCPs) to make choices about how, and indeed whether, to support these women.

In publications, clinicians question if maternal choice is a justifiable rationale to perform a caesarean section (Cotzias, Paterson-Brown, & Fisk, 2001; Farrel, Baskett, & Farrell, 2005; Rouhe, 2011; Turner, 2011) and there is not a consensus among clinicians that patient choice is an appropriate reason to perform a CD (SOGC 2008b, NICE 2011). However, there is a paucity of research exploring women's perspectives and their experience of their choice.

In this thesis, I have explored the question of how HCPs might understand women's choice to deliver by caesarean. As Davey (2006) states, "understanding does not merely interpret the world but changes it" (p. xiv). Knowing more about how women understand their choice, and

the context of choice, can inform the way HCPs understand, advise, and support women in making decisions about CD.

1.2 The History of Caesarean Deliveries

In 600 BC in Rome, the procedure was part of the Lex Regia which declared that after death a fetus must be removed from the mother prior to burial to recognize both lives that had been lost (Boley, 1935; Lurie, 2005; Todman, 2007). It was most often performed by those in religious orders who claimed the right to consecrate the bodies and the burial ground (Lurie, 2005).

Later in the 14th century, it became widely known that if the procedure was performed immediately after the death of the mother, they could deliver a live infant (Boley, 1935; Lurie, 2005). The goal of the post-mortem procedure then changed to an attempt to deliver a living infant (Lurie, 2005). The first documented CD was performed in 1337 in Prague (Pařízek, Drška, & Říhová, 2016). Both survived the procedure although it was unusual.

As medicine became a practice encompassing childbirth and the understanding of human anatomy and disease increased, surgical and medical techniques allowed for the use of caesarean delivery to safely deliver an infant with an increasingly likelihood of the mother surviving (Laurie, 2005; Sewell, 1993; Willson, 1988). The trend toward medicalization of birth beginning in the 1900s, removed women's choice in where to deliver in contrast to women achieving voting rights, legal rights and financial rites (Hahn, 1987). Medicalization contributed to the movement of hospitalized births and to the belief that CDs are safe and a reasonable alternative to vaginal delivery under some circumstances, usually determined by the physician (Cahill, 2000; Lee & Kirkman, 2007).

In 2000, the Public Health Agency of Canada produced national guidelines for Family-Centered Maternity and Newborn Care Recently which highlight the importance of individualized care and shared decision making (Public Health Agency of Canada, 2000). Recently, consumerism and patient autonomy have shifted CD from a necessary, life saving procedure to a medical service (Milne et al., 2009; Douché & Carryer, 2011). According to the College and Association of Registered Nurses of Alberta (CARNA), the ethical principle of autonomy is "the right to choose for oneself what one believes to be in one's best interests" (CARNA, 2010, p.7). In the case of women's choice for CDs, autonomy can be viewed as the right to choose surgical intervention rather than follow standard care of labour resulting in a vaginal delivery (Demontis, Pisu, Pintor, & D'aloja, 2011; Lurie, 2005; Wiklund, Edman, & Andolf, 2007). In this way, the trend in CDs has shifted from necessity to commodity.

1.3 The Trend in Caesarean Deliveries

Since the 1990s the rate of CDs in Canada has been steadily rising (CIHI, 2015a). In 2013-2014, the caesarean rate in Canada was 27.3 percent (CIHI, 2015a). For the same time frame, Alberta had a rate of 28.9 percent, and Calgary a slightly higher rate of 29.0 percent (CIHI, 2015a). The documented prevalence of PCCD has been difficult to determine. The Canadian Maternal Experience Survey (MES) reported that 13.5 percent of all births in Canada were planned CDs (Public Health Agency of Canada, 2007). Across Canada, women who had planned CDs without medical indications were more likely to be nulliparous and have a higher level of education as well as higher maternal age than women who followed standard protocol (Public Health Agency of Canada, 2007). However, only 8.1 percent of all births in Canada were requested CD during pregnancy, 5.3 percent of whom were multiparous; leaving 2.8 percent of births were requested by nulliparous women (Public Health Agency of Canada, 2007).

According to Statistics Canada (2015) the total births per year in Alberta from 2014 to 2015 was 57,677, implying 2.8 percent (1,615 births per) year were PCCDs.

Elective or planned CDs are performed for a number of medically sanctioned reasons. Medical indications for planned caesareans include fetal malpresentation, fetal compromise, and maternal illness (Moore & de Costa, 2003). However, due to the shifting culture of consumerism in health care and the drive to promote patient autonomy (McAra-Couper et al., 2012), the option for women to choose a CD with no medical indication has emerged. PCCD has become increasingly common over the past decade and has influenced national rates of CDs (Gallagher, Bell, Waddell, Benoît, & Côté, 2012; Liu et al., 2007). The leading organizations guiding maternity practice, such as the Society of Obstetricians and Gynecologists of Canada (SOGC) and WHO, have been challenged to make recommendations on how HCPs respond to women choosing CDs. At the international level, the WHO must balance the risks and benefits to both developed and undeveloped countries to create guiding recommendations that may be less relevant to the Canadian context; whereas the SOGC takes guidance from the WHO guidelines and makes recommendations directly applicable to the Canadian context.

In 2008, the SOGC published a media released paper explaining that the increasing caesarean rate was due to larger social issues: delayed childbearing, decreased fertility, increased use of assisted conception, and the lack of access to appropriate care providers in remote areas (SOGC, 2008a). These issues play a factor in the type of CDs that can be considered medically indicated and not a result of patient choice. Increasing maternal age and decreasing fertility can contribute to complications in pregnancy that may rule out the option for vaginal deliveries (SOGC, 2008a). Limited access to providers for high risk pregnancies can result in the need for a scheduled CD in some cases. These situations are complex and the woman and her physician

decide upon the safest plan of care. However, there are also cases that are not complicated by medical conditions where women choose CDs for personal reasons. In these circumstances, clinical guidelines and ethical practice are unclear as to whether or not HCPs should support women's choice for CDs (Reilly, 2009).

Clinicians are challenged with justifying resource allocation to provide for these costly deliveries, even with the seemingly small number of women making the choice for CD. I write "seemingly" as the prevalence of PCCDs continues to be an estimate due to the ambiguity in documentation that stems directly from the definition of PCCD. Visco et al. (2006) state a PCCD is a "chosen caesarean delivery of a singleton fetus to a primiparous woman in the absence of medical indication" (p. 1517). It is challenging to document the absence of an indication, especially since the start of this trend "maternal request" was not an option for indication of operative delivery on the delivery record in Alberta. Commonly a different indication was recorded in the delivery records (Robson, 2001) rather than as maternal choice. This may underestimate the trend.

Given cases without medical indication, the challenge was how to accurately document the reason for the surgery accurately on the delivery record. As of 2007, the Provincial Notice of Birth (PNOB) in Alberta included maternal request as an indication for a CD, reflecting the change. This inclusion was not implemented immediately and did not reflect a change in clinical practice of obstetricians and labour and delivery nurses. The debate continued, challenging women's choice as an acceptable indication to perform CDs (Husslein, 2001).

Since the caesarean rate continued to increase, and women's choice played a role in the rate, guidelines from leading organizations aimed to support clinicians in deciding if, when, and under what circumstances to perform a CD. In 2004, a national guideline was produced in the

United Kingdom, which outlined acceptable rationales for caesarean sections; maternal choice was not one of them (National Institute for Clinical Excellence [NICE], 2004). Similarly, the Society of Obstetricians and Gynaecologists of Canada (SOGC) produced a media release stating that the organization does not promote caesarean sections based on maternal choice (SOGC, 2004). However, both organizations maintained that although there is insufficient research to recommend performing CD based solely on women's choice, each case should be reviewed on an individual basis. In 2011, NICE updated their guidelines regarding women requesting CDs to include interventions and care plans; although they do acknowledge that "there is no clear evidence to suggest that any [of these care plans] are of benefit" (NICE, 2011, p.37). The statements from NICE and the SOGC highlight the need for further research if HCPs are to support PCCDs.

Maternity HCPs, predominately obstetricians, are being singled out as key stakeholders in the debate because of their integral role in PCCDs. Obstetricians have the power to choose whether to support and perform PCCDs. Yet, this is not purely a supply driven occurrence left up to obstetricians. Women are seeking and approaching obstetricians known to honour their requests for CDs (Lauer, Betran, Merialdi, & Wojdyla, 2010). Women are choosing CDs that has inherent costs to the healthcare system. These surgical procedures are seen as unnecessary by the WHO (Gibbons et al., 2010) and are hard to justify in the publicly funded health care system used in Canada. The costs of PCCD can be detrimental to the sustainability of such a health care system.

Gibbons et al. (2010) state that the fiscal cost of what they describe as "unnecessary caesarean deliveries" is over 2.32 billion U.S. dollars per year, globally. The cost of an individual, uncomplicated CD can be upwards of double that of a spontaneous vaginal birth

(Douché & Carryer, 2011). In Canada, between 2002 and 2003, an uncomplicated vaginal delivery was estimated to cost approximately $2,700 whereas the average CD was $4,600 (CIHI, 2006). This does not include the strain these procedures place on HCPs since additional obstetricians, nurses, and anesthetists are necessary to staff an operating room. Although finances are a driving force in health care, it is not the sole means of justifying procedures; patient outcomes including patient satisfaction are important aspects which also merit consideration.

The risks of CD for the mother and newborn can be equal to or greater than a vaginal delivery on a case by case basis (Dahlgren et al. 2009). In a Canadian study, Dahlgren et al. (2009) examined risks and benefits of pre-labour planned CD for breech presentation by comparing healthy nulliparous women who underwent spontaneous labour in anticipation of a vaginal delivery (38,021) or a pre-labour planned CD (1,046) between 1994 to 2002. They found maternal risks for planned CD during the intra- and post-partum periods and the prevalence represented in percentage include: infection (0.1%), postpartum blood transfusion (0.29%), complications with anesthesia (0.38%), hysterectomy (0.1%), or other life threatening morbidities (0.76%) (Dahlgren et al. 2009). When comparing the two groups, the significant differences were decreased risk of vaginal tears and an increased risk of wound infection in the CD group. No difference was found in the risk of hemorrhage requiring blood transfusion between the two groups. Dahlgren et al. (2009) also found that there was an increased risk for neonates requiring positive pressure ventilation with planned CDs. They also found a lower risk for endotracheal intubation, ventilation for longer than 60 minutes, or asphyxial events in planned CDs (Dahlgren et al., 2009).

Another Canadian study by Liu et al. (2007) analyzed 2,339,186 discharge summaries for delivery outcomes. The data was collected over six years from the Canadian Institute for Health Information (CIHI) discharge abstract database. They categorized the data into the comparative groups of planned vaginal deliveries (resulting in spontaneous, instrumental or emergency CDs) and planned CDs (for breech presentation). The prevalence of complications from planned caesarean sections included: death (0), thromboembolism (0.1%), uterine rupture (0.2%), hemorrhage (0.5%), hysterectomy (0.6%), cardiac arrest (1.9%), and infection (6.0%) (Liu et al., 2007, p.458). When compared to the planned vaginal delivery group, severe maternal morbidity (hemorrhage requiring hysterectomy, hemorrhage requiring blood transfusion, any hysterectomy, uterine rupture, and/or anesthetic complications) was higher in the planned CD group (19.3%); although overall maternal morbidity is considered relatively rare in Canada in both cases (Liu et al., 2007).

In a retrospective study by Karlstrom, Lingren, and Hildingsson (2013), the authors measured birth outcomes of women and neonates after planned CDs. They compared women who had planned CDs (n=5,877) to a control group. The control group of women (n=13,774) began to labour with a fetus in the vertex position and had a plan to deliver vaginally, which resulted in either a vaginal delivery (n=12,936) or an emergency CD (n=838). The maternal outcomes found most commonly with planned CDs were breastfeeding complications (Karlstrom et al., 2013). The most prevalent neonatal complication was respiratory distress which was found in 2.7 percent of the planned CD group. The planned CD group was more likely to have neonates with low birth weights but they were also less likely to have low Apgar score (less than or equal to 7). The neonates in the planned vaginal delivery group that resulted in emergency CDs had higher odds of low blood sugar, asphyxia, and infections then the planned CD group.

It is challenging to compare these studies for PCCD outcomes as women in the sample chose CD for medical reasons such as breech presentation, a common medical indication (Moore & de Costa, 2003). Women whose babies are breech are given the choice to plan a vaginal or CD. PCCD is a choice made in the absence of medical indication, where there are no risk factors identified.

It is additionally challenging to compare the outcomes of PCCDs and planned vaginal deliveries in randomized control trials because of ethical considerations. While taking these limitations into consideration, the current research does suggest that although the risks for either mode of delivery are low in Canada, the overall maternal morbidity is higher and neonatal morbidity is lower in planned CDs than vaginal deliveries (Dahlgren et al., 2009; Karlstrom et al., 2013; Liu et al., 2007).

Despite the clinical findings, women are still making a choice for CD, and pressing HCPs to respond. The response is often made by an obstetrician, during a prenatal visit. It is challenging for some obstetricians and nurses to care for women who have chosen PCCD, as they have not been privy to the prenatal discussions between the woman and her obstetrician. Nurses in Alberta supporting patient autonomy are guided by CARNA (2010) who emphasize the importance of respecting "a person's right to refuse 'the truth'", while acknowledging the necessary sensitivities to culture, beliefs, and individual circumstances in the patient-nurse relationship" (p.7). These women may not intentionally refuse 'the truth' but rather, experience a different truth, one more specific to their life situation where medical evidence neither supports nor refutes their decision. So then, how are care providers expected to provide care that supports a woman's choice for CD when they do not fully understand the context of that woman's choice or no not believe it is right? This poses an ethical dilemma as defined by the Canadian Nurses

Association (2002): a situation that inhibits a nurse from carrying out actions that he/she believes to be right. It is this ethical dilemma posed in clinical practice which embodies the contrast between a lay person's perspective of CDs and that of HCPs

The lay person's perspective of CDs is often different from that of the HCP. As a woman weighs the risks and benefits of vaginal birth and CD, she inherently weighs them in the context of her life. To the HCP, the risk-benefit analysis is quite different. The ethics of providing a public service obligate the provider to promote safety and quality of life. There is the pressure to apply evidence-based practice, where the most recent and rigorous research is implemented in care provision while supporting patient preference. The dilemma occurs when a woman chooses a CD in her best judgement. The HCP has to make sense of it in the context of clinical practice. From my clinical experience, I have encountered providers who are willing to support women's autonomy and those who do not agree that autonomy outweighs the risks posed by this choice.

The aim of this study was to answer the research question of how HCPs might understand women's choice for CDs. Throughout this study, I have explored how these women understand their choice for CDs, and I offer interpretations that can be shared with care providers. These findings can potentially impact the way all maternity care providers care for, support, and/or interact with women choosing their preferred mode of delivery from the community antenatal clinics, through labour, delivery, and postpartum. Specifically, this study can improve maternity care by opening perspectives to improve and promote positive birth experiences.

Chapter 2: Literature Review

2.1 Review of the Literature

In order to explore how women understand their delivery decision, I reviewed the literature focussing on the question of how women understand and experience PCCD. To clarify the search process, I developed a PICO table (Table 1) which describes Population, Intervention/Phenomenon, Comparison, and Outcomes. I also included Study design and Time in the table which helped to guide the literature review.

Table 1. Research question in PICO(ST) format

PICO(ST)	Specifications	Inclusion Criteria	Exclusion Criteria
Population	Primiparous women	Nulliparous or primiparous	If solely multiparous
Intervention/Phenomenon	PCCD	PCCD	CD with indication
Comparison	SVD, Operative* VD	Planned SVD (regardless of outcome)	None
Outcomes	Decision making, expectations, experience, rationale, awareness of choice, delivery preference, attitudes towards delivery	Related to women's experience of choice: rationale, delivery preference, decision making, experience, expectations, attitudes towards delivery	If not directly related to women's experience
Study Design	Qualitative, Quantitative, Mixed Methods	Primary research, literature reviews, meta-analyses	Commentaries, position/opinion papers
Time Frame	Recent	2005-2015	<2005

(Adapted from Nowell, 2016). *Deliveries involving vacuum or forceps extraction.

This literature search was conducted using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Ovid Medline databases in order to identify peer reviewed journal articles from a variety of disciplines that were published between the years 2005 and

2015. The search terms and results from the two databases are outlined in the table below (See Table 2).

Table 2. Search Terms and Yields

CINAHL	**Yield**	**Ovid Medline**	**Yield**
Caesarean OR Cesarean OR C-section	11,196	Caesarean OR Cesarean OR C-section	21,624
Nulliparous OR Primiparous	1,640	Nulliparous OR Primiparous	5,662
Request OR Demand OR Choice	61,807	Request OR Demand OR Choice	185,628
Primary AND Elective	851		
Joined all searches with AND*	255	Joined all searches with AND	79
		Total	**334**

*Using the SmartText search feature

The search and review process is depicted in Figure 1 and is described below (See below). The title and abstract of each article were reviewed. Articles that were not relevant to women's experiences of PCCD based on the PICO criteria were set aside and the abstracts were reviewed for additional context to topic (n=303). If it was unclear from the title and abstract whether the article would meet at least three PICO inclusion criteria, the article was kept in the review process and evaluated more thoroughly at a later stage. The remaining 31 articles were sorted into study type grouping primary research, literature reviews, and meta-analyses in one group (n=28) and commentaries/opinion papers in another (n=3). Although all of the abstracts were available in English, there were two articles that did not have an English version of the full article available and were discarded. The 26 available in English were reviewed for reference of additional, relevant studies. There were 12 additional studies added to the group for further

review. The 38 articles were reviewed in full to determine if they met at least three of the PICO inclusion criteria. The final group of articles (n=30) were further appraised for quality of research.

To determine quality of research, quantitative, mixed methods, and qualitative articles were critically appraised using the Mixed Methods Analysis Tool (MMAT) (Pluye, et al., 2011). This method of appraisal was chosen for its broad use to critically appraise methodological quality for qualitative, quantitative, and mixed methods studies using a single tool. Determining the quality of the study is based on the presence or absence of study characteristics listed in Table A1 (See Appendix A). An MMAT score was calculated based on the percentage of study characteristics present in the study. The articles which were found to be quality research had an MMAT score of 83% or higher and were included in this literature review (n=20). The summary of these articles can be found in Tables A2-A3 (see Appendix A).

The articles were analysed and sorted into themes by a similar process found in thematic analyses: “familiarization with data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes, and producing the final report” (Braun & Clarke, 2006, p. 87). The following themes provide a summary of the articles reviewed: prevalence, demographics, expectations, experiences, choice, rationales, and birth satisfaction.

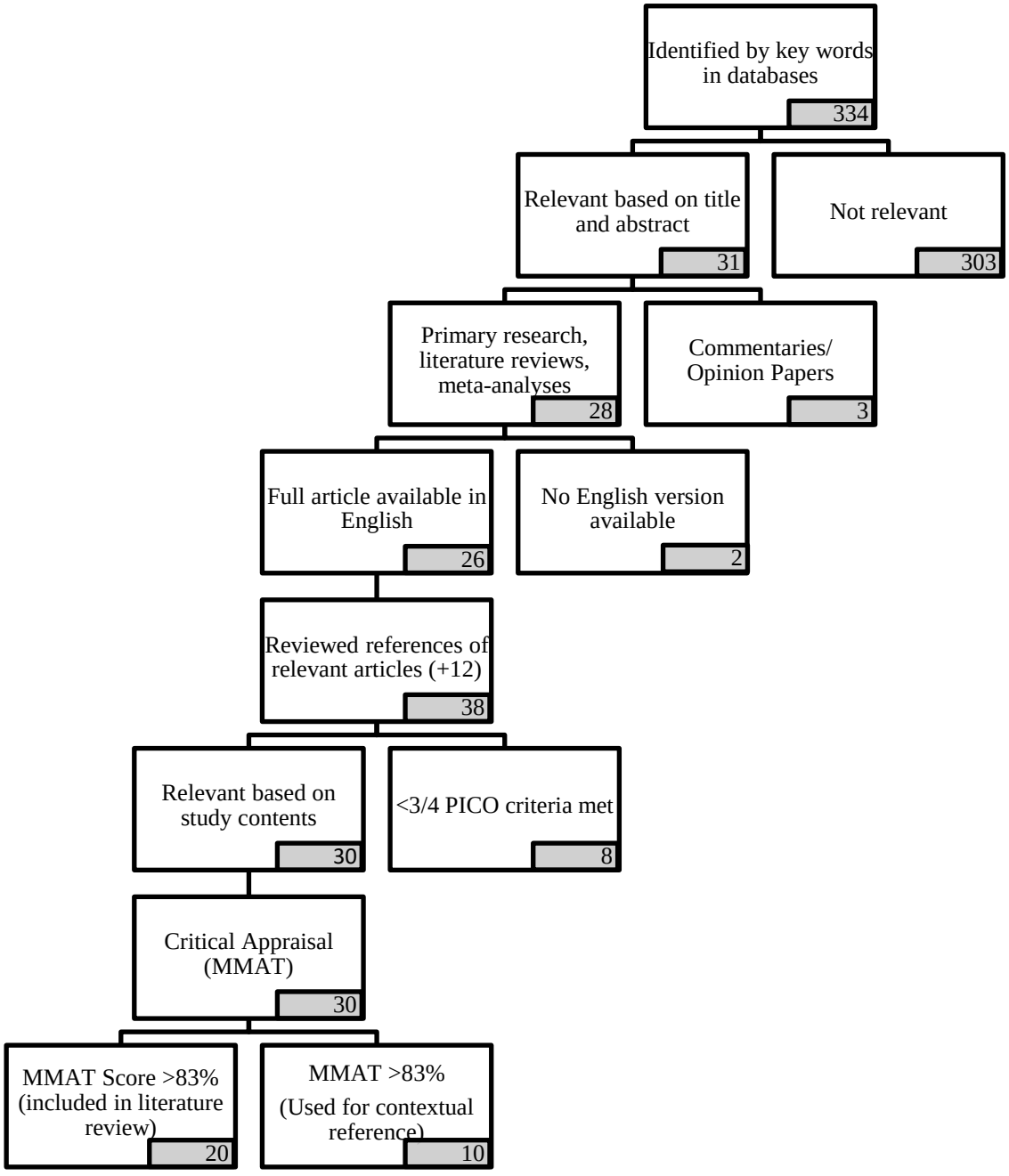

Figure 1. Flow chart for literature review process (Adapted from McCourt, et al. 2007).

2.1.1 Prevalence.

To better understand women's choice for CDs, Hutton and Kornelsen (2012) performed a chart review of 10,546 nulliparous women in British Columbia, Canada, and tried to establish the prevalence of PCCD. Even with the use of the chart review, Hutton and Kornelsen recognized the challenges of accurate charting and limited documentation of the true indication for CDs. They found only 0.34 percent of all nulliparous women chose a CD, with no predispositions that would indicate a CD. There was little discussion in the article about the form used to document indications for CD and what was vaguely termed predispositions for CD (Hutton & Kornelsen, 2012). The authors found that 1.09 percent of the women who had CDs did so by choice (Hutton & Kornelsen, 2012).

2.1.2 Demographics.

Hutton and Kornelsen (2012) found that women choosing CDs were more likely to be older, and their babies delivered at an earlier gestational age than other women in the study. In a similar study looking to better understand women's delivery choices, Romero, Coulson, and Galvin (2012) found that women who choose CDs were more likely to smoke, experienced higher anxiety, and reported poorer health than those who did not choose CD. Although there is limited information on the profile of women who are most likely to choose a CD, a better means of trying to identify women who are likely to make this choice in would be to explore the literature on women's birth expectations in relation to their birth experiences.

2.1.3 Expectations.

Women's expectations and experiences of childbirth have been explored in qualitative and quantitative studies. Wiklund, Edman, Ryding, and Andolf (2008) examined expectations and experiences of women choosing a CD. Using a prospective group comparison study, they analyzed data from 496 primiparous women in three groups: planned a CD by choice (n=104), planned a caesarean for breech presentation (n=128), and planned a vaginal delivery (n=264). They found that women choosing CDs had more negative expectations of vaginal deliveries; 43.3 percent of the sample group had a clinically significant fear of childbirth, tocophobia (Wiklund et al., 2008). The breech presentation and planned vaginal delivery groups were found to report more negative birth experiences than the other group.

Society imposes expectations on women as they undergo the transition into motherhood. Through a thematic analysis of interviews with 22 primiparous and 21 nulliparous women, Malacrida and Boulton (2012) found social expectations of motherhood and womanhood include the notion of "enduring discomfort as part of becoming a mother" (p. 757). This includes suffering through vaginal deliveries as a "rite of passage" into motherhood with the perception that choosing to have a CD is "copping out of your motherly duties… a lazy way to give birth" (p. 757). The nulliparous women in this study reframe vaginal birth a "loss of feminine norms" where vaginal deliveries are depicted as "messy… gross… disgusting" (p. 760). Through these findings, the authors suggest a connection to the social constructs of sexuality and dignity as these women feared potential physical changes resultant of birthing vaginally would be damaging to their future sexuality. A solution for one participant was to dissociate sex with birth, such that a CD would preserve anatomy, dignity, and sexuality (Malacrida & Boulton, 2012, p. 762).

Childbirth expectations vary from woman to woman. These expectations may or may not align with the realities of the risks involved. In a non-experimental, cross-sectional study, nulliparous women (n=122), midwives (n=84), obstetricians (n=166), urogynaecologists (n=12), and a colorectal surgeon (n=1) completed questionnaires regarding the childbearing risks women and clinicians were willing to accept (Turner et al., 2008). The nulliparous women in this study were willing to accept higher levels of risk than the HCPs. The risks women were most concerned about were those of fecal/urinary incontinency, emergency caesarean sections, and severe vaginal tearing (Turner et al., 2008).

Ghotbi et al. (2014) found similar results in their non-experimental, cross-sectional study of primiparous women choosing to have a CD in Iran. Of the 600 women in the study, 20.8% chose to have a CD. Ghotbi et al. (2014) found that the reasons for women requesting caesarean were largely related to "fear of pain (35.5%), fear of damage to the fetus (20.2%), fear of future maternal complication (28%), fear of losing vaginal tonicity (5.3%), fear of urinary incontinency (11%), and physician's advice (29%)" (p. 1261). Similar to the women in the study by Turner et al. (2008), these women were fearful of the potential negative outcomes of vaginal deliveries and sought out a PCCD to prevent those outcomes.

2.1.4 Experiences.

Expectations play an important role in the experience of women delivering a child. Fenwick, Holloway, and Alexander (2009) used a grounded theory approach to explore first (n=10) and second time (n=11) mothers' experiences after a CD. Although these women did not necessarily choose a CD, they were faced with the realities of childbirth when their expectations no longer matched with their experience. Regardless of whether they had experienced an elective or an emergency caesarean, both groups of women expressed that finding normalcy was

fundamental to their transition into motherhood, which implied that these women did not consider a CD normal. The themes found in this study included: expectations/reality, being in control, failure as a woman, and feeling different.

Control, to direct the actions or behaviour of something (Control, n.d.), is a central theme that runs through the majority of the studies looking at women's choice for caesarean (Douché & Carryer, 2011; Fenwick et al. 2009; McAra-Couper et al., 2011). The prospective, group comparison cohort study by Wiklund et al. (2007) also found control as a key factor in the experience of first time mothers choosing CDs. In this study, they compared data from 357 first time mothers; 266 planned a vaginal birth while 91 chose a CD. Anxiety regarding potential lack of support and loss of control were more common in the CD group than the planned vaginal delivery group (Wiklund et al., 2007). The need for control has been identified as a potential contributor to women's choice for CDs in studies describing women's childbirth experiences (Douché & Carryer, 2011; Fenwick et al. 2009; McAra-Couper et al., 2011).

2.1.5 Choice.

There were two studies in which the authors used interviews to explore the constantly shifting discourse regarding women's choice for CDs (Douché & Carryer, 2010; McAra-Couper, Jones, & Smythe, 2011). These studies were primarily from the perspective of the discipline of midwifery, although there were also nursing contributions to each paper. McAra-Couper, Jones, and Smythe (2011) found the theme of choice common in their interviews with women (n=33), midwives (n=5), and obstetricians (n=4) when discussing CDs. From the women's perspectives themes of convenience, control, and predictability were all central to their decision to choose a CD.

Douché and Carryer (2010) found similar descriptions of CDs from their Foucauldian discourse analysis of 25 interviews and popular medical and health texts. Central themes in their study included CDs as a convenient, safe, and controlled commodity. Douché and Carryer state that CDs are represented by women, childbirth professionals, and media as safe. Since vaginal birth and CD are often juxtaposed, the notion of CDs as safe implies that vaginal birth is not.

In a study by Huang, Sheu, Tai, Chiang, & Chien (2013), 15 Taiwanese women who underwent PCCD were interviewed in the post-partum period. Through an analysis founded in grounded theory, the authors developed a three phase decision-making process. The first phase of pre-decision includes the perception of risk. The negative expectations of vaginal deliveries can shape the initial desire for a CD (p. 842). The second phase, in-decision, is where the women actively gather information regarding both modes of delivery and perform a risk assessment. The third phase is the post-decision. Once a woman has reached this phase she is set in her belief in PCCD and will actively seek stakeholder agreement and the resources necessary to have a CD. Huang et al. (2013) did preface that although the model they presented had three phases, it was not sequential. A woman may go back and forth between phases as she gathers additional information or encounters an obstacle (p. 848).

2.1.6 Rationale.

Fear of childbirth is a prominent concept presented in the literature (Reiger & Dempsy, 2006). Stoll et al. (2009) used a mixed methods approach to study delivery preference, rationale, and confidence among Canadian university students. They found that fear of childbirth was an important factor in 3,680 nulliparous women's preference for CD. They also found that women who fear childbirth most commonly feared the damage that may result from a vaginal delivery,

as though they did not have confidence that their body would accommodate the physical changes or healing (Stoll et al., 2009).

Similarly, Haines, Rubertsson, Pallant, and Hildingsson (2012) used a prospective, longitudinal cohort design to explore fear of childbirth using the Fear of Birth Scale (FOBS). With a sample of 509 women surveyed during pregnancy and again after delivery, they identified a relationship between women's fear of birth and preference for delivery mode. Through a cluster and odds ratio analyses, they found that fearful attitudes towards birth were related to a less positive feeling about being pregnant (OR = 3.6 CI: 1.4-9.0), a less positive feeling about the approach to birth (OR = 7.2 CI: 4.4-12.), and an increased likelihood to prefer a CD (OR = 3.3 CI: 1.6-6.8) (Haines et al., 2012).

Fenwick, Staff, Gamble, Creedy, and Bayes (2010) also found that childbirth fear played a role in women's decision to choose a CD. In a qualitative study, 14 women who had a PCCD in their first pregnancy were interviewed and a thematic analysis was used to interpret their data. Fenwick et al. (2010) developed themes relating to women's fear of vaginal deliveries, birth as a means to an end, CD as a means for control, and "switching off" the risks related to CD (p. 397). Ultimately, childbirth fear, issues of control and safety were the main reasons for women's choice for CD in this study.

The fear and anxiety of childbirth are compelling reasons for women to choose a CD, but not all women experience the same degree of fear. There are those who hold strong beliefs in their ability to deliver vaginally. In fact, some studies report the majority of women still prefer to have vaginal deliveries (Bracken, Dryfhout, Goldenhar, & Pauls, 2008; Stoll et al., 2009). A non-experimental, cross-sectional study examining delivery preferences of women in the United States of America, found that 89.6 percent of the 550 women preferred vaginal birth (Bracken et

al., 2008). Stoll et al. (2009) found similar results when surveying young, nulliparous, Canadian women; 91 percent of women (3,771/ 3,680) reported a preference for vaginal birth. This supports what is seen clinically since the majority of births are vaginal, but it does not depict the number of CDs performed. It is likely that a minority of first time mothers are choosing CDs, but it would be helpful for care providers to understand each woman's rationale for that choice in order to improve patient care for those women.

Some women choose to have a CD as they feel there is more control in preventing the potential negative outcomes of vaginal birth (Tully & Ball, 2013). Desire for autonomy (Douché & Carryer, 2011; McAra-Couper et al., 2011), control (Douché & Carryer, 2011; Fenwick et al. 2009; McAra-Couper et al., 2011), convenience (McAra-Couper et al., 2011), fear of childbirth (Haines et al., 2012; Stoll et al., 2009), physical changes in sexual functioning (Douché & Carryer, 2011; Pakenham et al. 2006), and most often fear of injury to the fetus (Fenwick et al., 2009; McDonagh Hull, Bedwell, & Lavender, 2011; Romero et al., 2012; Stoll et al., 2009) were the most common reasons for women's choices for CDs.

McDonagh Hull et al. (2011) examined women's rationale for choosing CD in a sample of 359 women who preferred a CD, across 16 countries. This sample was a mix of primiparous and multiparous women. By using an online survey, the authors found that of the 57 percent preferred a CD, the reasons for the decision depended on the unique experiences of that individual (McDonagh Hull et al., 2011). A similar study with a non-experimental, between-subject, cross-sectional design found that the main factors behind 210 women's choice for CDs are the potential known risks of vaginal deliveries, emergency CD, and damage to the pelvic floor (Pakenham et al., 2006).

Interestingly, women's rationales for choosing a CD relate to their desire to control or prevent the risks of a planned vaginal delivery. It may not simply be the desire to control for maternal risks, but also for neonatal risks. Using a survey, Romero et al. (2012) examined preferences and rationales for choosing CD of 396 primiparous and multiparous women. They found that women who preferred a CD were more likely to think it was safer than a vaginal delivery for the infant. Overall, the fear of the potential adverse outcomes of vaginal birth for both mother and infant are a significant concern for women choosing CDs.

The timing of choosing a CD also holds some importance. Kingdon et al. (2009) explored women's decisions about delivery mode by using a questionnaire for their sample of 209 primiparous women. Interestingly, the preference for CD decreased as pregnancy progressed. There are unexplored, emerging factors that women could be experiencing that have an impact on their delivery mode preference.

2.1.7 Birth Satisfaction.

It appears that women's satisfaction with childbirth is related to women seeking control during childbirth. Haines et al. (2012) found women who were fearful about delivery were less satisfied with their birth experience. This corresponds with Fair and Morrison (2012), as they found that women who perceived having control during childbirth were more likely to be satisfied with their experience. However, simply having a CD was not the only means to have a satisfying birth experience. Women who were cared for by midwives and had a vaginal birth reported higher levels of control during childbirth and an overall higher satisfaction than those women who had a CD (Fair & Morrison, 2012). Given the drive for women to have a satisfying birth experience, it is important to note that there are various means to achieve it. Since there are birth options and choice does play a role in delivery method, further exploration on women's

understandings of their decision for CD may provide HCPs with insight into women's values and rationales in order to better inform the way providers understand, advise, and support women in making decisions.

2.2 Summary of the Literature

The normative expectation that all women should deliver vaginally is no longer universally held. There are women who are choosing CDs for their first childbirth delivery. These women are more likely to be older, deliver at earlier gestations, smoke, experience anxiety, and have an overall poorer view of their health than women who plan a vaginal delivery. Women's anxiety, fear, and control needs play a role in their choice for a CD. These women are more likely to expect vaginal deliveries to lead to negative outcomes and feel the need to control for those potential outcomes. Interestingly, women who experience control during delivery are more likely to have a positive birth experience; however, a CD is not the only means to experience control and birth satisfaction. Midwifery care was found to increase a woman's likelihood of experiencing control and having a positive birth experience. The postpartum experience after a CD is also something for women to consider since the transition to motherhood was found to be challenging even if the choice for CD was made. Making sense of the experience in terms of what it means to be a mother is a difficult process as social conventions guide our understanding of motherhood. There are numerous spheres which influence women's childbirth experience: personal, social, cultural, and political. The layered nature of women's choice makes it all the more complex, confusing, and in need of interpretation.

Chapter 3: Methodology

3.1 Philosophical Underpinnings

The aim of this research project was to explore how first time mothers understand their choices for CDs and offer an interpretation that can be shared with care providers. In the absence of medical indication, PCCD can be seen as confusing and conflicting for HCPs given the polarized perspectives on the topic. There are those care providers who support PCCD and those who do not. Without understanding each woman's case, it may be challenging to understand why a woman would choose to undergo a CD and the risks involved. There is a clear gap in how women and HCPs understand the choice for CDs. The risks that are being weighed are not necessarily the same in both cases. For HCPs, the perspectives of the women may be unfamiliar.

I chose to take up Gadamerian hermeneutics as the methodology of this study. I did not want to approach the topic with an assumption or hypothesis to test, rather, I wanted to understand a behaviour that was complex with various tensions at play. This methodological fit is articulated by Moules, McCaffrey, Field, and Laing (2015) when they state, "more than anything hermeneutics is concerned with understanding and not explanation" (p.5).

Hermeneutics is the "art of interpretation", a means of translating the unfamiliar to the familiar (Gadamer, 2006, p. 29). The contemporary philosophy of hermeneutics evolved with the contribution of the work of the German philosopher, Hans-George Gadamer (Binding & Tapp, 2002; Moules, 2002; Palmer, 1969; Warnke, 1987). Gadamer moved hermeneutics into its own identity as an interpretive branch of phenomenology. Although the two philosophies have similar roots, they use different frames of focus. Where phenomenology focuses on describing the lived experience, hermeneutics interprets the phenomenon and its context to reveal new understandings (Dowling, 2004). Moules (2002) articulated this relationship as symbiotic in that

"hermeneutics without phenomenology is interpretation without context" (p. 12). Hermeneutic research thus begins with close attention to a topic and its context. It is a useful method for exploring emergent topics in which different points of view are in play because of its emphasis on the value of individual experience within cultural contexts. In the case of PCCDs, there is a need for interpretation within the clinical and social contexts in which it occurs.

The focus of hermeneutics is on interpretation and care for words; their meanings play a large part of that interpretation. I will offer my understanding of what interpretation means. The word *interpret* is defined as the explanation of meaning or to understand (Interpret, n.d.). The word *interpret* can be traced to the old French word, *interpreter* or even further to its Latin root, *interpretari* meaning to explain or translate (Interpret, n.d.). Interestingly, *translate* is defined as "move[ment] from one place or condition to another" (Translate, n.d.). The question of hermeneutics plays with the tension or movement between the familiar and the unfamiliar, in other words, one's previous understanding and new unfamiliar understandings (Gadamer, 1985). Therefore, the foundation of hermeneutics rests in interpretation in the true sense of the word, the movement between understandings. In order to shape understandings, it is important to recognize the existing horizon of understanding or prejudices. As a researcher first coming to this topic, my understanding of PCCD was heavily influenced by prejudices prevalent in obstetric nursing practice.

Following the principles of hermeneutics, the researcher is situated in the matter and not closed off or removed from the topic (Gadamer, 1985). Acknowledging and reflecting critically upon our existing assumptions, or prejudices in Gadamer's usage, allows for more clarity when assimilating new understandings (Gadamer, 1985) and provides an insight into the topic which may have otherwise been lost. As Moules (2002) describes, "our prejudices allow us to hear

something we would not have heard otherwise, they determine what we can recognize, and they provide our access to the world" (p.25). Therefore, by using prejudices reflectively a researcher can guide and facilitate the data generation, interpretation, and ultimately moves to a place of new understanding.

As an obstetrical nurse, I carry my own assumptions surrounding women choosing CDs. Though this background has played a large role in the development of my understanding the complexities of childbirth, I am constantly reframing and expanding my understandings in order to see situations from a new perspective, which often included appreciating the woman's perspective. The bias often held by maternity care providers is that vaginal deliveries are the gold standard; they are the safest mode of delivery for both mother and baby. A challenge is presented when caring for women who choose a CD. The common place of understanding for nurses is that these women willingly choose not to attempt the ideal method of vaginal birth. I too, have come from that place of understanding and have continuously created new understandings from each interaction I have had with the topic. My understandings began to shift while developing the research question.

While I initially questioned why women would choose a CD, it began to change to how do women understand CDs. Performing the review of the literature formed another perspective to view PCCDs. There are numerous articles problematizing the CD rate (Gibbons et al. 2010) and there are also rich articles exploring birth satisfaction (Fair & Morrison, 2012; Haines et al., 2012). My understandings shifted again to include the possibility that women may be choosing CDs to control for circumstances, fear, or even simply to have a positive birth experience. Throughout the research process my understandings continued to shift until I arrived at the understandings presented in the interpretation chapter.

In the process of this research project, I also became pregnant and delivered my own child by CD. Although it was related to a medical indication, I had a very similar experience to the women in this study. This personal experience further shaped my understandings of women's choice for CD as safe, predictable, controlled, and overwhelmingly positive.

Although it is possible to bring assumptions into focus as a researcher, there is no way to fully be aware of all the ways in which my personal history and experience may influence my preconceptions of the topic. Throughout the research process, I continued to reflect on my prejudices and how they influenced my conversations with participants through journaling and conversations with my thesis supervisors. Similarly, I reflected on these prejudices throughout the process of interpreting the text. My professional history and life experience played a role in the process of inquiry, past, present, and future; it is in this way that I placed myself in the midst of the topic of choice of CD (Bruns, 2004).

3.2 The Address of the Topic

Throughout my nursing career, and as a student nurse, I encountered women's choice for CDs. The first experience I had was with a woman who had recently immigrated to Canada. The woman spoke little English and her husband insisted that she have a CD despite the apparent low risk pregnancy. I struggled to understand their rationale. I had been taught that a CD was far riskier than a vaginal birth. I had learned that cultural beliefs influence decision making and that in certain countries CDs were reserved for the wealthy, hence a symbol of status. So I had come to understand this family's choice of a CD as being a sign of wealth or prestige. Another patient, who was 34 years old, had chosen a CD for the delivery of her first child. Again, I attempted to understand her decision in order to accommodate my own biases and judgements that vaginal

birth was safest. The more times I witnessed a women opt for CD, the more I began to question how these women understood their choice.

3.3 Research Question

From my clinical practice, the disquiet led me to ask the question: how we, as HCPs, might understand women's choice for CDs? In the pages to follow, I will present my interpretations as an answer to this beckoning question.

3.4 Ethics

This study received approval from the Conjoint Health Research Ethics Board (CHREB) at the University of Calgary. Given the small number of participants and the potential detail that may be shared in the interview process complete anonymity could not be guaranteed and this was reviewed with each participant at the time of signing the consent form (See Appendix D). In the interpretation section of the thesis, pseudonyms were assigned to each participant. Autonomy was mentioned in the consent form to ensure that participants were aware that participation was purely voluntary and they could withdraw at any time. Although none of the participants required a referral, psychological resources to contact were outlined in the consent form as well, should they have experienced any distress due to involvement in the study. It was also stressed that participants' medical and nursing care during delivery and 6 weeks postpartum would not change based on their participation as the interviews would not take place until the postpartum period after their care was resumed with their family physician.

Chapter 4: Sampling and Recruitment

4.1 Sample size

In order to create a new understanding of women's choice for CD, four women who had chosen to have their first child by caesarean in the absence of medical indication were interviewed. These participants created sufficient data to provide rich new understandings. Sandelowski (1995) contended that in interpretive research the richness of the data is the determining factor in achieving an adequate sample size. I used purposive sampling, or rather a sample of participates were chosen purposefully, to provide rich depth and breadth of information (Patton, 2001). More specifically, I used a type of purposive sampling Palys (2008) refers to as criterion sampling, where you search for individuals who meet a set of criteria The criteria I used are explained below. The main criterion was women who have chosen CDs 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 CD.

4.1.1 Inclusion/exclusion criteria.

Women between the ages of 19 and 40 years, who were fluent in English, and who had chosen to have a CD for their first delivery were invited to participate in the study. The choice for CD implies that there are no other medically justifiable reasons for the CD; this includes breech presentation, multiple gestations, pre-existing or pregnancy induced maternal/fetal health conditions which impact delivery mode, or increased maternal age over 40 years old. These medical risks were used to indicate CD and so it is not solely the choice of the woman. Women who fell into this category were excluded from the study. Since choice for a CD can be rooted in an experience of previous pregnancies that did not result in a delivery, gravida status was not part of the exclusion criteria.

I conducted a medical chart audit of the delivery record accessible from the obstetricians' office to ensure the participants met the inclusion and exclusion criteria. If the participant did not meet the inclusion criteria, they were not included in the study. Women who met the criteria were contacted and an interview was arranged for approximately four to ten weeks postpartum at the participants' homes.

4.1.2 Recruitment.

Recruitment took place in an obstetrical office of a group of obstetricians who regularly perform PCCDs. The timing of the recruitment was at any point after the decision had been made between the patient and the obstetrician to schedule a CD in the absence of medical indication. Patients were informed about the study by a poster (Appendix E) featured in the obstetrician's office as well as being offered a pamphlet (See Appendix F) with the study and contact information. I was on site in the office to meet with patients who met the inclusion criteria and who were willing to meet and discuss the study while they waited to see their obstetrician. If the patients were seen in the clinic and they were willing to be in the study, the consent was reviewed and signed. Alternatively, if the participants were recruited by phone or email, the consent form was signed on the day of the interview.

Since fear and anxiety are found to be higher for first time mothers during pregnancy than in the post-partum period (Fenwick et al., 2009), the interviews were scheduled in the postpartum period. The participants were contacted in the postpartum period to reconfirm their willingness to be interviewed. Interviews were then scheduled for four to 10 weeks postpartum. By this point the participants' medical care had been transferred back to their family physician, minimizing any perception that participation in the study would have any impact on their medical care.

4.2 Data Generation

Data were generated through interviews. The origin of the word *interview* helps to explain why the data is generated as opposed to collected using Gadamerian hermeneutics. Interview stems from the French word "*entrevue*, to have a glimpse of, and *s'entrevoir*, to see each other, also *entre* meaning to enter and *voir* or *videre,* to see" (Binding & Tapp, 2008, p. 126). Interviews are the way in which a researcher and participant are able to enter into shared understandings of the world and may begin to see things differently. Hence, the data is generated rather than gathered or collected.

The interviews were semi-structured and lasted between 35-90 minutes. They were digitally, audio-recorded and transcribed verbatim. A list of leading and probing questions was used as an interview guide (See Appendix B). There were also notes that were taken during the interview to help guide the interview as well as the analysis. The interview questions revolved around the themes identified in the literature review: expectations of themselves, their family or friends, delivery preference, rationale, birth satisfaction, and demographics. Each interview informed the next with questions regarding transitions into motherhood, rituals or traditions regarding birth being added.

4.3 Interpretation

In order to develop a complex and highly contextualized understanding of the topic an interpretive analysis based upon the dialogic hermeneutics of Hans George Gadamer was conducted. I engaged with the interview transcripts, continuously reframing and assimilating new understandings throughout the analysis process until a point where new understandings of women's choice of CD could be presented.

The interpretive process is not arbitrary, but is guided by the problematic nature of women's choices which places patient autonomy and patient safety at odds with each other. I began by exploring the phenomenon of choice for CD and how it was experienced by each participant in the context of her life, her social context, and the larger contemporary health care system.

From there, I reviewed the transcripts from the interviews in order to develop meaningful interpretations. I maintained a research journal to record new understandings of the topic that emerged with each review of each transcript. Through this process, complex connections between the transcripts and interpretations were developed.

Once I arrived at interpretations of women's choice for caesareans, I reviewed the transcripts again to ensure they fit with what the women had said in the interviews as well as any notes that I had taken throughout the interviews. The final stage of the interpretive process was writing the results in an account of the topic that "bear up clinical descriptions and exemplars and expand them into rich and full descriptions of the understandings generated and created within the study" (Moules, 2002, p. 31). Continuously throughout this process, I consulted my thesis supervisors; Dr. Mannion being a content expert and Dr. McCaffrey being a method expert. The support and counsel of my thesis supervisors also added another level to the dialogic nature of the interpretive process in forms of triangulation by means of conversations between the researcher and the transcripts, the research team and the transcripts, and the researcher and the research team.

Chapter 5: Interpretation

Gadamer's philosophy of hermeneutics emphasizes understanding the historical horizon of a concept (Gadamer, 1985). In order to understand women's choice for CD, I will first

consider an historical context. There are a multitude of historical events which have shifted women's role in society and women's choice within health care. Moules et al. (2015) explained that understanding occurs within the balance of what has happened and what is currently happening. Although one can never fully see the relationship between past, present, and future in its entirety, being aware of the historical horizon provides an informed perspective, or horizon, from which to interpret the topic at hand. The historical influences on women's choice for CD include the women's rights movements, consumerism, and medical advances (Hahn, 1987). In this chapter, I present my understandings of how the women in this study experienced a choice for CD by first exploring the shifting context of how this choice came to be, how it is enacted presently, and the future implications.

5.1 Historical Context of Choice

In the Western world, choice is part of our everyday lives (Iyengar, 2010). Sheena Iyengar, one of the world's experts on choice begins her book, *The Art of Choosing*, by stressing the huge impact choice can have on our lives. "Choice is an enormously powerful force, an essential determinant of how we live" (Iyengar, 2010, p.3). I will use Iyengar's definition of choice: "the ability to exercise control over ourselves and our environment; …[however,] in order to choose, we must first perceive that control is possible" (Iyengar, 2010, p. 6).

Women have not always had control to make choices related to their health and wellbeing. Prior to 1929 Canadian women were not recognized as "persons" under the law (United Federation of Canadian Women [UFCW], 2015). In the past 100 years, the changes in women's recognition as "persons", becoming voting members of society, and the movements towards gender equality have given women new opportunities.

The opportunity for women to make choices is linked to the women's rights movements. In the 1900s the greatest change to women's rights occurred in Canada when women achieved the right to vote. Yet, it was not until the "Persons Case" in 1927-29 that women were established as "persons" under the law (Canada Online, 2015). This event was monumental in the establishment of women's rights and the wider availability of choices for women for education, career, and social independence.

Industrialization was also a factor shaping women's choice in Canada. Although industrialization began earlier, it led to the beginning of mass availability of consumer goods such as the sewing machine and the dishwasher, that began to give women choice as consumers. With the reduction of manual housework using consumer goods, women had more choice in how to spend their time. Women could choose to spend their time with their family and friends or to engage in employed work or education (The Report of the Royal Commission on the Status of Women in Canada, 1970).

Some women began to seek employment outside the home and the shift in women's place from the home to the work force impacted women's social status and not surprisingly, their health. With many women called to the labour force during World War I, the Women's Labour League was established to advocate for better pay, maternity care, and birth control (UFCW, 2015). There were also other advocates who fought for women's right to access maternity care and birth control. For example, Dr. Elizabeth Bagshaw illegally opened Canada's first family planning clinic from 1932 and Dorothea Palmer was arrested for informing women about birth control in 1936 (UFCW, 2015). Once birth control was legalized in 1969 and more available, women were able to choose a life beyond bearing and rearing children (The Report of the Royal Commission on the Status of Women in Canada, 1970). Women slowly gained choices for

deciding when and how often they became pregnant yielding a significant impact on their life span and quality of life (The Report of the Royal Commission on the Status of Women in Canada, 1970). Women's reproductive rights allowed women to have the control to choose *when* to become pregnant and where to give birth.

In the 1900's the "obstetrical revolution" (Hahn, 1987) shifted the care of mothers from community care givers to medical professionals in hospitals (Moscoso, 2015, p. 49; Oakley, 1984). In the early 1900s the majority of births were in homes and communities, but by 1939 half were in the hospitals, and at 1980s over 95 percent of births were in the hospitals in the United States of America (USA) (Hahn, 1987, p. 280). "Also by 1939, more than 90 percent of births were attended by physicians, 39 percent outside the hospital; [between 1960-1980] of more than 3.5 million births per year in the USA, more than 98 percent were attended by physicians in hospitals" (Hahn, 1987, p. 280). The obstetrical revolution led to the medicalization of birth in obstetrical techniques, and shifted *where* and *who* would care for pregnant women.

Physicians had medical authority over how and in whose presence women laboured and gave birth (Mitchinson, 2002). The *doctor knows best* mentality from the 1950s has slowly shifted to one of shared decision making and patient autonomy (Douche & Carryer, 2011). Patients are now considered health care consumers; only the consumer goods in health care have also changed over time. Where women once had to advocate for their husbands and partners to be present for the birth of their children (Elkins, 1985), they can choose to have a pain free labour using a gamut of drugs and an epidural (Camorcia, 2015, p. 108). Given choice, Canadian women are receiving epidurals for all deliveries 51.5 percent of the time (CIHI, 2015b).

This trend of women's choice is not isolated to reproductive health. Women choose health care services as a commodity such as elective cosmetic surgeries, vein ligation, and laser treatments. Cosmetic surgeries have become part of consumerist society (Larsen, Patterson, & Markham, 2014) and in Canada they have increased from 86,207 in 2002 to 100,569 in 2003 (Plastic Surgery Statistics, 2005). It is interesting to note the majority of patients undergoing plastic surgery in 2006 were women (Donohoe, 2006).

"The revolution in childbearing technology and technique has occurred in a cultural environment of deeply charged and rapidly changing values and practices regarding sexuality, reproduction, health and healthcare, identity, and autonomy" (Hahn, 1987, p. 257). Over the past century, women have become able to choose when to become pregnant, if and when to seek medical interventions for pain. They are able to advocate for their right to change their bodies with cosmetic surgeries; and most recently, women can choose *how* they want to give birth whether by planned vaginal or planned CD.

In this study, I have interviewed four women who have chosen to have a CD. In the sections that follow, I have outlined a brief sketch of each of the women with the pseudonyms as the headings. The data analysis follows with my interpretations grouped into the themes of: siding with caesarean, the right choice, horror stories, the promise of safety, and the future of choice.

5.2 Women Choosing Caesareans: Study Participants

5.2.1. Elizabeth.

The first woman I interviewed, Elizabeth, had a long health history involving back and knee injuries, multiple surgeries, and pelvic rehabilitation, in addition to a lengthy battle with

breast cancer. She struggled with perceptions of safety and certainty of the outcomes for her child in a planned vaginal versus CD. She viewed her child as a precious and miraculous baby.

5.2.2. Katherine.

The second participant, Katherine, also in her thirties, had a history of injuries, most significantly a broken tailbone requiring lengthy rehabilitation. Her decision related to an intense fear of having her tailbone broken again. Like Elizabeth, Katherine also feared for the safety of her baby. Katherine's fear was also related to her history of multiple lost pregnancies. Similar to Elizabeth, she viewed her child as "miraculous".

5.2.3. Leanne.

The third woman, Leanne, had no traumatic injuries. Although she initially used her history of vaginal herpes simplex virus (HSV) as a reason for requesting a CD, she revealed her reasons predominately related to the potential long-term complications of a vaginal delivery for both herself and her child. She also had a family history where her sister-in-law experienced significant birth trauma resulting in cerebral palsy.

5.2.4. Samantha.

The fourth woman, Samantha, had no significant health history that played a role in her choice. She was a physician, whose perspective on labour, delivery, and postpartum recovery evolved from her obstetrics rotations during residency. Her experience as a resident appeared to have the greatest influence on her choice. Over the course of her physician training, her choice for CD became more evident.

5.3 Siding with Caesareans

"Oh, you have the choice?" (Interview 1, Line 490-491)

Although it may come as a surprise to many individuals, in 2016 women have the choice of how they wish to deliver. The women in this study were first time mothers who chose to deliver by caesarean section in the absence of medical indication. Although the larger social context of women's rights, industrialization, and obstetrical revolution are common for the women in this study, each of them had individual life experiences that led them to their choice.

The four women in this study who sought CDs met inconsistent responses from obstetricians. Elizabeth found that the obstetricians she saw and those within her family supported her decision. In fact, her brother-in-law, a urologist, said to her, *"You are crazy to even consider a vaginal delivery"* (Interview 1, line 143-144). When she became pregnant, she found an obstetrician who supported her decision.

> *So I just emailed Dr. X and was like, "I just found out I'm pregnant and can't see my family doctor until this time. I would like to see an obstetrician because I want to have the option of having a c-section given my history" …and he emailed me back saying, absolutely!* (Interview 1, Lines 410-415)

Katherine had a similar experience with her obstetrician when she was debating on choosing a CD near the end of her pregnancy. She was told, *"let's hold off and see how this week goes and even if you end up going into labour, we can still deliver by caesarean if that's what you want"* (Interview 2, Lines 140-144). Katherine felt supported by the obstetricians:

> *...Both doctors would side with elective caesarean if I wanted it. And you know I think the doctors were really good. They were really supportive of the idea if I wanted to go that way but at no point in time did I ever feel like they were leaning one way or another. So it really did come down to my decision.* (Interview 2, Lines 847-852)

Hearing the same sentiments, Elizabeth was a bit more hesitant.

> *She said, "you always have a choice as long as the baby's head is not out and we haven't made any incision, you always have a choice." It is one thing for her to say that but you go into labour and it is totally dependent on who is on call and who you are going to get.* (Interview 1, Line 373-377).

Within Elizabeth and Katherine's descriptions of the support they received from obstetricians about their choice for CD, reflected a notion of "us and them," those who are on *my side* and those who are not. I see this specifically in Katherine's statement that, *"both doctors were on side"* in the above quotation. Although there were other mentions of *sides* concerning family and friends, no relationship seemed to be as influential as the patient-physician relationship. Obstetricians have the authority to decide whether to perform CDs. Given the power dynamic, these women came to their obstetrician with the request, and in some cases a plea, to have a CD. Katherine describes her experience requesting a CD. "*I was sweating when I asked [the obstetrician], I was so scared"* (Interview 3, Line 136).

Once the women's requests were supported, the relationship between the woman and the obstetrician became significant. The women had someone with authority who was on their *side,* who understood and supported their decision. Samantha described the fundamental elements of her relationship with her obstetrician as *"being known so well and being able to trust"* (Interview 3, Line 81). Being able to trust the obstetrician meant that they would have a CD and their baby would be delivered safely.

When the study participants encountered other care providers, whom they perceived as unsupportive or judgemental, a potential for profound negative impacts arose. Most of the women encountered some form of judgement or criticism largely when the hospital staff tried to determine the reason for the CD, which they were required to record on the chart.

> *Well the nurses at the [hospital] I thought were really phenomenal. They were fantastic. Yes, and besides the first nurse, it was not like she did not provide me good care… you could tell she was looking for a reason for the c-section. It was just like a little bit of an undertone.* (Interview 1 Lines 258-265)

Most encounters were similar to Elizabeth's. They occurred on the day of the delivery as the nursing staff were completing the paperwork. Although it may seem an insignificant matter to the nursing staff, it is interesting to note that even the manner in which a nurse asked a patient about the reason for her CD can be perceived as judgment and can negatively impact a woman's birth experience.

Katherine perceived judgmental tones from staff:

> *…maybe it was my own guilty conscience or something, but I felt like everyone kept asking why we are doing an elective, why are we doing a caesarean? And it was almost like they were saying, why are you choosing to be selfish?* (Interview 2, Lines 367-371)

I found it interesting to note that although Katherine said that the safe delivery of her baby was one of the most important reasons for her choice for caesarean but still interpreted others' judgment that she had made a selfish choice. There is a large stigma around women who are "too posh to push" (Song, 2004). "Posh" women do not want the pain, wear, and tear of labour or have a child when it would be inconvenient (Song, 2004). This does not seem to be the case in the group of women interviewed; however, Katherine still perceived that other care providers saw her in that way.

Leanne had a similar perception of how other care providers saw her.

> *They really probably just thought, "here's this blonde idiot, blonde bimbo, electing to have a c-section because she doesn't want to go through labour." And that's the thing, they have no idea what's going on in my life. They don't know. So I was really surprized at how quickly they judged me.* (Interview 3, Lines 464-469)

Leanne was followed for pregnancy induced hypertension in the antenatal care program. She was visited three times a week by a nurse and on each visit, the nurse would ask about her choice for CD. She explained:

> *Well, I definitely think I got judged by a lot of people…every nurse and doctor saw my file that I was electing to have a c-section and they would ask me. I can't even explain to you how many times people asked me why I was electing to have a c-section… but I had to explain myself a lot.* (Interview 3, Lines 151-164)

The continual need to explain herself exasperated Leanne throughout her pregnancy, but the most significant event occurred when she was in triage on the day of her delivery.

> *In triage one of the doctors, I think she was a resident, came in and she was quite rude to me. She said, "why are you even electing to have a c-section? You just don't want to go*

through labour and pain, is that it?" And she was talking super loud on purpose so that everyone in triage could hear. (Interview 3, Lines 174-179)

Leanne was continually questioned in triage and was discussed by the staff at the nursing desk in whispered voices.

They were like, "electing to have a c-section", whispering. If I had a dollar for every time someone said that when I was in triage. I don't know why, like am I the only person in Calgary who has ever elected to have a c-section? Because they made it a big deal. (Interview 3, Lines 337-342)

The reaction of the staff had a profound impact on Leanne as she referred to it as the *"worst part of the whole thing"* (Interview 3, Lines 589). At the time of the interview, I could see she was visibly upset discussing it. Leanne said, *"I'm not going to let one person's judgement and loud voice in triage ruin it for me. But that's when I was like, 'I wish Dr. X was here'…someone who just understood, that wasn't going to judge me"* (Interview 3, Lines 594-598). Even though she felt sure of her decision, she still felt the need to have someone on her side, who understood her choice.

Samantha's perspective of the safety of CDs came from her medical training. Unlike the other participants where it was through stories or their own health experiences, Samantha had seen firsthand the risks and benefits of both delivery types. That seemed to be sufficient background to avoid being judged by nursing staff, as Leanne had experienced. *"I think because I am a physician and they know that I am subspecialized in pelvic floor trauma they didn't really question it"* (Interview 4, Lines 103-105). Others' reactions, or lack thereof, may be related to her power and authority as a physician and especially as a pelvic floor specialist. The staff she worked with would make comments that she perceived as *"gentle jokes"* and not as offensive or

negative (Interview 4, Line 105). Although she did not receive any comments from her colleagues, Samantha was well aware of the dichotomy of opinions. *"A few other physicians in the call group can be judgmental, I just didn't bother to tell them my plan"* (Interview 4, Lines 109-111).

I found that the importance of women feeling supported, and having someone on their *side* is important when one chooses a path that is controversial and open to judgement from others. In these four cases, each woman was aware of the different reactions they could have experienced by the HCPs they encountered. When other care providers confronted them, none of the women doubted, regretted, or changed their decision.

Siding with a woman's choice for CD does not have to mean that the HCP agrees with them or thinks that CDs are best in all cases. It does mean that the woman's choice has been endorsed by at least one obstetrician, and other HCPs can *side* with the woman by understanding that she has made this plan of care with her obstetrician, and has come to an understanding that a CD is best for her. The reasons behind that understanding will vary for each woman. Rather than questioning the decision once it has been made other HCPs can be supportive by respectfully asking about the woman's story of how they came to their decision. It is important to note that when repeatedly questioned, these women did not rethink their decision.

5.4 The Right Choice

"Is this the right choice?" (Interview 1, Line 265)

The word *right* has many meanings. It can imply a sense of righteousness, superiority, and morality. Being *right* can mean acting in accordance with what is good or proper, acting in a way that is suitable or appropriate, or acting/judging in accordance with the truth (Right, 2015). It implies a dichotomy. If it is not right, it must be wrong. Yet, as I heard how these women came

to understand their choice as the right choice for them, what was really being said was that they saw a CD as the safest choice for them. It was not a matter of morality or appropriateness; it was a matter of what mode of delivery led to the safe delivery of their child.

"I really struggled with 'is this the right choice?', 'what if something goes horribly wrong?'... You go through the whole, 'am I making the right choice?' (Interview 1, Line 265-270). Here, Elizabeth struggled with the *rightness* of her choice. She goes on to compare the two possible outcomes. *"I don't know, things could just go really wrong or it could go really good"* (Interview 1, Line 276-277). Although she used the terms "wrong" and "good" to describe the outcomes, what she struggled with was deciding on a plan of care that may or may not have resulted in the safe delivery of her child. She made her choice given the unpredictable nature of both modes of delivery. Elizabeth found it difficult to trust her body to perform. She had previously felt betrayed by her body when she was seemingly healthy and then found out she had breast cancer. Similar to her prior experience, she was challenged with trusting her body to be as healthy and capable as she felt. *"You know I've always been super healthy, never smoked a cigarette in my life. I always make like really healthy choices then, breast cancer doesn't even run in my family…I felt so betrayed"* (Interview 1, Lines 602-608). I heard the strain in her voice and saw the tears well up in her eyes. It had been a struggle for her to weigh the risks and benefits of both options. Unlike the other participants, Elizabeth acknowledged the potential for vaginal deliveries to *"go really good"*, but still focused on the potential negative outcomes.

Katherine debated her choice of a CD saying, *"I don't want to regret my decision for any reason"* (Interview 2, Line 34-35). She also explained what weighing the risks of both delivery means. *"I am so thankful that I didn't do it [vaginally], that I didn't risk it. I think [recovery] would have been such a nightmare"* (Interview 2, Line 56-58). In Katherine's choice of words

there is not the struggle with right or wrong, but rather *risky* or *safe*. She focused largely on the potential risks of a vaginal delivery. Although she largely focused on the fear of breaking her tailbone again, fear of the potential negative outcomes seemed to be a significant factor in her choice.

> *I wouldn't have the confidence to have one of these natural childbirths where you have a midwife at your house. There's no way. I would want as much medical intervention as I could, just to make sure. I think that I would have a lot of fear, but that just comes with my journey.* (Interview 2, Lines 394-399)

Katherine was convinced that more medical intervention, or at least access to it, meant a safer delivery. Her history of multiple lost pregnancies also shaped her perspective and her desire to take no risks in the delivery of this unborn child.

Leanne did not exhibit the same internal struggle with her choice as Elizabeth and Katherine. She had read that CDs were safer (Interview 3, Lines 752-3) but was uncertain if that was true. Regardless of what she read, she said *"I feel like it would be safer"* (Interview 3, Line 759). Leanne's struggle was largely with justifying her decision to others. She felt the judgement of others for her choice to have a CD. "*I got judged by a lot of people… I can't even explain to you how many times people asked me why I was electing to have a c-section" (*Interview 3, Lines 151, 160). The highlight of the delivery experience for Leanne was when her choice was validated by the obstetrician performing her delivery found that the baby had the umbilical cord wrapped around her neck three times. The obstetrician pulled down the blue curtain and said, "*Good job on the elective C-section" (*Interview 3, Line 458). Leanne goes on to say "*That's when I knew, I don't care what all those nurses and doctors thought or said about me in triage. I don't care"* (Interview 3, Lines 459-461). Feeling the judgment of others may seem like a moral

stance of right or wrong, but as Leanne came to understand her choice of the right choice, it was only *right* in that the safety of her child would have been compromised if she had attempted a vaginal delivery with the cord wrapped around the baby's neck. Even though Leanne did not know this factor when choosing a CD, it factored into how she came to understand her delivery choice as the safest for her child.

Samantha did not use the language of *right* when discussing her choice. She used the language of *safety*. She understood the risks of choosing a CD, but also highlighted the same notion of *safety* for her child:

> *There was less room for unpredictability, that it was certainly safer for baby. No concerns about oxygenation in labour since labour wouldn't happen. The surgical risks to me seemed small. So the blood loss, anemia, post-op infection, none of that seemed like something I couldn't handle if that happened to me. I didn't feel that I had any risk factors for any major complications. And so, it certainly seemed safer.* (Interview 4, Lines 173-179)

The language of *right* choice that Elizabeth initially used to describe her struggle with her choice seemed to imply that there was a moral stance that was being made in the choice for caesarean. Elizabeth struggled to determine whether her choice was *right* for her. In Leanne's case, her struggle with choosing a CD was external when she was constantly being questioned by the HCPs with whom she came in contact. It became more evident with Katherine and Samantha when the language shifted from the *right* choice to the *safest* choice. Samantha's summary of risks highlight the true dilemma was not justifying *rightness* but weighing the risks for herself and her baby.

5.5 Horror Stories

"This is amazing, especially after hearing the horror stories of natural childbirth"

(Interview 2, Lines 1037-1039)

Stories are more than just the mere retelling of an event. The story itself, as well as the language used to tell it is an interpretation by the teller and is interpreted in turn by the listener. Moules et al. (2015) described how interpretation "peers behind language… ventur[ing] into the contextual world of a word" (p.3). I listened to these women retelling their own delivery stories as well as those they had heard and it was alarming to me how often the word "horror" was used in relation to vaginal deliveries. *Horror* is "an emotion combining loathing and fear" (Onion, Friedrichsen, & Burchfield, 1966, p.448) connected with the notion of something feared or disgusting (Horror, n.d.) The words *horror* and *horrible* were used 15 times throughout the four interviews. I looked more closely at the language the women used when describing their perspectives of planned vaginal deliveries. Specifically, I looked at the words used and their frequencies: *risk* (37), *tear* (25), *worried* (18), *fear* (20), *incontinence* (12), *scared* (9), and *petrified* (8). Each woman described their understanding of what they expected of vaginal deliveries as something they feared, that they were not willing to risk.

Elizabeth described her work where she witnessed all of the *"worst case scenarios…all the horror stories of vaginal birth"* as part of her reasoning behind choosing a CD (Interview 1, Lines 12-13). The *horrors* were in relation to the potential outcomes of both mother and child. She explained her fear for her child's safety:

> *She's totally a little miracle baby, and then you just hear stories about like well, vaginal deliveries and the babies come out and they're not breathing… She was just such a miracle I didn't want to take any chances.* (Interview 1, Lines 80-88)

Elizabeth's greatest fear was that her precious baby would not survive the birthing process.

She was not alone. Katherine had the same fear. *"I just couldn't let anything happen to him once we finally had gotten this far"* (Interview 2, Lines 1090-1091). Katherine's fear was partially influenced by the story of her cousin's loss.

> *All of my cousins went through natural childbirth but one of them had a stillborn. So that probably stuck out in my mind even though she had five children naturally and you know healthy. There was the one that was stillborn and that is the one that probably played the biggest factor on me. I focused more on the one that was stillborn than the five that came out healthy.* (Interview 2, Lines 1081-1086)

Katherine was willing to undergo major surgery to avoid the potential loss of her child. She understood the risks of surgery were largely related to her recovery. *"Really all the other risks I understood were mostly to me and I thought really I would rather me be at risk than the baby"* (Interview 2, Lines 752-754). Katherine wanted to guarantee the safe delivery of her child and was willing to manage whatever risks the CD meant for her.

The theme of horror stories continued in Leanne's case. Leanne had a similar experience with a family story that weighed on her decision. *"My husband's sister has cerebral palsy and she got stuck in the birth canal. That's why my mother-in-law was so like "if you can have a c-section, have a c-section"* (Interview 3, Lines 527-530). Leanne's mother-in-law had experienced her own traumatic birth, which led her to see CDs as the means to prevent outcomes such as cerebral palsy. Although Leanne acknowledged the risk for cerebral palsy in vaginal deliveries today is lower than when her mother-in-law delivered (Interview 2, Lines 532-533), that story influenced her perception of the risks of vaginal deliveries.

Samantha, the physician, spoke about the horror stories from her practice that, over time, made an impact on her decision for a CD.

> *That preference just sort of crept in over the course of residency, of seeing so many deliveries that seemed like they were going to go beautifully and end up in just horrible crash sections, or crash forceps. And then nobody is happy: the patient isn't happy, the obstetrical team isn't happy. You just can't predict those things.* (Interview 4, Lines 180-185)

As a practitioner, it is challenging to witness a delivery that is seemingly on course to have a positive outcome only end up in an emergency situation. At that point, the HCPs hope that the long-term impact on the child is minimal or none at all, but rarely do they follow the child's growth and development to allay their concerns. This uncertainty in emergency situations creates an uneasy feeling for the HCPs involved. Although Samantha describes it as simply "*not happy*" it is a feeling that lingers even after the patient is discharged. In her years of training as a physician, she saw many situations that resulted in "*horrible crash sections or crash forceps*"; each one taking its toll and influencing Samantha to decide to deliver by caesarean section. Whether it was from family stories or witnessed in practice, planned vaginal deliveries carried with them a connotation of being risky; unpredictable; *horrible*.

5.6 The Promise of Safety

> *"There is a peace of mind that comes with caesarean that you think nothing can go wrong"*
>
> *(Interview 2, Lines 110-114)*

The women in this study came to understand CD as a safer, more predictable alternative to vaginal delivery. As Katherine alluded to during the interview, more medical intervention carries with it the promise of safety (Interview 2, Lines 394-399). This perspective is poorly understood by some HCPs. There has been a slow shift towards choice for CDs and the women

in this study help us to understand that shift. What was traditionally assumed to be the best and safest method of childbirth, a vaginal delivery, has been reframed to be risky, unpredictable, and ultimately an unfavourable choice.

In the introduction, I mentioned that CD has long been known as a potentially life saving measure. This notion is perpetuated in stories from my participants. Katherine speaks of her neighbour's experience:

> *You know my neighbour even says that caesarean saved her baby's life. Here they were trying to do the whole natural thing. Ended up trying an induction… she ended up not dilating but her contractions were coming on so strongly that the baby's heart rate ended up just stopping. So her idea of how it went, I mean she sees [CD] as a life saver.* (Interview 2, Lines 788-795)

CDs have the potential to save lives when either the mother or unborn child is at risk. There are clinical situations that pose significant risk to the mother or fetus where obstetricians may decide that a CD is necessary to provide the best possible patient outcome for either/both the mother and fetus. These situations include, but are not limited to "previous CD, dystocia, malpresentation, and compromised fetal status" (SOGC, 2005). Although there were no clinical situations requiring CDs in the cases of the women in this study, they believed they were at risk and deemed a CD safer for their child. Penn (2001) discussed the different indications for CDs in a broader, cultural context.

> The determinants of the caesarean section rate are likely to be extremely complex and will include financial imperatives as well as characteristics of the birth attendant and the social and cultural attitudes of women and the societies in which they live. (Penn, 2001, p.2)

That description of determinants holds true for the women in this study. Each woman understood her choice for CD as being safer for her child, albeit, some acknowledged it would still be risky for themselves.

The notion of safety was emphasized when the women spoke of their children. Katherine described that her fear regarding delivery was centered on the uncertainty of having a live birth.

> *The fear was definitely more so in me knowing that there are a lot of things that can go wrong. And I just wanted to make the decision that means I can have this baby here in front of us. (Interview 2, Lines 1225-1227)*

When comparing this fear of the unpredictable to the sense of control in a planned caesarean, Katherine valued the *"peace of mind that comes with a caesarean…you think nothing can go wrong in the whole delivery process"* (Interview 2, Lines 112-114). Any possibility of having a vaginal delivery left Katherine "*petrified*", fearing for the life of her child. "*I would be petrified that something was happening to him*" (Interview 2, 738-739). Katherine had a debilitating fear of vaginal delivery and felt secure in the thought that medical intervention would mean that her child would be born safely. *"In my head I thought it was more medical intervention and if something went slightly wrong I figured there were more people, more specialists, more equipment so that [the baby] would live"* (Interview 2, Lines 506-509).

Katherine's trust in medical intervention is echoed in Leanne's, context. Leanne felt the same sense of safety in having a caesarean section. She associated the medical intervention of CDs with the certainty of a known, predictable outcome. *"It's the known versus the unknown…had I had a vaginal birth, I think I would have had a really hard labour and then ended up with an emergency c-section anyways"* (Interview 3, Lines 370-373). Her choice

seemed to be weighted on the outcomes of a planned CD being predictable when compared to a planned vaginal delivery.

Samantha perceived CDs as safer when looking at the long term, and sometimes unforeseen complications of vaginal deliveries she often saw in her practice. "*Even the smoothest delivery, somebody can come back 20 years later and have incontinence or a prolapse"* (Interview 4, Lines 145-147). She felt that a CD was more predictable with manageable risks (Interview 4, Lines 173-179). In Samantha's case, she was very aware of how she wanted her delivery experience to be. She wanted to see her son born, have him on her chest right away, and she was given every opportunity she asked for.

> *There were still a lot of options just like people have with a vaginal delivery, to look and see. I can't really think of any negatives… It was still all of the things that I would have wanted from a natural delivery [they] were accommodated with a c-section. So I can't think of any down side.* (Interview 4, Lines 55-64)

It is clear that the women in this study felt that a CD meant a safer, more predictable delivery. There are many studies comparing the risks involved in caesarean and vaginal deliveries, but they often compare all types of CDs versus all vaginal deliveries (Murphy & McDonagh Hull, 2012). This did not include the true risks of planned vaginal deliveries which include emergency CDs. Emergency CDs are often riskier than planned CDs (Liu et al., 2007) Furthermore, there is debate as to the adequacy, sufficiency, and quality of this research (Leeman & Plante, 2006; Murphy & McDonagh Hull, 2012). Regardless of the literature, the women in this study believed CDs promised a *safer* delivery.

5.7 The Future of Choice

"I think every woman should have a choice" (Interview 2, Line 1098)

Choice is a complex concept. It is shaped by personal, social, and cultural contexts. In the Western world we are accustomed to having a choices everyday. “The power of choice is so great that it becomes not merely a means to an end but something intrinsically valuable and necessary” (Iyengar, 2010, p. 9). In her book *The Art of Choosing*, Iyengar (2010) mentioned the significant findings of the Whitehall studies. The first Whitehall study looked at the relationship between social inequalities, work stress, and coronary heart disease among British civil servants (Marmot, Rose, Shipley, & Hamilton, 1978). After ten years of follow-up the highest ranking officers were less likely to suffer negative health outcomes than their lower ranking counter parts (Marmot et al., 1978). 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). The Whitehall II study showed that the health outcomes were related to the perception of control. Although these studies are not directly related to women’s choice for CD, they suggest that individual choice and sense of control is related to health outcomes.

Sen (2001) suggested that rather than making sure we have freedom of choice we should instead consider its impact: does the choice promote a state of well-being or hinder one? In health care, we promote autonomy, individualized care, and choice, but at what cost? Leeman and Plante (2006) reason that if you only evaluate short-term outcomes, planned CDs may appear safer, but they fear for the long term ramifications of a hypothetical future where the choice for vaginal deliveries is diminished:

> *The neonatal morbidity and mortality occurring from intrauterine fetal demise from 39 to 41 weeks would be eliminated, as well as the inevitable placental abruptions, prolapsed umbilical cords, shoulder dystocias, and fetuses “unable to tolerate labor.” If a*

> *sufficiently large population can be gathered and if the outcomes of future pregnancies are not considered, one might show a statistically significant decrease in perinatal mortality based on the intrauterine fetal death rate alone. Could women then lose the choice of vaginal birth altogether?* (Leeman & Plante, 2006, p. 267)

They present an interesting perspective to those who support women's choice for CDs. If women's choice for delivery is to be advocated, then so should choice for vaginal deliveries in situations such as Trial of Labour After Caesarean (TOLAC) or breech presentations (Leeman & Plante, 2006). Katherine also supported the idea of universally supporting women's choice, emphasizing that "it's their bodies, their decision":

> *I think at the end of the day, if we have the technology and we have the medical advances we don't necessarily have to only have childbirth one way just because that's the traditional way. I think that as long as [obstetricians] are open to it and they are willing to support their patients making that decision, because it's their bodies, their decision… I think that they should be able to have that without judgement and it should be accepted equally.* (Interview 2, Lines 1210-1217)

If we, as a society, are going to support women's choice for delivery, there must be equal voice for caesarean and vaginal delivery. Women's choice should be informed and with the collaboration of a health care professional, as was the experience of the women in this study. Elizabeth said, *"I think I made a really educated choice. I think I knew all the risks and everything before hand"* (Interview 1, Lines 216-217). Not every obstetrician, nurse, or woman will agree to what they feel is the best choice given a particular situation. Does everyone need to agree? Is every plan of care universally accepted for all patients? Or should we continue to respect ethical concepts of autonomy in individualized care plans? As Samantha concluded,

women should have the right to choose their delivery mode on whatever end of the *birth spectrum* it falls:

> *It's just a different value system. It usually comes from women who are well versed and well read about the topic and they should be afforded the same choice – everyone should have the same choice- how they want their delivery to be on the spectrum; and it really is a birth spectrum. They can be totally at the one end where they are delivering at home with untrained care providers and at the other end you have people who want a really surgical and precise delivery plan. And there's not a wrong choice along the spectrum as long as people are informed about their choice. (Interview 4, Lines 455-467)*

The women in this study took the opportunity to increase their perceived level of control over their delivery by weighing the risks, choosing a CD, and finding an obstetrician to support their choice. Given that choice is prominent in Western culture, it is not surprizing that the women in this study felt empowered and satisfied with their choice. So many times they said that their experience *"was very positive. I actually don't have anything negative to say about it at all, about the delivery itself"* (Interview 2, Lines 8-10) and that *"that it was still the best decision I made"* (Interview 3, Lines 661-662). For the women in this study, having the choice for CD meant less stress and worry, positive birth experiences, and their experiences matched their expectations. It could be as Iyengar (2010) suggested, that simply having a choice gave the women a sense of control. The choice for CD was one that these women valued and as Samantha and Katherine said, it is a choice they would hope other women could have as well.

Chapter 6: Discussion and Conclusion

6.1. The Importance of Birth Experience

In this study, I explored how we, as health care providers, might understand women's choice for CD. Although there were different personal contexts for each woman they came from the same social and cultural context: Canadian, educated, affluent, English speaking, and living in an urban area with access to a variety of HCPs.

To help understand women's choice for caesarean, I reviewed the major historical events which shaped women's ability to make choices in society and health care: the women's rights movements, consumerism, and health care commodification. There is also the culture of perceived control and the freedom of choice that is predominant in the Western world (Iyengar, 2010). The women in this study chose CDs partly as autonomous patients, partly because they were allowed access to CDs by their obstetricians and partly because of the broader cultural context where women see themselves as capable, rational, independent thinkers who have the right to make choices which directly impact them.

6.1.1. The role of HCPs.

Obstetricians play a unique role in the birth experiences of women who choose CDs. Each woman in this study stressed the importance of having the support of an obstetrician for a positive birth experience with CD. This emphasizes the need for women to have a champion, someone willing to support their decision, someone on their *side*. The NICE (2011) guidelines also highlight the need for continuity of a care giver when women request a CD. Having an obstetrician to *side with caesareans* is important to address the potential psychological outcomes of denying such a request, including: postpartum depression (PPD), post-traumatic stress disorder (PTSD), low self-esteem, and poor mother-infant attachment (NICE, 2011, p. 36).

I am not suggesting that every obstetrician should support PCCD. There is no conclusive evidence to promote that course of action for the reasons mentioned by the 2011 NICE guidelines. The WHO (2015) stated that at the population level "the effects of caesarean section rates on other outcomes, such as maternal and perinatal morbidity, pediatric outcomes, and psychological or social well-being are still unclear" (p. 1). If an obstetrician does not feel there is evidence to support a woman's choice for CD, the obstetrician "should refer the woman to an obstetrician who will carry out the [caesarean delivery]" (NICE, 2011, p. 7). In addition, the woman should be connected to psychological resources such as formal counselling and cognitive behavioural therapy when available (NICE, 2011) if the request for CD stems from fear of vaginal delivery. There are no guidelines if the request does not come from only the fear of vaginal delivery.

6.1.2. Fear of adverse outcomes.

Women may have self-doubt on the ability to physically achieve a vaginal birth (in the cases of Elizabeth and Katherine), damage to the baby during childbirth (in the cases of Elizabeth, Katherine, Leanne, and Samantha), or fear of damage to the maternal pelvic floor (in the cases of Leanne and Samantha) (NICE, 2011, p. 36). The women in this study referred to the fear of these adverse outcomes in the language of *right* choice. Choosing a CD was the *right* choice for each of these women in that it provided them a means to control for the unpredictable outcomes, or rather, the *horrors* of vaginal deliveries.

Similar to the findings in the study by Wiklund et al. (2008), the women in this study had more negative expectations of vaginal deliveries than CDs. Their overwhelmingly negative views focused on the potential for operative vaginal deliveries and poor neonatal outcomes.

These expectations frame the way in which the women came to understand childbirth: that vaginal deliveries are risky and unpredictable and CDs allow for control and safety.

The fear of adverse outcomes related to vaginal deliveries may be considered tocophobia. Based on a concept analysis, tocophobia is defined as "a pregnancy-related anxiety focused on labour and delivery which affects women before, during, or after childbirth" (Imanoff & Mannion, 2015, p. 118). There are different classifications of tocophobia depending on whether the fear is based on expectations or previous experiences (Fig. 2). The previous experiences include pre-existing mental health conditions such as anxiety (Hofberg & Brockington, 2000). Although this study did not examine tocophobia, pre-existing anxiety, or pregnancy-specific anxiety there may be relationships between these conditions and PCCD.

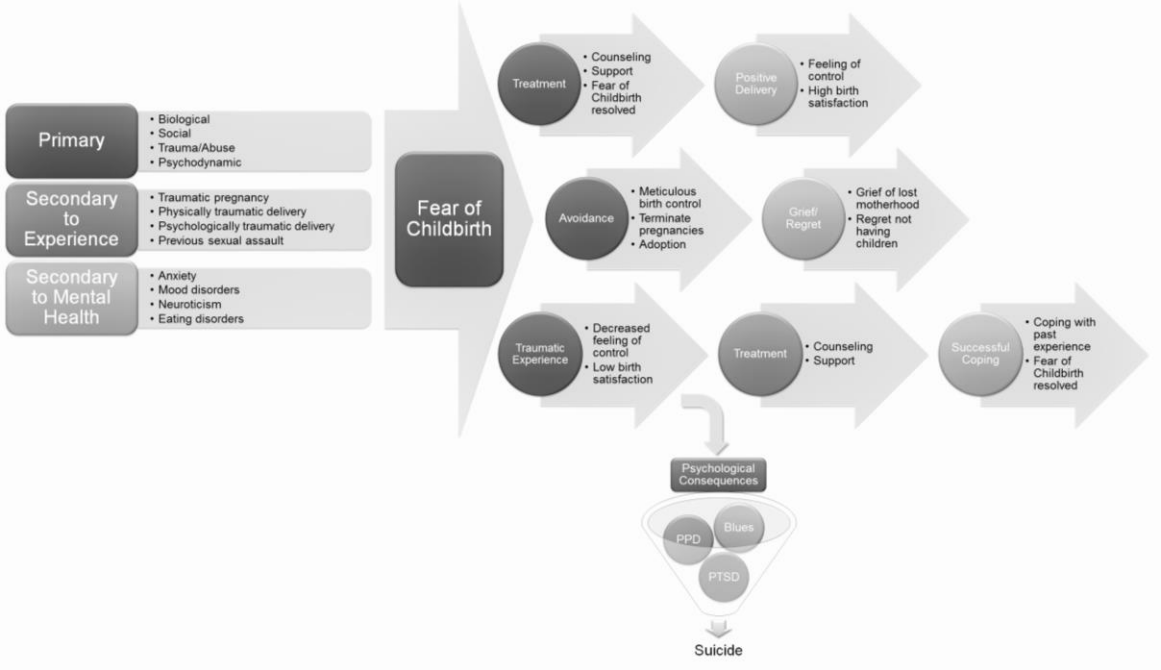

Figure 2. Fear of Childbirth Conceptual Model (Imanoff & Mannion, 2015)

6.1.3. The desire for control.

The desire to control the birth experience is a central theme in other studies that have looked at women's choice for CDs (Douché & Carryer, 2011; Fenwick et al. 2009; McAra-Couper et al., 2011). Douché and Carryer (2010) performed a Foucauldian discourse analysis of interviews and popular medical and health texts. They found that CDs are deemed to be a convenient, safe, and controlled commodity. These findings are congruent with this study where CDs were found to hold a *promise of safety* by offering a sense of control and predictability.

In a qualitative descriptive study, Haines et al. (2012) found that women who are fearful of labour and birth were less satisfied with their delivery when they experienced vaginal deliveries. A delivery may be obstetrically sound, yet still be psychologically traumatic to the woman (Hofberg &Ward, 2004). Although challenging to quantify, 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).

The psychological impact on mothers who experience traumatic deliveries can be detrimental to the child as well (Latimer, et al., 2012). PPD can deprive an infant of essential maternal interactions (Doucet, Denis, Letourneau, & Robertson Blackmore, 2009). Early deprivation is correlated to childhood behavioural disorders (Doucet, et al., 2009; Latimer et al. 2012). Alternatively, a perceived sense of control can have a positive effect on birth satisfaction (Fair & Morrison, 2012). As Samantha mentioned, birth is on a spectrum: for some control means having birth at home, in a familiar environment, allowing their body to dictate the course of events. For others, control is what the etymological definition suggests: "to exercise restraint" (Onion et al., 1966, p.211), to hold back from the physical exertion of labour and delegate the act of delivery to a trusted expert – the obstetrician. Regardless of how the woman perceives control,

the outcome of birth satisfaction can play a role in promoting positive psychological transition into motherhood (Fair & Morrison, 2012; Saisto & Halmesmaki, 2003).

6.2. Strengths and Limitations

Qualitative research does not strive to have generalizable findings in the sense of controlled replicability. The experiences of the participants are related to identifiable social trends such that the relevance of this study is applicable to maternity care providers and women choosing or considering a choice of caesarean delivery. It is estimated that between one and two percent of women having their first child are choosing caesareans (Hutton & Kornelson, 2012; Leeman & Plante, 2006). The birth of a child is a highly significant event which can have a profound impact on the woman's health and wellbeing (Simkin, 1991). The strength of hermeneutic research is in its ability to create a space in between, where tensions are held. PCCDs polarize the views of HCPs and child bearing women. There is no need to have a generalized plan of care for every birth. Care providers, patients, and families do not need to agree upon one birth plan but I suggest some agreement about time, space, and choice for a variety of plans. It is a woman's choice to decide what level of risk she is willing to take. There is no "right" or "wrong" choice in a moral sense. The "right" choice is one the woman perceived to be the safest for her and her child. The challenge moving forward is to hold the tensions in maternity care posed by PCCDs, to maintain the choice for each woman, whether they are choosing a caesarean or a vaginal delivery.

One challenge with hermeneutic research discussed by Davey (2006) is the "inability to arrive at a final interpretation" (p. xv). The goal of the final thesis is to contribute new understandings to inform practice, and yet it has to allow for the understandings of the topic to continue to stimulate further research and to impact practice. In this, I acknowledged that the

final interpretations will not be all that there is to contribute to the academic discussion. Even within the course of this study, the quantity of research on PCCD had increased substantially. Social media coverage of the topic in addition to changes in clinical practices, guidelines, and recommendations have all impacted the interpretations presented in this thesis. What is more, the individual experiences that I have had throughout this research study has also shaped the interpretations and understandings I have presented. The dynamic nature of the PCCD has made it challenging to study, but also highlights the timeliness and relevance of the topic. Women are choosing CDs and it is becoming increasingly important that care providers broaden their role in providing individualized care.

Although, I do not suggest that the findings in this study are definitive truth claims, as Madison (1988) said,

> When we opt for a given interpretation, we do not do so because we know it to be true… but because we believe it to be the best, the one that offers the most promise and is the most likely to make the text intelligible, comprehensible for us. (p. 15)

Despite the challenges of hermeneutics- the need to determine a final interpretation, the duration of the study, and the shifting context- these final interpretations are ones that I believe are the most likely to broaden understandings of HCPs and change the way we care for, support, and advise women choosing CDs.

6.3. Implications for Practice

There is an overabundance of information and evidence from the internet, friends, family, and media for women to inform their choices about pregnancy, delivery, and child rearing. There are also constant social pressures of doing the moral "right" thing for their child, and by extension, their family. This pressure starts as soon as a woman knows she is pregnant.

Throughout pregnancy, she is faced with an array of choices; what to eat, how to treat her body, and each of these choices will impact her baby growing within her. There are socially acceptable "right" choices such as eating a healthy balanced diet, not smoking or drinking alcohol, and exercising regularly (Alberta Health Services [AHS], 2014). Women retain the right to chose among these.

Decisions regarding childbirth and modes of delivery should be no different. There is a dichotomy within the medical community and so in some cases there is a sense of moral judgement towards women's choice for caesarean. Although the proclaimed gold standard for birth practices is a vaginal delivery (SOGC, 2008b), we are now seeing women - and obstetricians - whose perspectives of delivery do not match this standard. Women who are choosing caesarean may be judged as having made a wrong choice.

The social norm surrounding birth is that vaginal birth is preferred to CD. The implication is that a woman is 'wrong' to choose a CD unless there is a medical indication that would prevent a vaginal delivery. This can lead to the woman feeling judged. Yet this understanding is based upon a general plan of care that clearly does not fit for every maternity patient and is not aligned with women's choice.

HCPs can reflect on the fact that patients are equal decision makers in their plans of care and need to make an effort to consider the understandings of their patients. Trust and being respected as a shared decision maker were part of the fundamental relationship between a woman and her obstetrician that Samantha described. This aligns with the guiding principles in family-centered care which highlight individualized care and shared decision making (International Childbirth Education Association [ICEA], 2015). Although family-centered care is not a new to

maternity care, in light of the findings from this study these principles may be applied to clinical practice in new ways.

The term individualized care has been part of nursing literature since the 1960s (van Servellen & McCloskey, 1988). Individualized care is central to nursing practice (Radwin & Alster, 2002) and when used effectively "will recognize the uniqueness of a human being, their individuality, personality and human frailty. Individualized care will offer patients different ways of meeting their needs, allow choice, and involve the nurse in listening rather than telling" (Waters & Easton, 1999, p.83). Although nurses are not part of the decision making process of a chosen caesarean delivery that takes during prenatal visits, they can play a significant role in supporting the woman through her delivery. Throughout providing care for these women, the key concepts of individualized care – i.e. offering various ways to meet patient needs, allowing choice, and considering the uniqueness of the individual patients - are respected and upheld when women are supported by the HCPs involved in their choice for CD.

When these women arrive in the hospital whether it be throughout their pregnancy or on the day of their delivery, one course of action a HCP can take is to hear the woman's story. Through open conversation, HCPs can be better equipped to provide personalized care. This does not mean that they have to agree with the choice personally or professionally. The challenge is to provide a positive birth experience despite the tensions that may be present in this choice; the tensions being in the differences of values, beliefs and understandings.

In the same sense, obstetricians who are sought to perform a CD may want to explore how this woman has come to understand CDs. Their care and support may include referring them to psychological resources as suggested in the 2011 NICE guidelines. If the obstetrician is not willing to perform CDs by choice, then they should refer the woman to an obstetrician who is

willing to consider choices. Both the NICE (2011) guidelines and the SOCG (2008) position statement on women's choice for CDs leave the decision of performing the CD to the autonomy of the obstetrician.

The challenge for the primary care provider of these women, and other maternity care providers, is to decide how they will choose to respond and care for these women given the broad context in which this choice has come about. It is not a result of one individual woman's choice, nor a group of women. This choice has been shaped throughout historical and cultural events. Women are able to decide when to become pregnant, where to deliver their child, and currently they are choosing how to deliver.

The more women make this choice, the greater the need for an intentional response from the healthcare system. One means of managing PCCD is to develop a nurse-led caesarean referral clinic. Although this clinic would only be created if the strains of resource allocation were not an issue and if the clinic was found to be cost effective. However, in an ideal situation, this clinic would receive patient referrals from family physicians and obstetricians. A nurse would provide an intake assessment, a health history, and potentially a psychological screen for fear or anxieties related to childbirth. Obstetricians who are comfortable with performing PCCDs would be on-call on a rotation. The nurse would send the patient information to the obstetrician's clinic. The OB would then see that patient during regular clinic hours and provide prenatal care and would discuss the woman's understanding and choice in CD. Further training in psychological assessment and counselling could allow for more services to be provided by the managing nurse. Again, concepts of individualized and family centered care become pertinent to this example of care provision for women choosing CD; women would be seen as shared decision makers in the delivery plan which would be unique to them.

6.4. Autobiographical reflection

Qualitative research poses a challenge for the researcher to situate themselves in the balance of Self-Other. Fine (1994) wrote the following in regards to the relationship between Self and Other:

> Self and Other are knottily entangled. This relationship, as lived between researchers and informants, is typically obscured in social science texts, protecting privilege, securing distance, and laminating the contradictions… By working the hyphen, I mean to suggest that researchers probe how we are in relation with the contexts we study and with our informants, understanding that we are all multiple in those relations. (Fine, 1994, p. 72)

In this study I have "worked the hyphen" between Self and Other in a figurative and literal sense. I came to this research question as a HCP and a researcher, an Other. During the research process I became pregnant and had an elective CD, becoming an Insider. In this sense I have been able to hear, see, and interpret differently than I might have if I had not had this experience. Fine (1994) suggested that seeing the relations between Self and Other, researcher and participants allows the researcher to obtain richer data (p. 72). This section explains my oscillation between Self and Other.

Initially, I witnessed women's choice for CD as an obstetrical nurse. I struggled with how to provide unbiased care for these women. Throughout my training I had come to understand vaginal deliveries as the optimal mode of delivery for both mother and child and had applied this belief in my practice. I was alarmed that women would choose CDs. This alarm caused me to reflect on the culture of birth in the hospital, the city, the country where I practiced. I could not help but think we are doing something wrong if women are compelled to choose caesarean over vaginal deliveries.

I began to appreciate women's choice for CDs. Given the context of birth as I had witnessed in my practice, I started to think if I were to have a child I would also choose a CD. Ironically, I became pregnant and was faced with that choice. I sought an obstetrician whom I knew would support my choice. Throughout my pregnancy, I reflected on my own understandings of birth and CDs.

After a very positive childbirth class, I decided that I wanted a vaginal delivery and was willing and prepared to cope with the unpredictability and the lack of control. This was not an easy decision. At the end of my pregnancy my baby was breech and could not be turned. I was faced with the choice of vaginal breech or CD at which point I decided on a CD because I believed it to be the safest choice for my baby. The challenges and struggles I faced throughout my own pregnancy and delivery were very similar to the women in this study. Although I had completed the interviews prior to my delivery, the analysis took place after my baby was born. My interpretations have been shaped from my experience as a care provider, a woman who struggled with the uncertainty of vaginal birth, and a mother who had an elective CD.

6.5. 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 CDs. 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. For the women in this study, the most significant factor weighing in their choice is the perception of safety.

As early as the 1800s, there have been a small group of women who have actively sought medical care for the common ailments of pregnancy at a time when there was no prenatal care for women (Oakley, 1984). Some women believe that the safest delivery is one where there is

minimal intervention; for others, more medical intervention is safer. It is the perception of safety that draws a woman towards a certain type of care provider dictating the risks she is willing to take in delivery, and in this study, that influences a woman's choice for CD.

Women's choices have developed historically and now include the choice for caesarean. This choice is partly due to the perception of safety in CDs. As with other shifts in health care, now HCPs are faced with the responsibility of responding to this choice. When caring for women who chose a CD, HCPs 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 the broader contexts of choice. Obstetricians may reflect on whether or not they feel comfortable performing such deliveries and if they can refer the woman to another obstetrician who does feel comfortable. Other HCPs, including nursing staff, who are not involved in the initial decision for CD can reflect on how they can best care for this woman in order to promote a positive birth experience despite any potential tensions of conflicting beliefs.

PCCD can provide women with a sense of safety in their delivery, positive delivery experiences, and overall improved maternal mental wellbeing. Previous studies have suggested, there may be long-term economical and medical consequences to women's increasing choice of CDs (Gibbons, et al., 2010, Leeman & Plante, 2006). The long term impact of PCCDs on the health care system in Canada is uncertain given how few are performed. As the choice for delivery continues, HCPs 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.

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Appendix A

Table A1. MMAT criteria and appraisal template

Types of mixed methods study components or primary studies	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?				
	Do the collected data allow address the research question (objective)? (E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both of the screening questions				
1. Qualitative	1.1 Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?				
	1.2 Is the process for analyzing qualitative data relevant to address the research question (objective)?				
	1.3 Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?				
	1.4 Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?				
2. Quantitative randomized controlled (trials)	2.1 Is there a clear description of the randomization (or an appropriate sequence generation)?				
	2.2 Is there a clear description of the allocation concealment (or blinding when applicable)?				
	2.3 Are there complete outcome data (80% or above)?				
	2.4 Is there low withdrawal/drop-out (below 20%)?				
3. Quantitative non-randomized	3.1 Are participants (organizations) recruited in a way that minimizes selection bias?				
	3.2 Are measurements appropriate (clear origin, or validity know, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?				
	3.3 In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?				
	3.4 Are there completed outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?				
4. Quantitative descriptive	4.1 Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?				
	4.2 Is the sample representative of the population understudy?				

	4.3 Are measurements appropriate (clear origin, or validity known, or standard instrument)?				
	4.4 Is there an acceptable response rate (60% or above)?				
5. Mixed methods	5.1 Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?				
	5.2 Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?				
	5.3 Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?				
	Criteria for the qualitative component (1.1 to 1.4) and appropriate criteria for the quantitative component (2.1-2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be applied.				
	* These two items are not considered as double-barreled items since in mixed methods research, (1) there may be research questions (quantitative research) or research objectives (qualitative research), and (2) data may be integrated, and/or qualitative findings and quantitative results can be integrated.				

Table A2. Summary of the quantitative and mixed methods studies, methods, and findings

Study	Location	Purpose	Research Design	Sample	Data Collection	Variables	Outcomes
Bracken et al. 2008	USA, OH	Investigate preferences of delivery mode and explore relationships between preference for vaginal and caesarean birth	Non-experimental Cross-sectional	n=550 Inclusion: ->18 of age -Read/speak English Sample: -Nullip=43% -Multip=57% -20-41 week -69% Caucasian	Survey distributed by care coordinators at 2 hospitals when patients pre-registered for delivery	Independent: -Preference Dependent: -Risks and benefits associated with either vaginal or CD	-89.6% prefer vaginal (n=480) Preference correlated to: -∨pain in recovery -∨ scarring -∧ infant bonding -∨ PPH -10.4% prefer CD (n=56) - Preference correlated to: -∨ pain in delivery -∨ impaired sexual function
Fair & Morrison 2012	USA, NC	Explore the relationship between control, expectations, and experienced control in childbirth	Longitudinal, prospective	n=31primip, 26-40 weeks, and 6 weeks PP	Questionnaires administered by trained researchers in an interview format	Independent: -Pregnant (26-40wk) -PP 6weeks Dependent: -Prenatal control -Expectations of control -Experienced control -Health (mom/baby) -Birth satisfaction	-Negative correlation between depression and birth expectations -Positive correlations between health, birth satisfaction, experienced control, and birth expectations -Health negatively correlated to depression in postpartum -CD did not change experienced control or birth satisfaction
Gallagher et al. 2012	Canada, QC	Describe young nulliparous women's attitudes about PCCD	Non-experimental Between-subjects Cross-sectional	n=140 HS/voc=53 College=61 Uni.=18	Questionnaires given out in Canadian classrooms	Independent: -Personal characteristics -Social network characteristics Dependent: -Attitude of PCCD -Perceptions -Fear of SVD/CD	-57.1% prefer OB/GP to MW -28.6% would ask about PCCD and possibly request one -Social networks influence women's attitude and preference for PCCD -Negative thoughts of vaginal delivery ∧ likelihood of requesting PCCD

Primip = Primiparous Nullip = Nulliparous Multip = Multiparous CD = Caesarean delivery PP = Post-partum PPH = Post-partum hemorrhage
HS = High school Voc = Vocational Uni = University OB = Obstetrician MW = Midwife SVD = Spontaneous vaginal delivery

Table A2. Summary of the quantitative and mixed methods studies, methods, and findings (Continued)

Study	Location	Purpose	Research Design	Sample	Data Collection	Variables	Outcomes
Ghotbi et al. 2014	Iran, Tehran	Determine rate of CDMR and maternal attitudes/ knowledge of delivery modes	Non-experimental, cross-sectional	n=600, primip CD=501 VD=99	Questionnaires completed in presence of trained investigator at 1 day PP	Independent: -Maternal attitude -Maternal knowledge Dependent: -Birth location -Occupation -Education	- CDMR rate 20.8% (42.44% public, 6.08% private) -Reasons for CDMR were fear of pain (35.5%), fear of damage to fetus (20.2%), fear of maternal complications (28%). -Knowledge scores were largely poor (55.6%).
Haines et al. 2012	Sweden and Australia	Develop profiles of women's attitudes and fears about childbirth	Non-experimental Prospective, longitudinal	n=509 Sweden=386 Aus= 123	Questionnaires 18-20 weeks 2 months PP Birth Attitudes Profile Scale and Fear of Birth Scale	Independent: -Birth attitude -Fear of birth Dependent: -Pregnancy characteristics -Birth experience -Birth outcomes	-Attitude clusters: self determiner, take it as it comes, and fearful -Fearful more likely to prefer CD, have less positive feelings: (pregnancy, birth, PP), have elective CD, epidural, and experience more intense pain
Hutton & Kornelsen 2012	Canada, BC	Examine probable prevalence of elective CD	Retrospective, cohort	n= 10, 546 CD= 3 301 No indication= 510 OB suggested = 409 Requested= 36	Chart review, triangulation of data from chart	Independent: -Demographics Dependent: -CD without indication -PCCD -OB suggested CD	1.9% of women had CD by choice. Those who had CD by choice were older and delivered at earlier gestations than other women.
Kingdon et al. 2009	England	Explore women's views on deciding mode of delivery	Mixed methods Non-experimental Cross-sectional Phenomenology	n=209 for Questionnaires n=153 for Interviews, primips, >16 of age, no complications	Questionnaires and interviews at 24 and 36 weeks and 12 months Postpartum	Independent: -Gestation Dependent: -Delivery preference -Rationale for preference -Views on childbirth	72 % preferred of SVD at 24 wks. The higher the gestation the less preference for PCCD; 15 women changed their mind. Women like the idea of choice, but trust HCP to make the best decision.

CD = Caesarean delivery SVD = Spontaneous vaginal delivery OB = Obstetrician HCP = HCP PP = Postpartum Aus = Australia

Table A2. Summary of the quantitative and mixed methods studies, methods, and findings (Continued)

Study	Location	Purpose	Research Method and Design	Sample	Data Collection	Variables	Outcomes
McDonagh Hull et al. 2011	UK, England	Explore women's motivation for preferring planned CD	Mixed methods	n=359 Convenience sample, pregnant women, 16 countries	Online survey, semi-structured	Independent: -Demographics -Rationale Dependent: -Preference for caesarean	57% of sample preferred CD Themes for this choice included: -Against vaginal deliveries -Physical and psychological validation.
Pakenham et al. 2006	Canada, ON	Determine opinions and choices of women in mode of delivery	Non-experimental Between-subjects Cross-sectional	n=210 nullip=107 multip=103	Questionnaires given to patients at OB antenatal clinic	Independent: -Nulliparous -Multiparous Dependent: -Opinion/choice regarding CD	Nulliparous women more likely to request CD. Factors to choose CD avoid consequences of SVD: pain, emergency CD and to protect pelvic floor
Romero et al. 2012	USA, NC	Better understand women's delivery preferences and rationales	Non-experimental Between-subjects Cross-sectional	n=396 11% request 46% elective repeat CD	62 item survey Administered during pregnancy	Independent: -Demographics -Previous deliveries - Rationale/motives Dependent: -Delivery preference	Those who choose a CD for first child are more likely to make that decision in first trimester, smoke during pregnancy, and worry about delivery. They are also more likely to perceive CD as safer for baby.
Stoll et al. 2009	Canada, BC	Study preference, rationale of CD among non-pregnant university students	Mixed-methods Non-experimental Cross-sectional Thematic analysis	n=3 680, undergrad/ graduate students; n= 994 male and n= 2 686 female	Survey cover letter sent by admissions department of university, web surveys used	Independent: -Gender -Highest level of education Dependent: -Birth preference -Reason for preference	>91% both men and women preferred SVD, seen as more natural and safer. Negative beliefs in/low confidence of SVD predictive of CD preference.

Nullip = Nulliparous Multip = Multiparous CD = Caesarean delivery OB = Obstetrician SVD = Spontaneous vaginal delivery

Table A2. Summary of the quantitative and mixed methods studies, methods, and findings (Continued)

Study	Location	Purpose	Research Design	Sample	Data Collection	Variables	Outcomes
Turner et al. 2008	Australia	Quantify risks from VD women will accept before requesting CD compared to HCP	Non-experimental Cross-sectional	n=3 680, Nulliparous = 122 midwives = 84 OB = 166 Urogyne = 12 Colorectal = 1	Interview with women, survey with HCPs	Independent: -Willingness to accept risk -Demographics Dependent: -Risks from vaginal delivery	Women are willing to accept higher levels of risk than HCP. Women's acceptability to most like midwives. Women least accepting of fecal/urinary incontinence, emergency CD, and severe tearing.
Wiklund et al. 2007	Sweden	Investigate first time mothers requesting CD: self-esteem, experience of delivery, duration of breast feeding	Prospective, group comparison cohort study	n= 357 PCCD= 91 Planned VD= 266	Questionnaire completed at 37-39 weeks, 2 days PP and 3 months PP	Independent: -Demographics -PCCD -Planned VD Dependent: -Experience -Self-esteem -Breast Feeding	PCCD group had more negative view of own health and more often anxious about potential lack of labour support, loss of control, and maternal or fetal injuries from VD yet had better birth experience. BF same at 2 days PP, but PCCD group breastfed less than VD group at 3 months PP.
Wiklund et al. 2008	Sweden	Examine expectations/ experiences of women undergoing CD by choice or for breech	Prospective, group comparison cohort study	n=496, primiparas PCCD = 104 Breech = 128 Planned VD = 264	Questionnaire completed at 37-39 weeks and 3 months PP	Independent: -Demographics -PCCD -CD Breech -Planned VD Dependent: -Experience -Fear	PCCD group had more negative expectations of SVD. 43.4% had clinically significant fear of birth. Older in age than other groups. Other groups had more negative birth experiences.

VD = Vaginal Delivery PP = Post-partum PPH = Post-partum hemorrhage CD = Caesarean delivery BF = Breast feeding OB = Obstetrician SVD = Spontaneous vaginal delivery

Table A3. Summary of the qualitative studies, methods, and findings

Study	Location	Purpose	Method and Theoretical Foundation	Sample and Recruitment	Setting	Data Collection/ Generation	Findings
Douché and Carryer 2011	New Zealand	Explore the discourse constructing women's choice for a PCCD	Theoretical: poststructuralism Methodological: Foucauldian discourse analysis	n=25 Purposive: Childbearing women, MW, OB by newspapers, bulletins, fliers in staff mailboxes	Urban care center in New Zealand	2 focus groups, 7 women in each 2 focus groups, 5 MWs in each OB underwent guided interview Print sources of PCCD in popular media also included	Themes: Professional and popular portrayals of PCCD: Feminist portrayal Autonomy Risk and prophylaxis
Fenwick et al. 2009	England, South West	Explore experiences of women after a caesarean section	Grounded theory Interviews	n= 21 women who delivered by caesarean, purposive sample First (n= 10) or second-time (n= 11) mothers	In participants' homes	1hr unstructured, audio-taped interviews conducted 7-32 weeks postpartum	Successful passage to motherhood was rooted in achieving normalcy for these women Themes: Expectations/reality Being in control Failure as woman Feeling different
Fenwick et al. 2010	Australia	Describe Australian women's request for CD	Critical Hermeneutics	n=14 women who underwent PCCD for first pregnancy	Telephone questionnaire and interview	45-60min interviews, audio-taped, field notes	Childbirth fear, issues of control and safety were the main reasons for women's choice for CD. Women believed that medical knowledge reinforced CD as s 'safe' and 'responsible' choice.

Nullip = Nulliparous Primip = Primiparous PP = Post-partum PPH = Post-partum hemorrhage CD = Caesarean delivery MW = Midwife OB = Obstetrician

Table A3. Summary of the qualitative studies, methods, and findings (Continued)

Study	Location	Purpose	Method and Theoretical Foundation	Sample and Recruitment	Setting	Data Collection/Generation	Findings
Huang et al. 2012	Taiwan	Understand the decision-making process of choosing a CD among primips	Grounded theory Interviews	n=20 primip, 15 of whom chose CD	Private setting, convenient for participant	1-2hr semi-structured, in-depth interviews Took place post-partum Interviewer emailed or called participant to clarify contents	1) Pre-decision – risk perception, negative pre-existing ideas about SVD caused worry and desire for CD; 2) In-decision – risk assessment, proactive data collection about delivery (7 dimensions); 3) Post-decision – marching onward fearlessly, belief in PCCD and stress relief
Malacrida & Boulton 2012	Canada, AB	Explore women's perceptions of choice and birthing	Thematic analysis No mention of specific theoretical or methodological foundation	n=43 women: nullip = 21, parous = 22 Recruited through support groups, postings, and snowball sampling	Not mentioned	Semi-structured interviews Data collection, transcription and analyses done via team research approach	Choice in birth related to conception of normal femininity: sexuality, sacrificial, and moral CD as a failure of transition into motherhood Themes: -Rite of passage -Feminine dignity and messiness of birth -Motherhood, birth, and sexuality
McAra-Couper et al 2012	New Zealand	Investigate the shaping of understanding and practice related to rising PCCD rates in New Zealand	Critical hermeneutics	n= 42 OB/MW = 9 Women = 33, Purposive recruitment through author's networks	None mentioned	OB/MW – interviews, semi-structured, 60-90 min Women –focus groups, 60-90 min Open ended questions, audiotapes, and transcription used	Choice influenced by social changes; gendering of women; values of control, predictability, convenience, 'quick fix', and normalization of surgery

MW = Midwife OB = Obstetrician

Appendix B

Table B: Interview Guide

Leading Questions	Probing Questions
Tell me about how you came to the decision to have a CD.	• When did you start thinking about what way you wanted to deliver? • What influenced your decision? • What was the most important thing to you regarding your delivery?
How did you ultimately make the decision to have a CD?	• What risks and benefits did you compare? • Who did you talk to about this choice? • Who did you not want to tell? • Who was supportive of your choice? • Who was not supportive?
Looking back, would you change anything?	• Is there anything you wish you had of known before hand? • Is there anything you would have changed about your experience if you could? • Would you make the same decision in future pregnancies?
What has it been like for you to become a mother?	• When did you feel like you became a mother? • What is hardest part about becoming a mother? • What is the easiest part?

Appendix C

Table C: Robson's 10-Group Classification

Number	Group
1	Nulliparous, single, cephalic, ≥37 wks in spontaneous labour
2	Nulliparous, single, cephalic, ≥ 37 wks induced or CD before labour
3	Multiparous (excluding previous CD), single, cephalic, ≥ 37 wks in spontaneous labour
4	Multiparous (excluding previous CD), single, cephalic, ≥ 37 wks induced or CD before labour
5	Previous CD, single, cephalic, ≥ 37 wks
6	All nulliparous breeches
7	All multiparous breeches (including previous CD)
8	All multiple pregnancies (including previous CD)
9	All abnormal lies (including previous CD)
10	All single cephalic, ≤ 36 wks (including previous CD)

(Adapted from Robson, 2001)

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Appendix D

TITLE: *Understanding caesarean deliveries: A choice for new mothers*

INVESTIGATORS: Julia Wigmore RN, BScN, PNC(c) [redacted]
Cynthia Mannion RN, PhD [redacted]
Graham McCaffrey RN, PhD [redacted]

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

The rate of caesarean deliveries has been steadily increasing over the past two decades. Contributing to this rise are women requesting c-section for reasons other than medical indication. Debate among health care professionals has so far not been well informed by knowledge of women's own experiences. This study will explore how women understand their choice for caesarean deliveries.

WHAT IS THE PURPOSE OF THE STUDY?

This qualitative study aims to present an understanding of women's choice for caesarean deliveries and particularly first time mothers' experience of this choice. This research is being conducted as part of a Master of Nursing thesis project at the University of Calgary

WHAT WOULD I HAVE TO DO?

You will be invited to participate in an interview that will last between 60-90 minutes about your experience of caesarean delivery. The interviews will be audio taped. With your permission, the researcher will also review your medical chart to further clarify details regarding your pregnancy and delivery (e.g. diabetes, high blood pressure, anxiety, depression, delivery complications, etc.).

ARE THERE RISKS OR BENEFITS?

There are no foreseeable risks to you as a result of your participation in this research. There are no direct benefits for you, but other people may benefit given the increased understanding of this choice for health care providers.

DO I HAVE TO PARTICIPATE?

Your participation is completely voluntary. Your present and future obstetrical care will not be impacted by your involvement in this study. If you no longer wish to participate in the study prior to or during the interview, you can withdraw by informing the student researcher, Julia Wigmore. Should you wish to withdraw your information after the interview, you can inform the researcher and no further material will be added to the study. However, as discussions from your interview will help shape some of the researcher's understanding, it will be difficult to remove that experience entirely. For your comfort and convenience the interviews will take place at a location specified by you.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will not be paid nor will you be asked to pay for anything during your participation in this study.

WILL MY RECORDS BE KEPT PRIVATE?

Audio tapes and transcripts of interviews will be kept in an encrypted computer and in a locked cabinet in the primary investigator's office at the University of Calgary. Only supervisors and student researcher named will have access to the interview recording and the transcript made of the interview. After the completion of the project the interview recording will be deleted.

The nature of qualitative analysis involves using quotations from the interview in written research reports and presentations. Given the process of qualitative data analysis, we may be unable to ensure anonymity as direct quotations from interviews may be used in documents and future publications. Sometimes this may be identifying and therefore anonymity cannot be completely guaranteed.

IF I SUFFER A RESEARCH-RELATED INJURY, WILL I BE COMPENSATED?

There are no risks expected to occur in this study. However, in the event that you do suffer injury as a result of participating in this research, no compensation will be provided to you by the University of Calgary, Alberta Health Services or the Researchers. You still have all your legal rights. Nothing said in this consent form alters your right to seek damages.

Should you experience distress from recalling issues related to the interview please call the University of Calgary 24-hour Crisis Helpline at **403-266-HELP (4357).**

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Julia Wigmore, RN, BScN, PNC(c) [redacted]
Cynthia Mannion, RN, PhD [redacted]
Graham McCaffrey, RN, PhD [redacted]

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

Participant's Name	Signature and Date
Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix E

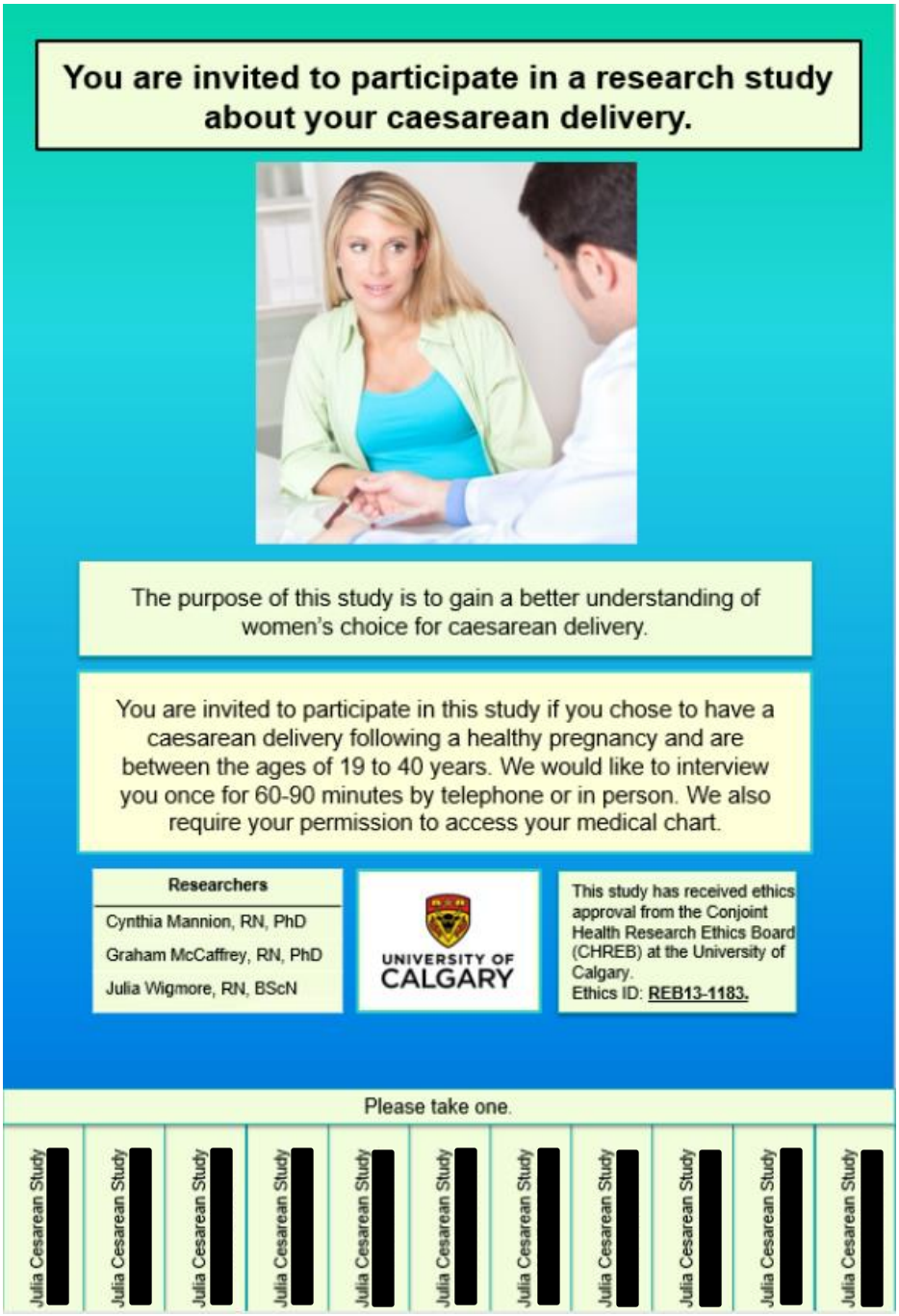

Figure 3. Recruitment poster

Appendix F

Contact Us

If you have any questions or are interested in participating in this research study, please contact:

Julia Wigmore, BSc, BScN, RN, PNC(c)

Phone: [redacted]

Email: [redacted]

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This study has received ethics approval from the Conjoint Health Research Ethics Board (CHREB) at the University of Calgary. Ethics ID: REB13-1183

Your Choice for Caesarean Delivery

Figure 4. Recruitment Brochure

The Caesarean Study

Who we are

We are nurse researchers. Dr. Cynthia Mannion and Dr. Graham McCaffrey are Professors of Nursing at the University of Calgary. Julia Wigmore is a Master of Nursing student at the University of Calgary. Julia is also a Labour and Delivery nurse with an interest in caesarean deliveries and is hoping to better understand your choice and experience of a caesarean delivery.

We want to hear your story! Tell us about:

- How did you decide to have a caesarean delivery?
- What was your experience like?

What is this study about?

Choosing to deliver by caesarean section is becoming more common. This creates a conflict for health care providers to perform the surgery without a medical indication. Debate among health care professionals has so far not been well informed by knowledge of women's own experiences. In this study, we will explore how women understand their choice for caesarean deliveries.

The Process

Step 1

Contact **Julia Wigmore** by phone/email. You can also provide her with your contact information by leaving it with the receptionist at your prenatal appointment.

Step 2


Consent Form

We will provide you with 2 copies of a consent form to read. One to keep for your files, the other you can sign and return it to **Julia Wigmore** by mail using the addressed envelope provided with this pamphlet.

Step 3

Arrange a time and place for you and Julia to meet after the delivery of your baby to discuss your experience. You can expect the interview to take approximately 60–90 minutes.

Figure 4. Recruitment Brochure (continued)