Women's Decision-Making for Subsequent Pregnancy After a Cesarean Delivery

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WOMEN'S DECISION-MAKING FOR SUBSEQUENT PREGNANCY
AFTER A CESAREAN DELIVERY

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THE FACULTY OF THE GRADUATE SCHOOL
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ABSTRACT

The purpose of this study is to generate a theory of the decision making process for women as they choose a birth option after a previous Cesarean delivery. The research method of choice when little is known about the phenomena is qualitative research. A qualitative approach was used to generate a substantive theory of decision making for women deciding subsequent pregnancy birth mode after a previous Cesarean delivery. The classical grounded theory methodology including sampling plan, recruitment, data collection and analysis outlined in Glaser and Strauss (1967) guided this study. Twelve study participants with a history of one previous Cesarean delivery were recruited for this study over a 9-month period. Each interview was audio recorded and transcribed verbatim. Consistent with the grounded theory method, the first interview was coded before proceeding to the second interview (Glaser & Strauss, 1967). Then, data from the second interview was constantly compared to the first interview codes and this process was repeated until all data were collected for the study.

The theory consists of a core category and seven conceptual categories. Based on the data, the decision making process of subsequent pregnancy birth mode of VBAC or RCS after a primary Cesarean birth begins with having a Cesarean delivery for the first birth. This is followed by the women’s judgments of the first Cesarean delivery experience. From the experience of the first Cesarean, women seek information about subsequent birth modes, which leads them to know more about subsequent birth modes and aids in getting to a decision of
wanting a VBAC or wanting a RCS for subsequent birth. In this process, depending on desired birth mode, women search for a supporting provider. The core category is central to other categories, recurrent in the data, and accounts for a majority of the variation in the pattern of behavior (Glaser, 1978). Wanting a different birthing experience emerged as the core category from the data. It was persistent in the data and central to all seven categories.

The theory provides unique implications to nursing research, education, administration and practice. The generated theory in this study will provide a research based theory for healthcare professionals to use to guide them in counseling women as they make the decision of subsequent pregnancy birth mode after a previous Cesarean delivery.
CHAPTER ONE
INTRODUCTION

Care given to pregnant women around their time of birth has changed over the past decade. Despite the excellent health of many pregnant women, childbirth interventions are being used without questioning if the interventions are medically necessary or wanted. One example of a childbirth intervention is a non-medically indicated Cesarean section delivery, often performed on low-risk mothers not presenting with a medical indication of needing a Cesarean section delivery. Women delivering by Cesarean section for first delivery face a decision to deliver Vaginal Birth after Cesarean section (VBAC) or repeat Cesarean section (RCS) in a subsequent pregnancy.

The occurrence of Cesarean births has increased in recent years from 31.1% in 2006, 32.2% in 2007, to 32.8% in 2010 and remained stable for 2011 and 2012 (MacDorman, Menacker, & Declercq, 2008; Martin, Hamilton, Ventura, Osterman, & Mathews, 2013). In 2013, the total Cesarean section rate in the United States was 32.7% (Martin, Hamilton, Osterman, Curtin, & Mathews, 2015). Approximately 1.2 million women delivered via Cesarean delivery in the United States in 2013 (Martin et al., 2015). In 2015, the overall Cesarean rate decreased to 32.0% (Martin, Hamilton, Osterman, Driscoll, & Mathews, 2017) and declined to 31.9% in 2016 (Martin, Hamilton, Osterman, Driscoll, & Drake, 2018).

Increases in Cesarean deliveries are partially a result of increased primary Cesarean rates. A primary Cesarean section is defined as a live birth or births delivered by Cesarean section to
mothers with no previous history of a Cesarean section delivery. In 1996, primary Cesarean rates in the United States were 14.6% (Martin et al., 2006). The rates have continued to increase from 20.6% in 2004 to 22.8% in 2013 (Centers for Disease Control and Prevention, 2014; Martin et al., 2006). In 2014, the primary Cesarean rate for low-risk mothers was 26.0% (Hamilton et al., 2015) and decreased to 25.8% in 2015 (Martin et al., 2017). In 2016, the low-risk Cesarean delivery rate was 25.7% and the primary Cesarean rate was 21.8% (Martin et al., 2018).

Cesarean delivery rates vary by state and territory. Utah has the lowest rate at 22.8% and Mississippi the highest at 38.0% (Martin et al., 2017). In 2015, Puerto Rico had a total Cesarean rate of 46.7%. In 2015, the state of Illinois had a Cesarean rate of 31.0% (Martin et al., 2017). Cesarean rates also vary for race, ranging from the highest in non-Hispanic black women (35.9%), Hispanic (31.7%), to the lowest in American Indian or Alaska native (28.0%) (Martin et al., 2018). Martin et al. (2018) found 47.9% of mothers aged 40-54 years delivered by Cesarean delivery compared to mothers 20 years of age and younger (20.2%). Cesarean rates are higher for women with a college education compared to women with less than a high school diploma (MacDorman, Declercq, & Menacker, 2011).

Many primary Cesarean deliveries are done as an elective procedure without the mother presenting with a medical or obstetric indication. Cesarean delivery by maternal request (CDMR) is defined as a Cesarean delivery for a singleton pregnancy, requested by the mother, without a medical indication (NIH, 2006). Hospitals offering CDMR have higher Cesarean rates compared to hospitals where CDMR is not offered (Lundsberg et al., 2017). In 2003, the rate of primary Cesarean deliveries without medical indication was 6.9% (MacDorman et al., 2008). This number has almost doubled since 1996 with rates of 3.7% (MacDorman et al., 2008). The
rate for first time mothers is even higher with 11.2% of mothers having a Cesarean delivery, who did not present with a medical indication (MacDorman et al., 2008). Physicians have identified CDMR as a major factor for the increasing rate of Cesarean deliveries, however, Romero, Coulson, and Galvin (2012) investigated women’s preferences and motivations for their desired mode of delivery and found 89% of primigravidas and multigravidas preferred vaginal deliveries, suggesting little contribution of CDMR to the increasing Cesarean delivery rate. The majority of the women, including women needing a repeat Cesarean delivery (RCS) desired a non-surgical, natural, vaginal delivery. Reasons for women choosing CDMR were medical problems, possible need for Cesarean, lack of confidence to deliver vaginally, bilateral tubal ligation and prevention of birth injury. Repeat Cesarean delivery candidates desired a vaginal delivery for reasons such as preferring and wanting to experience a natural birth, faster recovery and preventing surgery (Romero et al., 2012). Kalish, McCullough, Gupta, Thaler, and Chervenak (2004) investigated the incidence and factors influencing patients requesting Cesarean delivery during the intrapartum phase during labor. Patients planning elective Cesarean delivery who were prohibited from laboring were excluded. Overall, 45.1% of Cesarean deliveries were performed on laboring patients. Of those, 13% of the patients were offered Cesarean delivery before a medical indication and 8.8% electively requested Cesarean delivery during the labor. Physician reasons for offering Cesarean delivery were slow labor progression, fetal-maternal well being, and suspected macrosomia. Reasons for maternal request were exhaustion, fear of pushing, and concern about fetal status.

With Cesarean deliveries, there is the decision of subsequent birth option of Vaginal Birth after Cesarean section (VBAC) or repeat Cesarean section (RCS). Rates for VBAC
dropped from 28% in 1996, to 23% in 2001, to 12.7% in 2002 (Hamilton, Martin, Sutton, 2003). This dramatic decrease was partially attributed to a well publicized study in *The New England Journal Of Medicine* (McMahon, Luther, Bowes, & Olshan, 1996) reporting that VBAC resulted in more maternal complications than a repeat Cesarean Section. The decrease in VBAC reflects the restrictions that some hospitals and insurers placed on trial of labor after Cesarean (TOLAC) as well as decisions by patients when presented with the risks and benefits. Both VBAC and RCS have risks for the mother and baby, yet, researchers have found VBAC as an appropriate choice of delivery for subsequent birth mode after a Cesarean delivery (Guise et al., 2010). The American College of Obstetricians and Gynecologists (ACOG, 2017) guidelines recommend that women with one low transverse Cesarean section be counseled and offered a trial of labor. In 2004, the rates of TOLAC dropped to 9.2% (Martin et al., 2006) and continued to decrease to 8.3% in 2007 (Martin et al., 2010). In 2010, rates of TOLAC increased to 9.2% (Martin et al., 2012), 10.6% in 2013 (CDC, 2014), 11.9% in 2015 (Martin et al., 2017), and 12.4% in 2016 (Martin et al., 2018). Martin et al. (2018) found women aged 40 years and older (10.7%), and Hispanic women (11.5%) have the lowest VBAC rates. Cheng, Declercq, Belanoff, Iverson, and McCloskey (2015) reported in the state of Massachusetts younger maternal age (<20 years) and older gestational age (≥ 40 weeks) were associated with higher rates of VBAC. The authors reported non-Hispanic Asian women had a greater success rate of VBAC compared to other race/ethnicity groups (Cheng et al., 2015). The rate of successful VBAC reached a high of 69.8% in 2000 and a low of 38.5% in 2008 (Uddin & Simon, 2013). In 2009, the rate of successful TOLAC was 41% (Uddin & Simon, 2013). In 2006, successful VBAC deliveries were less than 10 per 100 women with a previous Cesarean Section (Hamilton, Martin, Ventura, 2007).
The main reason for the decrease in VBAC is contributed to Dr. E.B. Cragin’s (1916) address entitled "Conservatism in Obstetrics" to the Eastern Medical Society of New York in which he coined the phrase "Once a Caesarean, always a Caesarean." (Cragin, 1916). For most of the twentieth century, doctors followed this view believing that once a woman delivered by Cesarean section she should deliver all future pregnancies by repeat Cesarean section. However, clinical studies in the 1960’s concluded that this practice was not always necessary. Menacker, MacDorman, and Declercq (2010) examined trends and characteristics of repeat Cesarean deliveries of mothers between 1998 and 2002, and reported prior Cesarean delivery was a major indication for a repeat Cesarean delivery for more than 90% of women, even when there was not a medical indication. Zhang et al. (2010) collected labor and delivery information from 228,668 medical records from 19 hospitals across the United States between 2002 and 2008. The authors found repeat Cesarean deliveries due to previous uterine scar accounted for 30.9% of all Cesarean sections. In women with a previous uterine scar, 28.8% had a trial of labor and 57.1% were successful. Induced labor was associated with twice as many Cesarean deliveries than spontaneous labor. The authors found half of the Cesarean deliveries for dystocia in induced, nulliparous and women attempting VBAC were performed before 6cm of cervical dilation (Zhang et al., 2010). Faucett, Allshouse, Donnelly, and Metz (2016) found obese women are more likely to undergo RCS for arrest in labor before active labor (<6cm) despite more standard clinical interventions (maximum oxytocin dose, longer duration of oxytocin, IUPC placement and allowance of longer labor) than non-obese women.

Repeat Cesarean delivery rates vary by region in the United States. California, Texas, Florida and Maine are several states with the highest repeat Cesarean section rates of 90% to
93.9% (MacDorman et al., 2011). Illinois, New York, and Oregon are several states with the lowest between 74% and 83.9%. VBAC rates vary with California having the lowest (4.7%) to Vermont having the highest (19.4%) (MacDorman et al., 2011).

Influential factors are a key to the decision making process of VBAC or RCS, however, these influential factors continue to highlight the uncertainty woman face when deciding on a birth option. Shorten, Shorten, and Kennedy (2014) found women’s reasons of uncertainty of birth mode were highlighted by needing more information about deliveries and advice provided by doctors and medical providers. Women deciding for trial of labor for subsequent pregnancy after a Cesarean section decided on choice of delivery because of ease/speed of delivery, feelings that vaginal birth is normal and natural, and desiring to experience labor (Shorten et al., 2014). Wu et al. (2014) found women desiring a Cesarean delivery without a medical indication desired delivery mode for convenience, less time and pain, resulting in a faster recovery than a vaginal delivery. Women receiving prenatal care from a Certified Nurse Midwife (CNM) for subsequent pregnancy after a Cesarean delivery choose VBAC for reasons of faster and easier recovery and personal importance of having a vaginal delivery (Chinkam, Ewan, Koeniger-Donohue, Hawkins, & Shorten, 2016). The reasons for choosing an elective repeat Cesarean delivery (ERCS) were positive experience with previous Cesarean, convenience of knowing birth date, and being afraid of vaginal complications (Chinkam et al., 2016). Emmett, Montgomery, and Murphy (2010) explored women’s mode of delivery preferences at 19 and 37 weeks gestation with one previous Cesarean. The authors found 56.9% preferred the same mode of delivery at 19 and 37 weeks, 31.8% changed from being unsure at 19 weeks to a preference at 37 weeks, 8.1% changed from one preference to another, 2.3% changed from a delivery preference to being
unsure, and 0.8% were unsure at both times. Amongst the women who changed from one preference to another, 75% changed their preference from VBAC to RCS (Emmett et al., 2010).

A major influence in a woman’s decision of choosing VBAC or RCS is the information about birthing options provided to the mother. However, information coming from family, friends, media, other women experiencing the decision making process of birth option, and health care practitioners is not always completely useful or trustworthy (Farnworth, & Pearson, 2007). Obstetricians are influential and powerful in the decision making process (McGrath, Phillips, & Vaughan, 2010b) as many women report considerable pressure from healthcare providers to not choose a TOLAC (Lundgren, Begley, Gross & Bondas, 2012). Fenwick, Gamble, and Hauck (2006) reported that medical providers often intensify women’s concerns and fears regarding birth option, concluding women often follow the advice of their provider, consenting to the delivery rather than choosing a birthing option they feel is safest for them and the baby. Dahlen and Homer (2013) found women deciding subsequent pregnancy birth mode after a Cesarean feel healthcare providers reinforce the belief that their bodies are inadequate to deliver vaginally. The authors found that providers are not supportive and have negative attitudes regarding women delivering VBAC (Dahlen & Homer, 2013; Lundgren et al., 2012). However, Godden et al. (2012) found women stated their medical providers and midwives were confident, supportive and did not fear VBAC.

Information received during pregnancy influences childbirth preference and satisfaction (Renner, Eden, Osterweil, Chan, & Guise, 2007). However, women are receiving insufficient information about birthing options of VBAC or RCS (Renner et al., 2007; Chigbu, Enwereji, & Ikeme, 2007; Schoorel et al., 2014). As a consequence of receiving insufficient information,
many women feel a sense of uncertainty and difficulty in making a decision between VBAC or RCS (Farnworth, Robson, Thomson, Watson, & Murtagh, 2008), and report lacking knowledge regarding the risks and benefits of delivery options (Berstein, Matalon-Grazi, & Rosenn, 2012; Chen & Hancock, 2012). Women reported information provided from health care providers is minimal, wanting information specific to their particular situation rather than general information about birth options (Moffat et al., 2007). Women deciding birth mode after previous Cesarean delivery report clear and relevant information about birth modes is hard to find (Schoorel et al., 2014). Information provided to women by health care professionals often relate to actual procedures rather than health risks and benefits of birthing option (Emmett, Shaw, Montgomery, & Murphy, 2006). However, Meddings, Phipps, Haith-Cooper, and Haigh (2007) and Chinkam et al. (2016) found most women are provided enough information and feel involved in the decision process.

Pregnant women utilize the internet for information, empowerment, and to share experiences and support to assist in their decisions (Lagan, Sinclaire, & Kernohan, 2011; Konheim-Kalkstein, Whyte, Miron-Shatz & Stellmack, 2015). Konheim-Kalkstein, Barry, and Galotti (2014) and Romano, Gerber, and Andrews (2010) found the internet as a powerful source on women’s decision to choose a VBAC. For some women, finding a healthcare provider and hospital permitting VBACs can be challenging. Konheim-Kalkstein et al. (2015) found women contemplating a VBAC utilize VBAC online discussion boards to seek information and advice about finding and communicating with health care providers. However, Bantan and Abenhaim (2015) assessed the quality of online information in relation to VBAC using the most common search engine Google, and found online sites required a college reading level, making the
information beyond comprehension for the general population. Peddie, Whitelaw, Cumming, Bhattacharya, and Black (2015) assessed the content and presentation of web-based information regarding birth after a previous Cesarean and found government funded agency sites were the most user friendly and provided evidenced-based information of risks and benefits of both VBAC and RCS.

Practical issues influence a woman’s decision to choose a birthing option of VBAC or RCS. These influences include the need to maintain family obligations, inability to drive for several weeks after a Cesarean delivery, needing assistance from other family members, and financial strains from a longer recovery period after a Cesarean delivery (Eden, Hashima, Osterweil, Nygren, & Guise, 2004; Moffat et al., 2007; Meddings et al., 2007; Shorten et al., 2014). Cleary-Goldman, Cornelisse, Simpson and Robinson (2005) found women having a VBAC after a previous Cesarean delivery were more satisfied with their birth and rated their recovery as better than after a Cesarean delivery. Women attempting VBAC but having a RCS reported having the most difficult recovery and were least satisfied with their birth (Cleary-Goldman et al., 2005). However, the majority of women attempting VBAC but not succeeding were overall pleased with their birth experience because they attempted a trial of labor. Women having a successful VBAC were found to have the highest scores of satisfaction, whereas, instrumental birth and emergency Cesarean delivery had the lowest satisfaction scores. (Shorten, Shorten, Keogh, West, & Morris, 2005; Cleary-Goldman et al., 2005). However, Law et al. (2010) did not find a significant difference between satisfaction and mode of delivery for subsequent pregnancy after a previous Cesarean delivery.

A woman’s previous delivery is a major influence in the decision making process of birth
option with subsequent pregnancy after a Cesarean delivery. Women who preferred a RCS indicated they knew what to expect (Moffat et al., 2007), Cesarean section was a quick procedure (Moffat et al., 2007), experienced an uncomplicated previous Cesarean delivery (Shorten & Shorten, 2014), and feared emergency Cesarean section or uterine rupture (Moffat et al., 2007). Women who preferred TOLAC experienced a horrific previous Cesarean section (Moffat et al., 2007; Lundgren et al., 2012), experienced problems with their previous Cesarean section (Shorten & Shorten, 2014), or birthed vaginally in a past pregnancy (Shorten & Shorten, 2014). Shorten & Shorten (2012) found women having experienced either an emergency Cesarean section or instrumental vaginal birth would less likely chose to make the same choice of delivery in a subsequent pregnancy. Godden et al. (2012) found women achieving VBAC felt their previous Cesarean delivery experiences were unacceptable, disappointing, along with feeling “ripped off”. These feelings from their last pregnancy reinforced their decision to have a VBAC for subsequent birth.

The decision making process of deciding on a birth option after a Cesarean section is an individual decision that each woman will make if given the chance. If given the chance, most women express the need to be involved with their decision of birth option (Hundley, Ryan, & Graham, 2001), however, the amount of involvement varies on an individual basis. Women vary in involvement of their decision of birth option from minimal to total involvement (Moffat et al., 2007). Some women are afraid to make the decision alone wanting input from their clinicians, while others want complete control in making the decision about their birth decision. Health care professionals should guide women in the decision making process of birth option through providing them with sufficient, valid information so that they can make a personal decision.
(Moffat et al., 2007; Frost, Shaw, Montgomery, & Murphy, 2009; Fenwick et al., 2006).

Provider practice style and provider cognitive traits are a major influence for women deciding VBAC or RCS. Women with one previous Cesarean are more likely to attempt TOLAC and have a successful VBAC if they are cared for by an Obstetrician with high proactive coping skills and lower trait anxiety (Yee, Liu, Grobman, 2015). High proactive coping and lower trait anxiety was characterized as behaviors such as self confidence and efficacy, proactive goal attainment, and the ability to manage anxiety and cope with situations during periods of uncertainty and stress (Yee et al., 2015). According to Wells (2010) physician practice patterns are biased and impact the decision of birth mode after a previous Cesarean delivery. Physicians more likely to offer VBAC deliveries practice in a hospital delivering more than 5000 deliveries per year, a hospital with an in-house Obstetric resident, and the physician performs fewer than 100 or greater than 200 deliveries a year (Kenton, Brincat, Mutane, & Brubaker, 2005; Wells, 2010). However, Wells (2010) found Obstetricians practicing less than ten years were likely to be non-VBAC providers. Physicians not offering VBAC deliveries had previously cared for women with a uterine rupture that resulted in maternal hemorrhage, organ injury, hysterectomy, neonatal complications, or they had previously been involved in a medical malpractice litigation related to their failure to perform, delay in performance, or complications during a Cesarean delivery (Wells, 2010). Out of 219 non-VBAC providers, 88% said they would not reconsider changing their policy and offering VBAC to their patients because of risks of adverse outcomes, belief that VBAC is not safe, liability concerns, and mandated guidelines put into practice by ACOG (2010) stating a physician and anesthesiologist have to be “immediately available” during a trial of labor (Wells, 2010).
A variety of clinicians, besides Obstetrician-Gynecologists, attend to healthcare needs of pregnant women. Certified Nurse Midwives (CNMs), Nurse Practitioners (NPs), and Physician Assistants (PAs) provide a range of care to women before, during, and after pregnancy (Kozhimannil, Avery, & Terrell, 2012). In recent years, there has been a substantial increase in the percentage of pregnant women who report receiving care from a midwife, PA, or NP. Kozhimannil et al. (2012) found that the percentage of pregnant women receiving care from midwives, NPs, and PAs has increased by 48% over the past decade. The researchers also found a 30% increase in the percentage of pregnant women receiving care from both an Obstetrician-Gynecologist and a midwife, NP, or PA. In 2010, medical doctors (MDs) attended the vast majority (86.3 %) of hospital births, followed by CNMs (7.6 %), and doctors of osteopathy (DOs) (5.7 %) (Martin et al., 2012). Researchers reported that CNM’s caring for pregnant women through pregnancy, birth and postnatal phases have significantly reduced the Cesarean section rate (McLachlan et al., 2012). Hospitals staffing an in-house CNM at all times have lower Cesarean rates compared to hospitals without a CNM at all times (Lundsberg et al., 2017). Women having CNMs for their care are less likely to use regional analgesia, use intrapartum analgesia/anesthesia, or use instruments during the birth, along with feeling in control during labor and childbirth, and experience spontaneous vaginal birth (Hatem et al., 2008). Rosenstein, Nijagal, Nakagawa, Gregorich, and Kuppermann (2015) found that offering an in-house, 24 hour/day, collaborative midwifery-Obstetrician (laborist) team to privately and publicly insured patients was associated with a decrease in the rate of primary Cesarean deliveries and increase in VBAC rates. However, Feldman et al. (2015) found community hospitals in California staffing laborists had more women attempting VBAC, had lower RCS rates, but no difference in VBAC
success rates or primary Cesarean rates when compared to non-laborist hospitals.

In 2013, the United States national inpatient hospital costs totaled $381.4 billion, and liveborn (principal diagnosis) was the third most expensive condition treated in United States hospitals by all payers (Torio & Moore, 2016). In 2013, hospitalizations related to pregnancy and childbirth accounted for five of the twenty most expensive conditions for hospital stays covered by Medicaid, and three of the twenty covered by private insurance (Torio & Moore, 2016). Previous Cesarean section was the eighth most expensive condition during hospital stay billed to Medicaid, and sixteenth billed to private insurance (Torio & Moore, 2016). For uninsured individuals, liveborn was the sixteenth most expensive condition for hospital stays. Yet, despite significantly higher healthcare spending levels than other countries in the world, the United States ranks 50th in the world for maternal mortality (WHO, 2010) and 26th in infant mortality (MacDorman, Matthews, Mohangoo, & Zeitlin, 2014). Healthy People 2020 priorities include the provision to decrease the national Cesarean rate by 10 percent by 2020 (Office of Disease Prevention and Health Promotion, 2014). To accomplish this goal, research is needed to identify major influences that affect pregnant women when making decisions about a subsequent pregnancy after a previous Cesarean birth. A substantial number of international research studies have been done in the area of women making decisions regarding a subsequent pregnancy after a Cesarean birth. However, an empirically generated theory is needed, grounded in the experience of women, to discover, explain and describe the process pregnant women go through deciding VBAC or RCS, in the United States, within our healthcare system.

The purpose of this study is to generate a theory of the decision making process for women as they choose a birth option after a previous Cesarean delivery. The research method of
choice when little is known about the phenomena is qualitative research. For this study, classical grounded theory methodology will be used. The grounded theory method was used to generate a theoretical model explaining the basic social process of the decision making process of subsequent birth mode after a previous Cesarean delivery. The research question for this study is, “What is the experience of women deciding subsequent birth option of VBAC or RCS after a previous Cesarean Section delivery?” It is anticipated that findings from the proposed grounded theory study will provide a research based theory for healthcare professionals to use to guide them in counseling women as they make the decision for the delivery of their next baby. Grounded theory methodology is the research design of choice to generate an empirically derived substantive theory for decision making of birth option after a previous Cesarean delivery.
CHAPTER TWO
LITERATURE REVIEW

This chapter is a review of the literature related to decision making of subsequent birth mode after a previous Cesarean delivery, including a brief history of Cesarean birth and VBAC, along with current literature about risks and outcomes for both delivery modes, success rates of VBAC, and current ACOG (2010) VBAC guidelines.

Decision making is an important and necessary process of human nature. As a result, the decision making process occurs every day in life, especially in healthcare. Literature in clinical decision making, a term used for decision making in healthcare, has increased over the last decade with particular emphasis on how patients make decisions regarding their healthcare. This decision making process varies for individual patients, where some feel uncertain about making a decision, while others insist a need to be completely involved, wanting total control of the decision being made. Understanding the patient’s desire to participate in the decision process will provide health care professionals with information about health beliefs, concerns, and overall health behaviors of their patient. Understanding a patient’s desire to be involved in clinical decision making will help health care professionals provide appropriate patient education and individualized care to maximize a desired outcome for their patient.

The decision making process for birth option of subsequent pregnancy after a previous Cesarean section delivery is very challenging for some women. A woman’s decision for mode of delivery can be influenced by a previous birth, family obligations, risks involved in the
procedure, a family member, or health care provider. Some women prefer to participate in the decision of birth option, however, many women have found the decision process very complex. Some women experience a sense of uncertainty and need complete guidance, while others seek to be involved in their decision of birth method wanting some guidance from their provider, and some women, adamant about delivery method, want total control of the decision.

The concept of decision making of subsequent birth mode after a previous Cesarean delivery was investigated by conducting a literature search using Cumulative Index of Nursing and Allied Health Literature (CINAHL) Plus, Ovid Medline, Science Direct, and ProQuest Dissertation and Theses. Key words searched included decision making, VBAC, TOLAC and Cesarean delivery. The keyword decision making produced over 101,000 results. When combining terms, decision making and VBAC, over 70 results were identified. Combining terms decision making and Cesarean delivery produced over 200 results. The criteria for inclusion of articles included literature between 2000-2018. Quantitative and qualitative peer reviewed research articles were selected with an emphasis of women’s decision making with one previous Cesarean delivery and healthcare provider and healthcare system involvement in decision making of subsequent pregnancy birth mode after a previous Cesarean delivery.

In reviewing articles about decision making in the health care literature, particular to the decision making process of VBAC or RCS, much of the literature focuses on the provider’s practice patterns in the decision of VBAC or RCS, the patient’s role/involvement in the health care decision, influencing factors in the decision process, and the relation of the influencing factors to the final decision and delivery outcome. In the next section, the history of Cesarean birth and VBAC, current literature of risks and outcomes for both delivery modes, success rates
of VBAC, and ACOG (2010, 2017) VBAC guidelines will be discussed. Following, are three main sections of the literature review: decision making-provider, decision making-hospital, decision making-patient.

**History**

Between 1970 and 2011, Cesarean delivery rates have significantly increased from 5% to 32.8% (ACOG, 2010; Martin et al., 2013). The first written record of a Cesarean delivery was in 1500. The husband performed the operation on his wife. After several days in labor and help from 13 midwives, the woman was unable to deliver her baby. As a desperate measure, the husband gained permission from local authorities to attempt a Cesarean. Because the story was not recorded until 82 years later, historians question its accuracy. The first recorded successful Cesarean was conducted in the British Empire. Sometime between 1815 and 1821, James Miranda Stuart Barry performed the operation while masquerading as a man and serving as a physician to the British Army in South Africa (United States National Library of Medicine, 2011).

As Cesarean deliveries became safer, Obstetricians increasingly argued against delaying surgery. Rather than waiting hours/days of unsuccessful labor, doctors in the USA, Germany, and United Kingdom decided to operate more in order to improve the outcomes for mother and baby. However, in the 1970’s, women began to achieve successful VBAC and this mode of delivery was viewed as a reasonable option for women (ACOG, 2010). Vaginal Birth after Cesarean rates increased from 5% in 1985 to 28% in 1996 (ACOG, 2010). However, by 2002, VBAC rates had decreased to 12.7%. The reason for this significant decrease is a well publicized study in *The New England Journal of Medicine* stating VBAC resulted in more maternal
complications, especially uterine rupture, than a repeat Cesarean delivery (McMahon, Luther, Bowes, & Olshan, 1996). This article led hospitals, insurance companies and physicians to put restrictions on VBAC deliveries. From this action, VBAC rates decreased to 8.3% in 2007 (ACOG, 2010).

Due to a drastic decrease in VBAC rates, the National Institutes of Health (NIH) examined the safety and outcome of Trial of Labor after Cesarean (TOLAC) and recommended TOLAC was a reasonable option for many women with a prior Cesarean delivery (NIH, 2010). Subsequently, VBAC rates increased from 9.2% in 2010, to 10.6% in 2013, to 11.9% in 2015 (Martin et al., 2012; Martin et al., 2015; Martin et al., 2017).

**Maternal Morbidity and Mortality Rates**

Success and failure rates along with risks of VBAC and RCS are crucial for healthcare professionals to communicate with women deciding subsequent birth mode after Cesarean delivery. Neither VBAC nor Cesarean delivery is without maternal and neonatal risks (ACOG, 2010). Maternal morbidity rates increase progressively with increasing number of Cesarean deliveries (Silver et al., 2006; Marshall, Fu, & Guise, 2011). Lydon-Rochelle, Cahill, and Spong (2010) and Curtin, Gregory, Korst, and Uddin (2015) found women with a previous Cesarean delivery, having a successful VBAC have fewer hysterectomies, thromboembolic events, blood transfusions, ICU admissions and shorter hospital stays compared to women having an elective repeat Cesarean delivery (ERCS). However, women having a failed TOLAC, needing an emergency repeat Cesarean delivery have increased rates of uterine rupture, hysterectomy, operative injury, blood transfusion, endometritis, ICU admission, longer hospital stay, choriamnionitis, and major neonatal morbidities compared to women with elective repeat
Cesarean deliveries (Lydon-Rochelle et al., 2010; El-Sayed et al., 2007; Curtin et al., 2015; Rossi & D’Addario, 2008; Landon et al., 2004). Hehir, Mackie, and Robson (2017) found women with one previous Cesarean delivery, presenting in spontaneous labor, attempting TOLAC but ultimately needing a repeat intrapartum Cesarean delivery had greater blood loss (>1000ml) compared to women having a successful VBAC. Cahill, Tuuli, Odibo, Stamilio, and Macones (2010) found maternal morbidity (uterine rupture, bladder injury, surgical injury, blood transfusion, fever) in women with three or more previous Cesarean deliveries attempting VBAC were not significantly different from women with one previous Cesarean delivery attempting VBAC and women delivering by elective repeat Cesarean delivery. Women attempting VBAC who have a history of previous abdominal surgery or who underwent augmentation or induction of labor have an increased risk for major maternal morbidity (uterine rupture, bladder injury, bowel injury) (Scifres, Rohn, Odibo, Stamilio, & Macones, 2011). Women attempting VBAC with a prior vaginal delivery have a decreased risk of maternal morbidity (Scifres et al., 2011). Maternal morbidity rates increase for women eligible for a TOLAC having a greater body mass, of African-American ethnicity, and no prior vaginal delivery (Grobman et al., 2009a; Hibbard et al., 2006). Overall estimates of maternal death number 3.8 per 100,000 for women who have a TOLAC compared to 13.4 per 100,000 for elective repeat Cesarean delivery (NIH, 2010). At term (39 weeks and greater) the numbers decrease to 1.9 per 100,000 for TOLAC compared to 9.6 per 100,000 ERCS (NIH, 2010). Guise et al. (2010) found maternal mortality significantly increased for women having an elective repeat Cesarean delivery (0.013%) compared with TOLAC (0.004%).

The principle risk of TOLAC that significantly increases the chance of maternal or
neonatal death is uterine rupture. Uterine rupture rates are higher for women attempting VBAC than elected repeat Cesarean Section (ERCS) (Rossi & D’Addario, 2008; Guise et al., 2010; NIH, 2010; Fitzpatrick et al., 2012; Stattmiller, Lavecchia, Czuzoj-Shulman, Spence, & Abenhaim, 2016). Curtin et al. (2015) found rates of uterine rupture were not significantly different between successful VBAC births and repeat Cesarean births without a trial of labor. However, rates of uterine rupture with a failed trial of labor were seven times higher (495.4 per 100,000) than for women with repeat Cesarean deliveries who did not labor (65.6 per 100,000) (Curtin et al., 2015). Rates of uterine rupture and dehiscence are lower for preterm TOLAC pregnancies compared to term TOLAC pregnancies (Durnwald et al. 2006). Women with two or more Cesarean deliveries (Macones et al., 2005; Tahseen & Griffiths, 2010; Fitzpatrick et al., 2012; Barger et al., 2011), short interval (< 12 months) since their last Cesarean delivery, placenta previa (Fitzpatrick et al., 2012), unfavorable cervix (Harper et al., 2012), gestation greater than 40 weeks (Barger et al., 2011), epidural analgesia (Hesselman, Hogberg, Ekholm-Selling, Rassjo, & Jonsson, 2015) and macrosomia (Barger et al., 2011; Jastrow et al., 2010; Hesselman et al., 2015) have increased risk for uterine rupture. A previous vaginal delivery or spontaneous labor decrease the risk of uterine rupture for women with a previous Cesarean delivery (Barger et al., 2011; Algert, Morris, Simpson, Ford, & Roberts, 2008; Macones et al., 2005). Hibbard et al. (2006) found morbidly obese women having a TOLAC have a greater risk of uterine rupture/dehiscence than morbidly obese women having an ERCS. Fitzpatrick et al. (2012) found the incidence of uterine rupture was 2.1 per 1,000 for women with a previous Cesarean delivery attempting VBAC compared to 0.3 per 1,000 for women with a previous Cesarean delivery having an elective repeat Cesarean delivery.
Uterine rupture is increased with the induction or augmentation of labor with oxytocin (Landon et al., 2004; Algert et al., 2008; Fitzpatrick et al., 2012; Barger et al., 2011) and prostaglandin (Fitzpatrick et al., 2012; Hesselman et al., 2015). Palatnik and Grobman (2015) compared obstetric outcomes between women experiencing induction of labor versus expectant management with one previous low transverse Cesarean delivery. Uterine rupture risk was higher for women induced at 39 weeks gestation compared to women undergoing expectant management (Palatnik & Grobman, 2015). However, Harper et al. (2012) found after accounting for labor duration, the risk of uterine rupture for induced women having a TOLAC was similar to the risk for women having spontaneous labor having a TOLAC. Shatz et al. (2013) found no difference in rate of uterine rupture between women who had an induction of labor, ERCS and spontaneous labor with one previous Cesarean delivery. Similarly, Ouzounian, Miller, Hiebert, Battista, and Lee (2011) assessed the rate of uterine rupture in patients undergoing labor induction for attempted VBAC in the southern California Kaiser Permanente System between 1998 and 2001. A total of 16,218 patients had a prior Cesarean delivery. Of these, 42.1% had a trial of labor. Women experiencing spontaneous labor had a VBAC success rate of 86% compared to patients with labor induction having a 66% success rate. The uterine rupture rate was not significantly different between women with spontaneous labor or induction of labor using oxytocin or prostaglandin. Hesselman et al. (2015) found no increased risk of uterine rupture when comparing a single layer uterine closure to a double layer closure.

**Neonatal Morbidity and Mortality Rates**

Neonatal adverse outcomes such as hypoxic-ischemic encephalopathy occur more in women having a TOLAC compared to women having an elective repeat Cesarean delivery
(Landon et al., 2004). Over half of the cases of hypoxic - ischemic encephalopathy occurred following uterine rupture (Landon et al., 2004). Holmgren, Scott, Porter, Esplin, and Bardsley (2012) found the estimated time frame from diagnosis of uterine rupture to delivery being a significant variable affecting neonatal adverse outcomes. Neonates delivered within 18 minutes after a diagnosis of uterine rupture have decreased risk of neonatal adverse outcomes. Neonatal adverse outcomes increase when an infant is delivered more than 30 minutes after diagnosis of uterine rupture to delivery (Holmgren et al., 2012).

Guise et al. (2010) found perinatal mortality significantly increased for TOLAC (0.13%) compared to ERCS (0.05%). Perinatal mortality is increased for a trial of labor (130 per 100,000) compared to elective repeat Cesarean delivery (50 per 100,000) (NIH, 2010). Crowther, Dodd, Hiller, Haslam, and Robinson (2012) found women with one previous Cesarean delivery having a planned ERCS for their subsequent delivery had lower fetal and infant death rates or serious infant outcomes compared to women having a planned VBAC. Neonatal mortality rate (first 28 days of life) is 100 per 100,000 for women having a TOLAC compared to 50 per 100,000 for elective repeat Cesarean delivery (NIH, 2010). Menacker et al. (2010) found neonatal mortality was 29% higher for low risks mothers (singleton, full term, vertex presentation) delivering repeat Cesarean delivery compared to VBAC. Infants born to mothers with one previous Cesarean delivery, who presented in spontaneous labor and attempted TOLAC, but ended up needing a repeat intrapartum Cesarean, were more likely to have Apgar scores <7 at 5 minutes, requiring NICU admission, compared to infants born to mothers having a successful VBAC (Hehir et al., 2017).

Neonatal respiratory conditions occur more in high- risk (one maternal condition) women
having a VBAC than low-risk (no maternal condition) (Gregory et al., 2008). Hibbard et al. (2006) found morbidly obese women delivering an infant via VBAC had increased neonatal injury (fractures, brachial plexus injuries, lacerations) than morbidly obese women delivering via ERCS. Infants delivered by successful VBAC have lower rates of respiratory morbidity and NICU admission than infants delivered RCS (Kamath, Todd, Glazner, Lezotte, & Lynch, 2009; Kolas, Saugstad, Daltveit, Nilsen, & Oian, 2006). However, neonates born by failed VBAC required the most significant measures of resuscitation (bag or mask ventilation and endotracheal intubation) compared to elective repeat Cesarean delivery (Kamath et al., 2009). Researchers have found no significant differences in five minute Apgar scores of 6 or less between infants born VBAC versus ERCS (Agency for Healthcare Research and Quality, 2010).

In summary, both VBAC and elective repeat Cesarean delivery are associated with maternal and neonatal morbidity and mortality risks. Women with one low transverse Cesarean delivery should be counseled and offered a TOLAC (ACOG, 2017). Successful VBAC is associated with decreased maternal morbidity/mortality risks compared to elective repeat Cesarean delivery (ACOG, 2017). However, an unsuccessful/failed VBAC is associated with increased maternal and neonatal morbidity/mortality rates when compared to elective repeat Cesarean delivery (ACOG, 2017). Therefore, it is crucial for providers to discuss with patients individual risks of both birth modes and likelihood of successful VBAC.

**Success Rates—VBAC**

Women attempting TOLAC after one previous Cesarean delivery (low-risk – no maternal condition) have demonstrated a success rate of 60-85% (Landon et al., 2004; Macones et al., 2005; Hibbard et al., 2006; Zweifler, et al., 2006; Spong et al., 2007; Gregory et al., 2008; Rossi
& D’Addario, 2008; Tahseen & Griffiths, 2010; Eden, Hashima, Osterwell, Nygren, & Guise, 2012; Knight, et al., 2014; Shatz et al., 2013; Metz., et al., 2013a; Hehir et al., 2017). Yet, high-risk women (one maternal condition) have a 50.31% success rate (Gregory et al., 2008). Regan, Keup, Wolfe, Snyder, and DeFranco (2015) reported in the state of Ohio high-risk pregnant women (BMI ≥ 30, hypertension, diabetes) with one previous Cesarean delivery had a 68.0% successful VBAC rate. Deline et al. (2012) reported a VBAC success rate of 95% in a birthing center in Wisconsin serving Amish women. Trial of labor success rates for preterm pregnancies compared to term pregnancies are similar (72.8% vs. 73.3%) (Durnwald et al., 2006). Cormier et al. (2010) evaluated the rate of VBAC success in 624 diabetic pregnant women and found VBAC success rate was 64% compared to 73.6 % of non-diabetic women. Women with three or more prior Cesarean deliveries attempting VBAC have similar success rates (79.8%) compared to women attempting VBAC with two previous Cesarean deliveries (71.7%) and one previous Cesarean section (75.5%) (Cahill et al., 2010; Tahseen & Griffiths, 2010). Macones et al. (2005) also found no significant difference between VBAC success rates in women with one previous cesarean delivery compared to two Cesarean deliveries.

Increased probability of success rate is associated with younger women (<34 years of age) (Knight et al., 2014), married (Knight et al., 2014), privately insured (Knight et al., 2014), BMI <30 (Knight et al., 2014), white ethnicity (Knight et al., 2014; Regan et al., 2015), pregnancy weight gain ≤ 30 pounds (Regan et al., 2015), favorable Bishop’s score (>6) (Bujold et al., 2004; Madaan, Agrawal, Nigam, Aggarwal, & Trivedi, 2011), greater cervical dilation on admission (>4cm) (Landon et al., 2004), lower birth weight (<4000 g) (Landon et al., 2004; Hehir et al., 2017), gestational age (<41 weeks)(Landon et al., 2004), previous history of vaginal
birth after Cesarean (Bujold et al., 2004; Obeidat et al., 2013; Madaan et al., 2011), spontaneous onset of labor (Shatz et al., 2013; Madaan et al., 2011), previous vaginal birth (Shatz et al., 2013, Cahill et al., 2006; Bujold et al., 2004; Regan et al., 2015), parity of ≥ 2 (Obeidat et al., 2013), and labor augmentation (Regan et al., 2015). Decreased probability of VBAC success rates are advanced maternal age (Kamath et al., 2009; NIH, 2010; Hehir et al., 2017), low parity (Kamath et al., 2009), African American women (Knight et al., 2014), Hispanic women (NIH, 2010), gestational diabetes (Knight et al., 2014), less than 12 years of education (NIH, 2010), single marital status (NIH, 2010), women delivering in rural and private hospitals (NIH, 2010), increased maternal body mass index (Landon et al., 2004; Hibbard et al., 2006; Merwe, Thompson, & Ekeroma, 2013, Siddiqui, 2013; NIH, 2010), epidural analgesia (Merwe et al., 2013; Hehir et al., 2017), labor augmentation (Merwe et al., 2013, NIH, 2010; Hehir et al., 2017), infant in occipito-posterior (OP) position (Hehir et al., 2017), presence of maternal disease (NIH, 2010), birth weight (4000g or more) and macrosomia (Jastrow et al., 2010; NIH, 2010; Hehir et al., 2017), premature rupture of membrane (Knight et al., 2014), previous Cesarean indication for arrest of labor (NIH, 2010), high risk women (one maternal condition) (Gregory et al., 2008), gestation > 40 weeks (Siddiqui, 2013; NIH, 2010; Hehir et al., 2017), cervical dilatation < 4cm on admission, station of vertex -2 or higher on admission (Siddiqui, 2013), and longer interval (years) between most recent vaginal delivery and TOLAC (Miller & Grobman, 2016).

In summary, individual maternal/neonatal characteristics affect the likelihood of successful VBAC. Overall, women attempting TOLAC have a 60-80% successful VBAC rate (ACOG, 2017). Women with a previous Cesarean for breech presentation, spontaneous labor
without augmentation and previous vaginal delivery have an increased likelihood of successful VBAC (ACOG, 2017). Women with a previous Cesarean for arrest of labor, women experiencing labor induction or augmentation, increased maternal age, high BMI, advanced gestation age, increased neonatal birth weight, presence of pre-eclampsia at delivery, and shorter interdelivery have a decreased likelihood of successful VBAC (ACOG, 2017).

**Decision Models to Predict the Probability of Successful VBAC**

Grobman et al. (2007) developed a model to predict the probability of successful VBAC in term women with one previous Cesarean delivery from six maternal variables (maternal age, ethnicity/race, indication for prior Cesarean delivery, prior VBAC, prior vaginal delivery, BMI). The authors found successful VBAC was significantly more likely for women of younger age, lower pre-pregnancy BMI, white race, non- recurrent indication for Cesarean section, and previous history of vaginal delivery. The model includes factors that can be obtained at the first prenatal visit, allowing time for counseling between patient and provider.

Grobman et al. (2009b) elaborated on the first decision model (Grobman et al., 2007) combining factors early in pregnancy along with factors as the pregnancy progressed. Variables included in this model were BMI within two weeks of delivery, estimated gestation age at delivery, development of obstetric conditions (gestational diabetes) and circumstances at admission (preeclampsia, cervical exam at admission, labor induction). The authors found the newly derived model improved the precision of prediction of VBAC success compared to the first model as factors determined at admission may change the probability of VBAC success (Grobman et al., 2009b).

The authors found maternal and neonatal morbidity rates decreased as probability of
VBAC success increased in women attempting VBAC. Women attempting VBAC and having a predicted success rate below 70% were more likely to have increased maternal and neonatal morbidity rates than those who underwent an elective repeat Cesarean section. The authors found no differences in maternal and neonatal morbidity rates in women having a VBAC or elective repeat Cesarean delivery when predicted TOLAC success rate was 70% and greater. However, women with a 90% and greater predicted TOLAC success rate who underwent a TOLAC had lower neonatal morbidity rates than women having an elected repeat Cesarean section (Grobman et al., 2009a).

Constantine et al. (2011) validated both VBAC prediction models (Grobman et al., 2007; 2009) in an independent cohort and found both models were predictive of success of TOLAC. Although, the second decision model incorporating variables close to or at delivery was significantly more accurate of VBAC success. The predicted success model is available for clinical application and can be found at https://mfmu.bsc.gwu.edu/PublicBSC/MFMU/VGBirthCalc/vagbrth2.html.

Metz, Allshouse, Faucett, and Grobman (2015) performed a secondary analysis of all women in the Maternal-Fetal Medicine Units Network (MFMU) Cesarean Registry with a singleton pregnancy, ≥ 37 weeks gestation, cephalic presentation, and attempting TOLAC after two Cesarean deliveries. The probability of successful VBAC was calculated using the MFMU VBAC prediction model (Grobman et al., 2007). The authors found the mean predicted probability of successful VBAC after two Cesarean deliveries was 70% and the MFMU VBAC prediction model (Grobman et al., 2007) accurately predicted successful VBAC in women with two previous Cesarean deliveries.
Metz et al. (2013a) generated a tool for predicting the likelihood of successful VBAC using variables available at the time of delivery. Demographic variables such as maternal age, parity, gestational age at delivery, race, marital status, pre-pregnancy body mass index, insurance status, obstetric variables such as preeclampsia or eclampsia, gestational diabetes, mode of delivery, oxytocin usage, small for gestational age neonate, cervical examination during admission when delivery occurred, indication for Cesarean delivery and Bishop score were included in the model. The authors collected data on 5,445 women with a primary Cesarean delivery having a subsequent delivery from July 2000 to July 2008. Overall, 1,170 women attempted VBAC with 80% having a successful VBAC. The five variables associated with successful TOLAC at admission were history of vaginal birth (4 points), absence of recurrent indication for Cesarean (3 points), maternal age less than 35 (2 points), BMI less than 30 (2 points), and each point on Bishop score. At admission, women with an integer VBAC score less than 10 had a likelihood VBAC success rate less than 50%. Women with a score of 16 or more had a VBAC success rate more than 85%.

Mardy, Ananth, Grobman, and Gyamfi-Bannerman (2016) developed a model predicting the success of VBAC in preterm women (26-36 weeks gestation) with one previous low transverse Cesarean delivery from eight maternal variables (chronic hypertension, any prior vaginal delivery, prior VBAC, indication for prior Cesarean of arrest of dilation or descent, dilation on admission, hypertensive disease of pregnancy, induction of labor, pre-gestational or gestational diabetes). Factors that decreased the success rate of VBAC were chronic hypertension and recurring indication of prior Cesarean. Prior vaginal delivery and a prior VBAC were factors that increased the rate of successful VBAC. The predicted success model is available for clinical
application and can be found at http://perinatalquality.org/wfVBACCalculator.aspx.

In summary, for women considering TOLAC, ACOG (2017) recommends providers to educate and counsel their patients using Grobman et al. (2007) VBAC prediction model. This model has been widely used and validated in a variety of populations and countries.

**ACOG Guidelines**

According to ACOG (2017, 2010), candidates for TOLAC are women with one previous Cesarean delivery with a low-transverse incision and clinically adequate pelvis. Contraindications are contracted pelvis, multiple gestation greater than twins, breech presentation, women with a previous classical or T-incision, prior uterine rupture or transfundal uterine surgery, or contraindications of vaginal delivery (complete placenta previa, herpes simplex virus with active lesions, untreated HIV infection) (Patterson, Winslow, and Matus, 2008). Possible appropriate candidates for TOLAC are women with two previous low transverse Cesarean deliveries, macrosomia, gestation beyond 40 weeks, women with one previous Cesarean delivery with a low transverse incision who are appropriate candidates for twin vaginal delivery, women with one previous Cesarean delivery with an unknown uterine scar type, unless a previous classical uterine incision is suspected (ACOG, 2017, 2010). Because of the risks associated with TOLAC, ACOG (2017, 2010) recommends the delivery should be undertaken at Level 1 facilities, capable of emergency deliveries, with a physician, anesthesia, nursing personnel, pediatric staff, and operating room staff available. The decision of trial of labor after Cesarean delivery should be made through a collaborative process between the patient and health care provider. The patient should be counseled of potential risks and benefits of both TOLAC
and RCS. Documentation of the counseling is to be recorded in the patient’s record (ACOG, 2017, 2010).

**Costs of VBAC and RCS**

The increasing Cesarean rate adds an economic burden to the medical system in the United States due to increased cost of Cesarean delivery compared to vaginal delivery (Druzin & El-Sayed, 2006). Successful VBAC was associated with shortest length of stay for mothers and infants in hospitals (Kamath et al., 2009). For both mother and infant, elective repeat Cesarean delivery was significantly more expensive than VBAC. However, costs for a failed VBAC delivery ($6631-$16,275) exceeded both successful VBAC and elective repeat Cesarean delivery ($6,212 - $13,968) (Macario, El-Sayed, & Druzin, 2004; Kamath et al., 2009; Friedman, Ananth, Chen, D’Alton, & Wright, 2016). Successful VBAC was the least expensive for total cost ($3,793-$10,333) (Kamath et al., 2009; Friedman et al., 2016). Druzin and El-Sayed (2006) found in a busy tertiary hospital in California, increased Cesarean rates were associated with longer length of stay and higher occupancy rate, leading to reduced patient satisfaction, increased stress on staff and increased costs to maintain safe practice. Wymer, Shih, and Plunkett (2014) estimated costs and outcomes of women having a TOLAC compared to ERCS. For their second delivery, although relatively small, TOLAC was less expensive than ERCS. However, with successive deliveries, the cost of TOLAC was substantially less than that of ERCS. Gilbert et al. (2013) estimated the cost-effectiveness of a TOL after one previous Cesarean delivery compared to ERCS in singleton, term gestation women without a previous vaginal delivery. TOLAC was found to be less expensive and more effective than ERCS to deliver a second child; however, when the probability of successful TOLAC was below 46%, TOLAC was no longer cost effective.
**Decision Making: Provider**

Physician practice patterns and bias impact the decision of birth method after a previous Cesarean section delivery (Wells, 2010). Malpractice litigation pressure has a significant effect on Obstetricians’ practices (Yang, Mello, Subramanian, & Studdert, 2009; Zwecker, Azoulay, & Abenhaim, 2011). A concern over liability is one main reason why physicians have stopped offering VBAC (NIH, 2010; ACOG, 2010; Coleman, Erickson, Schulkin, Zinberg, & Sachs, 2005; Cox, 2011), contributing to the decrease in VBAC rates (Schifrin & Cohen, 2013). Higher malpractice premiums for Obstetrician-Gynecologists increase rates of Cesarean delivery and reduce rates of VBAC (Yang et al., 2009). Zwecker et al. (2011) found annual Obstetrician malpractice premiums over $100,000 were associated with higher rates of Cesarean deliveries and lower rates of VBAC compared to average malpractice premiums less than $50,000 a year.

Kenton et al. (2005) concluded recently trained physicians favor VBAC over RCS. Obstetricians-Gynecologists practicing in suburban and urban areas were more likely to offer VBAC compared to those practicing in rural areas. Physicians not offering VBAC stated it was not an option because of availability of anesthesia. Of the 304 respondents in the study, 92% counseled VBAC candidates differently and 84% quoted different VBAC success rates. Risks counseled by physicians to patients undergoing VBAC were uterine rupture (99%), neonatal morbidity/mortality (86%), hemorrhage/transfusion (79%), hysterectomy (68%), urinary incontinence (30%), pelvic organ prolapse (28%), fecal incontinence (25%) and sexual dysfunction (14%). The authors found 59% of physicians would perform a primary Cesarean section on their patients. In this study, 1 in 5 patients were offered a Cesarean delivery during labor without a medical indication.
Contrary to Kenton et al. (2005) results suggesting recently trained physicians favor VBAC over RCS, Wells (2010) found Obstetricians practicing less than ten years were likely to be non-VBAC providers. Physicians more likely to offer VBAC deliveries practiced in a hospital delivering more than 5000 deliveries per year, the physician’s hospital has an in-house Obstetric resident, and the physician performs fewer than 100 or greater than 200 deliveries a year. Physicians not offering VBAC deliveries were previously involved in the care of a woman with a uterine rupture that resulted in maternal hemorrhage, organ injury, hysterectomy, neonatal complications, or previously involved in a medical malpractice litigation related to a Cesarean delivery for failure to perform, delay in performance, or complications during the Cesarean delivery. Out of 239 VBAC providers, 96% would exclude the offer to patients with multiple gestations and 88% to women with gestational diabetes. Eighty-five percent of VBAC providers would not induce labor with oxytocin and 46% would not augment labor with oxytocin in women with a previous Cesarean delivery. Out of 219 non-VBAC providers, 88% said they would not reconsider changing their policy and offering VBAC to their patients because of risks of adverse outcomes, belief that VBAC is not safe, liability concerns, and mandated guidelines put into practice by ACOG (2010) stating a physician and anesthesiologist have to be “immediately available” during a trial of labor (Wells, 2010).

Gochnour, Ratcliffe, and Stone (2005) researched 291 physicians practicing obstetrics in Utah to explore their knowledge of ACOG Practice Guideline (1999) number 5 (physician, anesthesiologist, labor/operating room staff be immediately available for women attempting TOLAC), evaluate change in physician’s VBAC practice in the last year and reasons for change, evaluate physicians ability to comply with ACOG Practice Guideline (1999) number 5 according
to hospital location (urban, rural, suburban), and explore reasons that may be associated with physicians offering more VBAC/TOLAC. The authors hypothesized that the ACOG Practice Guideline (1999) number 5 would have little or no effect on physicians offering VBAC/TOLAC for larger hospitals having obstetric, anesthesia, and staff available for women attempting TOLAC. A second hypothesis was that ACOG Practice Guideline (1999) number 5 would significantly impact physicians offering VBAC/TOLAC in community and rural hospitals. Physicians (N=291) were surveyed via mail. The survey consisted of closed-ended questions including demographics, hospital data, practice patterns, awareness of ACOG Practice Guideline (1999) number 5, changes in VBAC/TOLAC and repeat Cesarean section patterns in the last year and reasons for change. The authors used Statistical Analysis Software (SAS) to analyze data using Chi-Square analysis and Fisher’s Exact Coefficient. A confidence interval of 95% (p<0.05) was considered statistically significant.

Overall, 97% of Obstetricians and 79% of family physicians were knowledgeable of ACOG (1999) Practice Guideline number 5. When comparing location, 92% of urban physicians and 93% of suburban physicians were knowledgeable of the ACOG (1999) practice guideline number 5, however, only 65% of rural physicians reported being knowledgeable about the specific guideline. Forty-five percent of obstetric physicians reported a decline in their VBAC practices within the last 12 months. VBAC/TOLAC practices significantly decreased in suburban and rural areas. The top three reasons for changes in VBAC/TOLAC patterns were ACOG (1999) Practice Guideline number 5, medicolegal issues, and physician’s personal experience. Eighty-seven percent of Obstetric physicians reported having personnel immediately available for women attempting VBAC/TOLAC. Obstetric physicians practicing in rural areas reported the
least likelihood to have personnel immediately available for women attempting VBAC/TOLAC. Urban physicians were more likely to offer VBAC/TOLAC compared to suburban and rural physicians. More Obstetricians offered VBAC/TOLAC to their patients compared to family physicians with obstetric/Cesarean section privileges.

Doret, Touzet, Bourdy, and Gaucherand (2010) collected data via mail questionnaire from 160 Obstetricians to evaluate practice patterns, opinions and factors influencing decision making about mode of delivery in women with two prior Cesarean deliveries. One hundred percent of the Obstetricians would routinely offer VBAC to women with one previous Cesarean delivery, however, only 23.8% would offer VBAC to women with two previous Cesarean deliveries. “Increased maternal and fetal risks” and “VBAC is not the standard care in women with two previous c-sections” (p.1489) were common reasons for not offering a VBAC to women with two previous Cesarean deliveries. Almost 100% of the Obstetricians discussed maternal and neonatal risks with their patients with previous Cesarean deliveries, however, risks were discussed differently according to the quantity of Cesarean deliveries. Uterine rupture, hemorrhage/blood transfusion, hysterectomy, neonatal mortality and cerebral palsy were risks discussed by Obstetricians to women attempting VBAC, however, hysterectomy, neonatal mortality and cerebral palsy were significantly discussed more with women with two Cesarean deliveries who attempted VBAC. Risks discussed with women desiring a RCS were hemorrhage/blood transfusion, hysterectomy, post surgical pain, infection, thromboembolism, and risks for subsequent pregnancies (placenta previa, placenta accrete, next planned Cesarean section and limits in the number of pregnancies). Overall, in this study Obstetricians preferred a planned repeat Cesarean delivery to VBAC with women having two Cesarean deliveries.
Kamal et al. (2005) conducted an exploratory qualitative study of the views of doctors and midwives about factors that influence rates of repeat Cesarean deliveries. Inclusion criteria included Obstetricians and midwives involved in the care of women in pregnancy and labor. One-on-one interviews were conducted, tape recorded and transcribed verbatim. Theoretical saturation was reached after 14 interviews. Eleven more interviews were performed to confirm, deepen and validate the initial analysis. Data analysis was done using the constant comparative method originated by Glaser and Strauss (1967). The participants included 12 doctors and 13 midwives. Six themes emerged; professionals’ attitudes towards repeat Cesarean, clinical indications for repeat Cesarean, evidence and contingency, organization of care, external pressures, and professional-patient relationships.

The participants stated the rates of Cesarean deliveries (primary and repeat) were high and acknowledged that vaginal birth was preferred because it poses fewer risks to the mother and child, along with allowing mothers to function better after birth. However, the participants reported providers have a low threshold for performing Cesarean deliveries. The participants reported absolute reasons for the decision to perform a repeat Cesarean delivery were fetal distress and breech presentation. Less absolute indications for performing a repeat Cesarean delivery were poor fetal growth, pre-eclampsia, scar from previous Cesarean delivery, and the same clinical indication that prompted a Cesarean for the first delivery. Most of the participants felt evidence based research from clinical trials and guidelines/protocols had an important role in the decision of performing a Cesarean delivery. Yet, most of the participants reported that evidence from research studies was not the sole basis for decision making as some participants questioned the quality of evidence. The participants reported that judgment of decision was
based on individual cases. Organization of care, particularly how and whom women were looked after during their postpartum time frame had an important role in provider’s decision making for repeat Cesarean section. Women not debriefed properly after their first Cesarean were likely to decide on repeat Cesarean delivery. Trust between provider and patient was identified as an important factor in encouraging women to attempt VBAC. The participants reported external pressures such as conditions of the unit (number of beds), clinical governance, and cost of Cesarean compared to vaginal delivery affected their decision making of performing a repeat Cesarean delivery. Most of the participants emphasized how the decision of repeat Cesarean delivery was not solely made by the healthcare provider, yet, it was a joint decision between patient and provider. Nineteen participants reported that women had the right to choose mode of delivery as long as they fully understood risks and issues. Two participants reported that women had an absolute right to choose mode of delivery, while two participants reported women should not have the right to choose their delivery.

Munro, Kornelsen, Corbett, Wilcox, Bansback, and Janssen (2017) conducted a qualitative constructivist grounded theory study (Charmaz, 2006) in British Columbia, Canada exploring physicians, midwives, nurses, anesthetists, and administrators attitudes towards and experiences in providing and planning maternity care services to women with a prior Cesarean delivery. The research questions guiding this study were; 1.“What are care providers’ attitudes toward and experiences with providing care for women considering mode of delivery after Cesarean in British Columbia? 2. What are decision maker’s experiences with planning services for birth after Cesarean in British Columbia? (Munro et al., p. 54). Data collection was conducted through open-ended interviews in the participant’s home or work. Interviews were
audio-taped and transcribed. Data were analyzed using a coding process by two independent coders; open and in vivo coding, focused coding, comparing data (constant comparison), and theoretical coding. The coded transcripts were merged and coded in NVivo analysis software (version 11). Recruitment continued until the data demonstrated theoretical sufficiency (Charmaz, 2006).

Thirty-five participants (Midwives = 4, OBs = 4, Family Physicians = 3, General Practitioners = 3, Nurses = 7, Anesthetists = 1, Hospital Administrators = 5, Regional Decision Makers = 4, Provincial Policy Makers = 4) were interviewed and four themes emerged; supporting women to make a choice (core theme), being an informed provider, listening to woman’s voice, and making it work. Maternity care providers expressed that their role in women’s decision making for birth after a Cesarean was supporting both patient and family in an unbiased manner to make an informed decision. The providers counseled women per The Society of Obstetricians and Gynecologists of Canada (SOGC) practice guidelines to choose VBAC, however, recommended an elective repeat cesarean if a woman’s risks factors decreased her from having a healthy/successful VBAC.

Being an information provider, supporting each individual woman’s decision, was expressed by all care providers. The participants provided risk statistics of uterine rupture and success rates of VBAC to women, but stated they rarely provide information comparing repeat Cesarean risks to VBAC. Providers stated when providing information about birth modes, they focus more on potential harms than benefits. Some participants provided women with SOGC clinical guidelines, information brochures, and/or websites to seek additional information to aid in their decision. Information provided to women about subsequent pregnancy birth modes was
primarily discussed during the antepartum period of the woman’s subsequent pregnancy, yet, one participant stated subsequent risks/benefits information should be provided to women after their primary Cesarean. Some urban care providers and administrators involved in malpractice lawsuits related to subsequent birth mode after a Cesarean felt it was necessary to inform women about limited access to an operating room and possible harm to infant if a Cesarean was needed in an emergent situation. Some of the care providers experiencing maternal or infant injury or death from VBAC did not feel such adverse outcomes affected their attitude toward allowing their patients to VBAC.

The participants expressed many women having an unplanned intrapartum Cesarean often had feelings of “failure” for not being able to birth vaginally. Although a common expression heard from women, many providers did not discuss previous birth experiences during antepartum visits with a subsequent pregnancy. To get an understanding of women’s concerns, midwives differed and stated a one-hour “debriefing” discussion about previous birth experience occurred at the first antenatal visit.

Both care providers and administrators expressed a concern for safety of mother and infant if a Cesarean was needed as facilities lacked a dedicated obstetric operating room, limited in-house anesthesiologist, and competing general operating room access. “Making it work” was characterized as providers working with limited resources, yet, having a “strategy” if a women attempting VBAC needed a Cesarean. The in-house anesthetist would be paged away from their current patient, making sure the patient was stable, leaving the patient under the care of the nurse, to attend the Cesarean. Providers felt more comfortable managing women attempting VBAC on days when the general operating room had only a few scheduled elective cases.
Coleman et al. (2005) conducted a study assessing Obstetrician-Gynecologists current practice patterns and opinions regarding VBAC. Six hundred thirty-nine ACOG fellows completed questionnaires regarding information on their percentage of Cesarean and VBAC deliveries performed, factors influencing changes in rates in the last five years, VBAC hospital protocols, and factors influencing the recommendations for VBAC. The authors found approximately 48.6% (n=244) of the study participants reported performing more Cesarean deliveries than VBACs in the past five years. Reasons for the increase were concerns of liability and patient preference. Seventy-three percent of study participants reported over half of their patients with a previous Cesarean delivery have repeat Cesarean deliveries for subsequent births. Male physicians performed significantly more repeat Cesarean deliveries than female physicians. More than half, 57.9% (n=290) of physicians reported VBAC success rates of 50%-80% and 8.8% (n=44) estimated having VBAC success rates of 81-100%. Almost all of the study participants (98.6%) (n=495) reported they knew the risks and benefits of VBAC, current ACOG guidelines (93.3%) (n=471) and necessary screening tools (80.8%)(n=406) to assess each individual patient for VBAC. However, only 60.9% (n=306) of study participants reported being competent in determining which patients would have a successful VBAC. Seventy-eight percent of physicians (n= 392) reported having a VBAC policy in the hospital, 76% (n=382) reported having in-house anesthesia for VBAC, 66.1% (n=332) reported having in-house Obstetrician for VBAC, and 65% (n=326) used oxytocin to induce women undergoing VBAC. Over half (60.2%)(n=302) of physicians felt the national Cesarean delivery rate was not too high. Only 78% (n=396) of physicians reported always discussing the risks and benefits of VBAC with women with a previous Cesarean delivery, with 71.5% (n=359) of physicians stating one-on-one
discussion along with an informed consent VBAC form was the preferred method of communication of risks and benefits. Over half (74.5%) (n=374) of study respondents disagreed with the dictum “Once a Cesarean, always a Cesarean.”

Metz, Stoddard, Henry, Jackson, Holmgren, and Esplin (2013b) conducted a retrospective cohort study of women to compare good candidates for TOLAC who underwent RCS compared to candidates who chose TOLAC. Inclusion criteria included women who had a primary Cesarean delivery and their subsequent delivery in one of 14 Intermountain Healthcare hospitals. The authors used a decision nomogram (Grobman et al., 2007) to predict the likelihood of successful VBAC to select women who were considered good candidates for TOLAC. The final study population consisted of 3120 women who were calculated to have a likelihood of VBAC success greater than or equal to 70%. The final study group consisted of 2195 (70.4%) deciding RCS and 935 (29.7%) who chose TOLAC. The authors found women whose care was managed by a Certified Nurse Midwife (CNM) or had a history of a previous vaginal delivery chose TOLAC. Obese women and women whose care was managed by a family practitioner were less likely to choose TOLAC. Only one Obstetrician-Gynecologist group out of 10 practices differed substantially regarding TOLAC and RCS rates. Only 37% of the groups’ patients with a prior Cesarean delivery choose RCS compared to other Obstetrician-Gynecologist providers (53%). The practice consisted of all women who had completed residency within the last 10 years, employed by the health system, and a physician office located one floor below the labor and delivery unit. The practice offered TOLAC to all of their patients with a history of low transverse Cesarean delivery. Overall, the authors found less than one-third of good candidates
(n=935/3120) for TOLAC chose TOLAC and managing provider was a major factor associated with the decision of TOLAC or RCS.

Gonzales-Mendez, Gonzalez-Maddux, Hall, Maddux-Gonzalez, and Handley (2012) researched 117 multiparous Hispanic women attending three clinics in Monterey and Sonoma counties in California that had the birth option of VBAC during August 2003 through February 2004. Over half of the participants in the study were born in Mexico. Among the women with two or more previous births, 55% had a history of a previous vaginal delivery and Cesarean. Forty-three percent of the women reported having delivered by Cesarean in Mexico, however over half of the women were not able to report indication for previous Cesarean delivery, and less than one third of the women’s charts did not have a clinical notation written by the healthcare professional requesting previous medical records. Twenty-nine percent of the women having a prior Cesarean delivery reported requesting previous medical records, however, only one medical record was received. All of the women in this study were candidates for TOLAC, with half having a previous vaginal delivery, significantly increasing the success rate of VBAC (Macones et al., 2005). Overall, the authors found having limited access to previous medical records, to identify previous surgical scar, can lead physicians to scheduling routine repeat Cesarean deliveries, decreasing the chances for women to have a successful VBAC. In decreasing the Cesarean delivery rate in the United States, the authors concluded healthcare professionals must obtain previous medical records to identify women eligible for a TOLAC.

Cox (2011) conducted an exploratory qualitative study to explore the barriers associated with ACOG (2010) Practice VBAC Guidelines and how Obstetricians and midwives minimize their legal risks when offering TOLAC to their patients. The aim of the study was to identify the
characteristics that facilitate and limit obstetric providers to offer TOLAC to their patients. The study took place in the state of Florida, USA. Purposive and snowball sampling was used to recruit participants. Inclusion criteria included ages 21 to 70, fluent in English and currently licensed to practice in Florida. Obstetricians and Certified Nursing Midwives (CNM) had to have current hospital privileges and Licensed Midwives (LM) currently practicing in either home or birth center settings. Hospital administrators had to currently have primary oversight of a licensed hospital labor and delivery unit or birth care center. Twenty-four participants were recruited to the study (11-OB, 8- CNM, 4- LM, 1- hospital administrator). One-on-one and small group interviews were conducted at a setting most convenient to the participants. Interviews were recorded and transcribed verbatim. Thematic analysis was used to generate themes.

Five themes emerged from the data; fear of liability, minimizing risks, convenience of Cesarean, defining “immediately available,” and marginalization of midwives. For many of the providers practicing in community, rural and large medical academic hospitals, fear of liability was a major concern for offering TOLAC. Avoidance of offering VBAC was the most common strategy to minimize risks associated with caring for a women attempting TOLAC. Both Obstetricians and midwives reported scheduling a RCS was convenient. Some of the midwives were opposed to Obstetricians promoting delivering via repeat Cesarean delivery. Although convenient for Obstetricians, a few of them reported letting a woman try to TOLAC if she desired. ACOG (2010) guidelines state physician, anesthesia and operating room staff need to be immediately available for women attempting VBAC in case a Cesarean delivery is needed. In this study the term, “immediately available” varied considerably. For some, immediately available meant being in-house while others defined it as being within 10 minutes of the labor
and delivery unit. The role of the midwife is not mentioned in the current ACOG (2010) VBAC guidelines. For this reason, the midwives in this study felt marginalized by being excluded from delivering VBAC because of financial and malpractice insurance reasons. In the state of Florida, birthing centers are unable to offer VBAC legally, restricting women’s choices of delivering VBAC. One Obstetrician thought restricting midwives to deliver VBAC was an unwise strategy, allowing his practicing midwife to deliver VBACs.

Foureur et al. (2017) conducted a qualitative descriptive focus group study to explore the views and experiences of maternity care providers caring for women eligible for a VBAC. The study was conducted in a maternity unit in New South Wales, Australia. The facility permits VBACs and is fully equipped and staffed to care for women and neonates if emergency Cesarean is needed. Purposive sampling was used to recruit Midwives and Obstetricians providing antepartum and intrapartum care to women with a previous Cesarean delivery. Recruitment flyers were posted in staff areas and letters were sent via mail to all obstetric care providers and midwives. Eighteen participants were recruited. Four focus groups discussions were conducted at the facility. The discussions were audio-taped and transcribed. Thematic analysis was used to generate themes.

Three central themes emerged from the data; developing trust, navigating the system, and optimizing support. Five sub-themes were identified under the main theme developing trust; impact of past professional experiences, continuity and relationships, weighing up risks versus benefits, work as a team and communication and language. For doctors, a previous VBAC adverse outcome provoked anxiety and was a constant reminder when providing labor care to VBAC women. Both midwives and doctors expressed continuity of care and supporting the
women’s decision are key elements to developing and maintaining trust for VBAC women. The midwives and doctors expressed the need to provide information focusing more on the chances of normal birth rather than the risks of Cesarean section, yet not being dismissive of the risks. Developing trust meant healthcare providers work as a team and provide consistent information to women. Effective communication and language from provider to participant develops trust. For example, some of the providers eliminate the word rupture when talking to VBAC women and describe/talk to the women about what actually happens. They felt the word rupture was dramatic and negative.

Two sub-themes were identified under the second theme navigating the system; system and control. Participants described the system as a non-supportive VBAC system. Time restraints during appointments limited discussion and information and the lack of some Obstetricians following hospital policy supporting VBAC contributed to women wanting a repeat Cesarean delivery. The participants expressed the need for women to make an informed decision, own up to the decision and take control of their decision. For many women, fear, uncertainty and miscommunication impacted their decision as some women changed from VBAC to RCS after seeing a different provider that wasn’t supportive towards VBAC. The participants described many women want control of their decision which is not always possible when attempting a VBAC and decide for RCS. Planning, knowing the surgery date in advance and not going through hours of labor were key factors for women deciding RCS. The third theme, optimizing care was described as providing women with a previous Cesarean section interested in VBAC with standardized care according to hospital policy and guidelines. Informing women of all risks and benefits of VBAC, yet remaining impartial to each woman’s
decision, and respecting each woman’s decision was recognized by providers as an important element when providing care to women with a previous Cesarean. Having a dedicated midwife in the antepartum and intrapartum periods and allowing women desiring a VBAC to remain active during labor were key elements to the decision to attempt and have a successful VBAC.

In summary, although ACOG (2017, 2010) recommends women with one previous Cesarean delivery with a low-transverse incision and clinically adequate pelvis to be offered a TOLAC, some providers remain reluctant to offer this to their patients, for reasons such as decreased availability of resources/staff, previous poor patient outcome, involvement in medical malpractice litigation, increased malpractice premiums, and non access to patient’s previous medical records. The type of provider managing care during antepartum and intrapartum phases of pregnancy is a major factor associated with the decision to have a VBAC or RCS. When compared to an OB, women whose care is managed by a CNM chose TOLAC over RCS. The timing, amount and method of information communicated from provider to patient about both birth mode risks statistics and benefits varied. Some providers did not always discuss information about subsequent pregnancy birth modes with their patients, while others discussed information during the postpartum time frame of first pregnancy and/or during antepartum visits. Methods of information from provider to patient varied from one-on-one discussion, brochures, professional clinical guidelines and professional websites. ACOG (2017) recommends both risks and benefits of VBAC and RCS and individual maternal characteristics that could possibly affect an outcome should be discussed with each patient and documented.

**Decision Making- Hospital**

Leeman et al. (2013) surveyed directors of maternity wards of each hospital in New
Mexico and found TOLAC was offered in 100% (N=22) of counties with maternity units in 1998. Availability decreased in 2008 to 32%. After changes in ACOG national guidelines in 2010, availability increased to 41% in 2012. The authors found major barriers to offering TOLAC were anesthesia availability, medical malpractice policies, costs and obstetric surgeon availability.

Women delivering in hospitals with high delivery volumes, tertiary care centers, teaching hospitals, residency programs and higher levels of obstetric support were more likely to have a TOLAC (Catling-Paull, Johnston, Ryan, Foureur, & Homer, 2011; Eden et al., 2012), while women delivering in smaller hospitals, rural or non-teaching urban hospitals were least likely to deliver TOLAC (Kabir, Pridjian, Steinmann, Herrera, & Khan, 2005; Catling-Paull et al., 2011). Additionally, hospitals with residents, midwives, not-for-profit, and public hospitals have higher VBAC rates and are factors that are associated with decreased primary Cesarean delivery rates (Rosenstein et al., 2013; Defranco et al., 2007). Repeat Cesarean delivery is the only option for many women living in rural areas due to VBAC not being offered in nearby hospitals. Heinrich, Vogel and Kozhimannil (2016) surveyed 306 rural maternity hospitals in the United States and found less than half (38.1%) allowed VBAC deliveries. The hospitals with higher birth volumes, births attended by Obstetricians and CNMs, and a specific obstetric operating room were more likely to allow VBAC deliveries. The hospitals only having a general operating room and births attended by family practice physicians and general surgeons were less likely to allow VBAC deliveries (Heinrich et al., 2016).

Shihady et al. (2007) surveyed nurse managers from 225 hospitals in the state of California, evaluating each hospitals adherence to ACOG VBAC guidelines (1999). Of the 225
hospitals, only 167 allowed VBAC. Fifty-eight hospitals surveyed did not allow VBAC because of the hospital’s inability to adhere to ACOG (1999) guidelines of providing 24-hour availability of operating room personnel. Several of the nurse managers reported not allowing VBAC because of corporate policies, inability to meet time requirements, and concerns for malpractice liability. The researchers evaluated individual hospital policies and their adherence to five content areas and 34 specific items, recommended by ACOG (1999) (patient criteria, procedure, staff and resources, uterine rupture and other complications and miscellaneous clinical issues). The researchers found overall adherence to ACOG (1999) recommendations was insufficient. Over 75% of the hospital VBAC protocols had less than 50% of the ACOG (1999) items. The highest percent adherence to ACOG (1999) guidelines was represented in the procedure and staff/resources area, where two-thirds of the hospitals demonstrated 75-100% adherence to ACOG (1999) guidelines.

Roberts, Deutchman, King, Fryer, and Miyoshi (2007) researched hospitals in the states of Colorado, Montana, Oregon and Wisconsin. Head nurses from labor and delivery units were contacted via telephone to complete semi-structured interviews regarding VBAC practices and availability before and after ACOG (1999) issued their VBAC practice guidelines. Overall, 230 hospitals participated in the study. Deliveries per year ranged from 6 to 5,700. The authors found following the policy requirements of having a surgical team “immediately available” for women attempting VBAC, resulted in VBAC services being significantly decreased. Of the hospitals participating in the study, 67.2% allowed women with a previous Cesarean delivery to attempt VBAC. Seven of the hospitals never allowed VBAC and 68 had once permitted VBAC but no longer allowed due to lack of in-house presence of surgery and anesthesia. For the hospitals
offering VBAC, the majority changed their VBAC policy after the ACOG (1999) policy release, with 30% discontinuing VBAC entirely. Discontinuation of VBAC affected smaller hospital (58 beds/458 deliveries per year) compared to larger hospitals (157 beds/1010 deliveries per year).

In summary, ACOG (2010) guidelines stated operating room staff, OB surgeon, neonatal and anesthesia team should be immediately available for patients attempting VBAC. Some hospitals inability to adhere to such guidelines decreased TOLAC availability, resulting in decreased VBAC rates. This occurred more in rural area hospitals compared to suburban and urban area hospitals. Current ACOG (2017) VBAC guidelines state women attempting VBAC should be cared for in a Level I or higher care facility, capable of performing emergency deliveries.

**Decision Making Patient: Qualitative Research**

Emmett et al. (2006) conducted a qualitative interview study as part of a developmental phase of a randomized control study (Montgomery et al., 2007) to explore women's decision making regarding mode of delivery after a previous Cesarean birth. Inclusion criteria included women of parity two or greater, who had delivered a live birth 2-8 months prior to recruitment, and one previous Cesarean birth. The study was conducted in England and Scotland. Data were collected via interviews in participants’ homes. Data analysis was conducted using the Framework approach; familiarization, identifying a thematic framework, indexing, charting and mapping, and interpretation (Ritchie & Spencer, 1994). Twenty-one participants were consented to the study. Six dominant themes emerged: (a) factors influencing decision to plan a VBAC; (b) factors influencing decision to plan an ECS; (c) attitudes to motherhood; (d) certainty in maternal decision making; (e) information provision; and (f) decision making roles.
The researchers found that many of the women experienced feelings of uncertainty in determining the right mode of delivery. Levels of certainty varied for the participants. Some women were certain about birth choice prior to their pregnancy, while others were uncertain about their decision after their infant’s birth. Certainty of delivering VBAC was based on beliefs of having a shorter recovery time, the experience of having a natural delivery, and fear of having a Cesarean birth. Certainty of delivering ERC was based on beliefs of fear of having a vaginal birth, having a sense of control or a plan, and having a lack of confidence in delivering VBAC. Some of the women reported being ill-informed and would have liked more facts and figures to assist in decision making. Most of the women stated their healthcare providers allowed them to make their own choice regarding birth mode. Two of the women stated their choice of birth mode was ignored and they were forced to deliver by a birth mode not desired.

Frost et al. (2009) conducted a qualitative study nested within a randomized controlled trial of thirty women (Montgomery et al., 2007) to obtain views of women and their experiences of decision making of subsequent birth after a previous Cesarean delivery and the role of decision aids in this process. A purposeful subsample of thirty women from the randomized trial were interviewed prenatally and 22 were interviewed during the postpartum period. One-on-one interviews were conducted at 37 weeks gestation and 6 to 8 weeks postpartum. Topics explored during prenatal interviews were information provision and knowledge in preparation for their previous and next delivery, usefulness of the decision aids versus usual care, understanding of risks and benefits of both delivery modes, decisional conflict experienced in deciding delivery mode after previous Cesarean, and preferences for repeat Cesarean or VBAC. Topics discussed postnatally were the relation between preference of delivery and uncertainty of actual outcome,
and if the relation between preference of delivery and actual outcome were mediated by either
the information program or the decision analysis program. All interviews were digitally recorded
and were transcribed verbatim by a professional transcriber. The transcripts were coded by three
of the authors and three themes emerged from the data: (a) role of decision aids in reducing
decisional conflict and uncertainty; (b) impact of the decision aids upon knowledge and anxiety;
and (c) the relationship between the prior preferences/decisions, actual outcome and mediating
role of decision aids.

The first theme highlighted the role of the decision aid in reducing decisional conflict and
uncertainty of deciding RCS or VBAC. Many of the women receiving the information program
stated the quality and depth of information provided helped their decision making and decreased
their uncertainty. For several women the information program and decision analysis program
was a starting point to seek additional information via discussion/asking questions with
providers. A few women stated their healthcare professionals managed information provision to
encourage women to deliver the provider’s preferred mode. A minority of the women reported
the decision analysis was not helpful in the decision process.

A second theme generated from the data was the impact of the decision aids upon
knowledge and anxiety. The authors concluded the women in the information program group
were able to state general risks of both delivery modes. The women in the decision analysis
group were able to state specific risks for both deliveries such as hemorrhage and perineum
tearing. Only two women in the usual care group were interviewed and neither could identify
possible risks and health outcomes for RCS or VBAC. Overall, the women in the study reported
the decision analysis program was helpful and each decision aid increased their understanding of
the decision to be made without increasing their natural anxiety.

The third theme highlighted the relationship between the prior preferences/decisions and actual outcome, and the mediating role of decision aids. Post delivery, women in the computer based information group reported the information helped with making an informed choice. Several women in the decision analysis group reported the program confirmed their prenatal delivery preference, while others reported the decision analysis facilitated the exploration of certain topics, expanding further clarification of risks and benefits. A few women in the decision analysis group wanted information particular to their individual circumstances.

Shorten, Shorten and Kennedy (2014) analyzed the qualitative component of a randomized clinical trial study (Shorten et al., 2005) to explore women’s values and expectations during their decision process of VBAC or RCS. For the qualitative segment of the study, a narrative analysis design was used to capture women’s experiences in making a choice for subsequent birth after a Cesarean delivery. Data were collected from open-ended questions in written survey 6-8 weeks postpartum. Data were entered into a qualitative software program to organize and code data. Also, each researcher independently coded the data and memos were written to represent narrative messages provided by participants. Consensus of themes was achieved from discussion.

The authors reported the decision making process was influenced by multiple factors such as contradictory information, family pressure and/or needs, medical practitioners not supportive of TOLAC, and women’s personal beliefs of their capacity to birth. The majority of the women relied on medical advice, which was stated as the most trusted source of information. However, many of the women were not adequately informed about the risks and benefits of
TOLAC versus RCS. For women choosing ERCS, the ability to plan the date of the delivery was a major influence. Avoidance of risks, avoidance of emergency Cesarean delivery, obstetrical indication, size of baby, prior delivery experience, personal control, fear of danger to baby, family pressure, and the perception that recovery would be better were reasons why women decided to have an ERCS. Many of the women deciding ERCS perceived the mode of delivery to be less risky than TOLAC. Reasons given by women to choose TOLAC included the need to experience natural, normal labor, avoid separation to breastfeed, quicker recovery, personal control and involvement in the delivery, and personal feeling of achievement expressed as feeling confident in their bodies to deliver vaginally.

Phillips, McGrath and Vaughan (2009-2010) conducted a qualitative descriptive phenomenologic study interviewing 20 women having a previous Cesarean delivery and subsequent birth six weeks prior to data collection. The aim of the study was to explore, from a mother’s perspective, the process of decision making about subsequent birth after a previous Cesarean delivery. Two women gave birth by VBAC, two attempted VBAC but ended with a Cesarean and 16 chose elective repeat Cesarean delivery. Data collection was conducted using open-ended interviews conducted at the time and location of the participant’s choice. The authors concluded the group of women can be divided into three groups based on their attitudes and beliefs about birthing options: (a) very pro VBAC; (b) very pro ERC; and (c) women having an ERC for a range of issues such as clinical indication or convenience.

One of the themes derived from the data was maternal instinct about what is best for the baby, with a belief in the significance of a natural birth. Another theme was the passionate, determined, strong minded and highly motivated women who believe in choice and natural birth.
The mothers attempting VBAC were clear and focused in the determination to own the decision making process, as the women reported not having a choice for their first birth. Mothers attempting VBAC along with mothers who achieved VBAC reported having feelings of satisfaction and empowerment for trying or/and giving birth naturally. Even the women attempting VBAC, yet ending with a Cesarean delivery, felt the importance of having the choice to have a vaginal delivery.

Overall, the group of women who either wanted or achieved a VBAC, stated their healthcare providers reported VBAC was the most risky option. The extent of prenatal information was biased towards RCS. The women reported they were not given sufficient information about risks for both delivery modes and accessed information from books and internet (McGrath, Phillips & Vaughan, 2010b).

The women choosing RCS desired the delivery method to avoid pain and fear of childbirth, reported it was safer and easier than VBAC, quicker delivery, knew what to expect for second delivery reducing anxiety, avoiding the induction process, avoiding trauma of a repeat emergency Cesarean if needed, having control regarding work arrangements, knowing the process of Cesarean delivery, and having an environment that is calm with staff ready at check in. Feelings of regret and failure about not giving birth vaginally were reported by some of the women attempting VBAC but ultimately having a RCS. The sense of regret and disappointment was acute for this group of women experiencing their last birthing experience (McGrath, Phillips, & Vaughan, 2010a).

Women express a desire to be involved in the decision making process of VBAC or RCS, however, the level of involvement ranges from minimum to total (Moffat et al., 2007). Moffat et
al. (2007) conducted a qualitative study in Scotland of 26 women to explore their decision making process regarding mode of delivery after a previous Cesarean birth. Data were collected from participants’ diaries, observations during a clinic consultation in the third trimester, interviews with participants six weeks postpartum, and field notes made by the researcher. Data were analyzed using a thematic analysis approach. Three dominant themes emerged; (a) the evolution of decision making; (b) women’s participation and involvement in decision making; and (c) factors affecting decision making.

The evolution of the decision was strongly influenced by previous mode of delivery, recommendations from medical staff, and medical evidence provided to the women. Most of the women acknowledged that the decision could never be final and stated the decision continued to change over the course of the pregnancy. Only one woman was definite about her decision regarding birth mode from the beginning of her pregnancy. All women expressed the desire to be involved in the decision, however, participation and involvement varied from total to minimal. Wanting a normal and natural delivery, recovery time, family obligations, information provided to women from healthcare professionals, family, friends, television, and internet were all factors affecting what birth mode to decide. A few of the women reported the information provided from healthcare providers was minimal, wanting information specific to their particular situation rather than general information about birth options. However, some women reported information provided was sufficient.

Munro, Janssen, Corbett, Wilcox, Bansback, and Kornelsen (2017) conducted a constructivist grounded theory (Charmaz, 2006) qualitative study exploring 23 women’s attitudes and experiences with decision making for subsequent birth mode after a Cesarean
delivery. Inclusion criteria included women ages 18-45, English speaking, previous Cesarean delivery, considering a future pregnancy, eligible for VBAC according to Canadian clinical practice guidelines, and lived in one of the purposively sampled communities in British Columbia, Canada. Data were collected via one-on-one open-ended interviews either at the participant’s home, work or by phone. Interviews were audio-taped and transcribed. Data were analyzed using a coding process by two independent coders; open and in vivo coding, focused coding, comparing data (constant comparison), and theoretical coding. The coded transcripts were merged and coded in NVivo analysis software (version 11).

Women’s decision making for birth mode after a Cesarean delivery was a process of “seeking control in the midst of uncertainty,” which was organized around six conceptual themes; (a) reflecting on their birth; (b) clarifying their values; (c) becoming informed; (d) considering the feasibility of options; (e) deliberating with the care team; and (f) making an actual choice (Munro et al., 2017). Many of the women, having a previous unplanned Cesarean delivery expressed feelings of being “out of control” during their birth. The women expressed the need to seek and regain control for their subsequent pregnancy birth. For some of the participants, having a Cesarean birth was seen as a “failure” for not achieving a desired vaginal birth. Women that had a planned Cesarean delivery (breech presentation and placenta previa) expressed positive experiences with their Cesarean and leaned towards repeat Cesarean delivery for a subsequent delivery.

Each woman’s values and what was considered important to her influenced the decision for VBAC or RCS. For example, women that valued immediate bonding with their infant often opted for a VBAC. Lack of information from health care providers explaining why the Cesarean
occurred made women actively seek information online to gain knowledge of risks and benefits of both birth modes. Available resources and safety of their hospital to fully support a VBAC delivery influenced women’s decision of VBAC or RCS. To increase their chances for a successful VBAC, some of the women switched to midwifery care while others opted to have an unattended homebirth.

Many of the participants felt their discussions with physicians about their previous cesarean and wishes for subsequent birth were brief, rushed and many feared to ask questions. However, Midwife patients did not feel rushed and discussions/deliberations often lasted over an hour. Patients seeing a midwife or family practice physician for maternal care consulted with an Obstetrician at 36 weeks gestation. This appointment was not positive for the women. Many left questioning their decision, felt pressured to make a decision, and regretted signing an informed consent for a RCS.

Seventeen of the twenty-three participants were certain of their decision of VBAC or RCS, yet, all found the decision difficult to make. The remaining six were uncertain of their decision and needed more time before making a choice. Feeling confident with their decision varied for the women. Some of the women formed an early confidence in their preference of VBAC or RCS while others took longer.

Kelly, Hauck, Bayes, and Hardwick (2013) conducted a qualitative descriptive phenomenologic study to understand women’s perceptions of factors that contributed to the women not achieving their desired VBAC. Semi-structured individual telephone interviews were recorded and transcribed verbatim. Colaizzi’s method of thematic analysis was used to analyze data. Fifteen women desiring a VBAC, commencing labor, yet delivered via non-
elective repeat Cesarean section due to failure to progress in labor and/or fetal distress were consented. Five themes emerged from the data: (a) tentative commitment with lingering doubts; (b) my body failed me; (c) compromised by a longer than tolerable labor; (d) unable to effectively self-advocate in a climate of power-struggling and poor support; and (e) the inflexibility of hospital process.

The researchers found many of the women reported a degree of uncertainty and doubt about their possibility of achieving a VBAC. For several of the women, the uncertainty and doubt began during antepartum visits, as medical staff depleted their confidence in having a vaginal birth, while others attributed the uncertainty to their own ambivalence. Most of the women reported they didn’t successfully deliver VBAC because their body lacked capacity to deliver vaginally/naturally. Because labor did not progress as expected, many of the women stated medical interventions such as drugs and epidurals were introduced to them, limiting access to labor care such as baths/showers.

Not achieving a VBAC was a result of individual provider practice and hospital’s VBAC policies and processes. Several of the women stated hospital policies negatively impacted successful VBAC depending on how strict their provider was at abiding policies. Several of the women felt frustrated by restrictions placed on them, such as continuous fetal monitoring and intravenous infusion to deliver naturally, and stated their midwife was more interested in protocols of the hospital rather than helping to facilitate natural delivery. The women expressed lack of caregiver’s support and inability to advocate for themselves during labor were factors that contributed them to not achieving a VBAC. The women felt grateful to have a healthy child, yet
continued to feel emotions of disappointment and sadness with the reality of an unsuccessful
VBAC delivery.

Farnworth and Pearson (2007) conducted a qualitative study exploring nine women’s
decision making experience of subsequent pregnancy after a previous Cesarean birth, along with
the influences of their decision. Inclusion criteria included women with a history of one previous
Cesarean birth, current uncomplicated pregnancy, and 36 weeks gestation. A purposeful sample
was used to reflect range of ages, reasons for first Cesarean birth, gender of Obstetrician, and
preference for VBAC or ERCS. The study was conducted in England. Data were collected via
one-on-one interviews with the participants in their homes. Data were analyzed using the
constant comparative method (Strauss & Corbin, 1990) to identify concepts and themes within
the transcripts.

Four dominant themes emerged; (a) morality; (b) uncertainty; (c) knowledge; and (d)
expectations. Many women expressed the desire to “do the right thing,” hoping their decision
made would not impact the health of their baby. Fear of blame was a concern for many women if
their infant had a poor outcome. Uncertainty and inability to control the birth process
complicated the decision process. Women’s knowledge of birth options was acquired from
personal experience and knowledge from Obstetricians. The women reported Obstetricians
provided clarity for the reasons of their previous Cesarean birth along with providing
individualized advice for the current pregnancy. The popular attribute of having a VBAC was the
“natural” feeling of delivery, quicker recovery period, and feelings of achievement and intimacy.

Factors identified as major influences affecting the decision process were people, time,
and practical issues. Information and advice was offered from family, friends, television, books,
and healthcare practitioners, however, some women stated the information was not considered useful and trustworthy. All participants reported their Obstetrician respected their choice and allowed each woman to make their choice of birth mode. Input in the decision from Obstetricians ranged from none to sharing and advising. General Practitioners and midwives were seen as having a supportive rather than advisory role. Practical issues, such as maintaining an independent role within the family, post birth bonding, breastfeeding, body image, and future pregnancies were major influences in the decision process.

Fenwick et al. (2006) conducted a qualitative study to describe childbirth expectations, influences, and knowledge of the 49 western Australian women who experienced a Cesarean birth for their first delivery and preferred a Cesarean birth for subsequent pregnancy. Inclusion criteria included women with a previous Cesarean birth wanting a planned repeat Cesarean birth for their subsequent pregnancy. Data were collected via telephone interviews. Data were analyzed using a constant comparison method and thematic analysis. Three themes emerged: (a) reconstructed childbirth expectations; (b) influences on women’s decision making; and (c) women’s subsequent knowledge, attitudes, and perceived benefits of Cesarean birth.

Many of the women associated vaginal birth with pain, risk of complications, and fear and anxiety from the impact of their first Cesarean birth. Because of traumatic experiences from their first Cesarean birth, some of the women expressed uncertainty regarding subsequent birth options and did not know if they wanted to get pregnant a second time. After having a previous Cesarean birth, many of the women were more open to having another Cesarean birth since Cesarean birth is more “acceptable” and “reasonable” (p.124). The primary care provider was identified as a major influence in the decision to have a planned Cesarean birth for the
subsequent pregnancy. The women stated they did not have an option or choice because birthing vaginally was not possible or their doctor only believed in Cesarean section. The women were informed that Cesarean birth was the safest option. The women identified the concept of language as a major influence. How the doctor negatively discussed the option of VBAC made the women want to comply with their doctor. Family and friends were identified as a major influence in the decision making process, along with the women’s personal experiences from their previous birth. The women stated Cesarean birth was the safest way to have a baby. Wanting a Cesarean for their subsequent pregnancy was also influenced by the planning of time and day of the birth.

Fenwick, Gamble and Hauck (2007) conducted a qualitative descriptive study exploring the childbirth expectations and knowledge of 35 women living in Perth, Australia who had experienced a VBAC or stated a preference to have a VBAC for their subsequent pregnancy. The aims of the study were; (a) explore and describe childbirth expectations, knowledge, attitudes and beliefs from women with a previous Cesarean delivery who prefer to have a VBAC for a subsequent pregnancy, and (b) investigate the influences of the women’s decision to have a VBAC. Sixty percent of the 35 women experienced a non-elective or emergency Cesarean birth for their first birth. Interviews were conducted via telephone at a time convenient to the women. The interviews were audio-taped and were transcribed verbatim. Thematic analysis was used to analyze the data. Open coding was used to sort and organize the data to generate themes. The generated themes/subthemes provided a description of the women’s experience.

Three major themes were generated: (a) childbirth expectations: the importance of vaginal birth reinforced; (b) women’s decisions: influencing factors; and (c) knowledge and
beliefs around vaginal birth and/or VBAC. For this group of women, their beliefs, desires and expectations were to give birth naturally, vaginally and normally. Such beliefs were reinforced and strengthened from their first Cesarean birth experience. For many of the women, seeking knowledge and information to achieve a VBAC was prominent. Most of the women felt ill-informed and unprepared for their first birth, stating they would change hospitals and specialists to avoid interventions such as induction or epidural for their subsequent birth.

A major influence for wanting a VBAC for subsequent pregnancy was a deep belief and importance of experiencing a natural birth. This group of women perceived their Cesarean section as negative and focused on never wanting to repeat the experience. Many of the women expressed feeling powerless and helpless during their previous Cesarean delivery, desiring to retain control in their subsequent delivery. Findings showed health care provider support was not as important as family and friends support, as women felt pressure from their physician to have a repeat Cesarean delivery. Many of the women stated communication with health care professionals was poor, including a lack of understanding of wishes, and needs being neglected by health care professionals. Many of the women felt health care professionals were insensitive, rough, rude, and aggressive.

Women choosing VBAC were emotionally supported from friends and family members who had experienced a VBAC, along with support groups for VBAC mothers. The support provided positive reinforcement for women desiring a VBAC through information, research, and hearing other women’s experiences. The women reported an advantage of VBAC was maternal and infant well being and bonding between mother and infant. The women stated their Cesarean
delivery physically and emotionally hindered their state of health, and resulted in longer recovery and increased separation from their baby after birth.

Meddings et al. (2007) conducted a qualitative phenomenology study in the United Kingdom to explore women’s lived experiences of previous Cesarean birth that elected to attempt a VBAC for subsequent pregnancy, and how they interpreted their experiences post delivery. Inclusion criteria included women who had given birth in their last pregnancy by Cesarean birth and planned to have a VBAC in their current pregnancy. Eight women participated in this study. Data were collected through semi-structured interviews at 34 weeks gestation and 6 weeks postpartum and analyzed using thematic analysis. Three dominant themes emerged: (a) informed choice; (b) differences in recovery; and (c) influences on bonding.

Many of the women expressed that being given a choice of birth option was very important. Most of them wanted a normal birth, which was defined as experiencing the function of the female body and they wanted to make the decision about planned mode of delivery. All of the women stated recovery after a Cesarean birth was longer, straining family obligations. Influences on bonding differed for participants. Some women reported there was no difference in bonding with either Cesarean birth or VBAC. Yet, others stated Cesarean birth did negatively affect their ability to bond with their infant due to the use of analgesia. In contrast, one woman reported a decrease in bonding after her VBAC which was related to the anesthetic used during delivery.

Goodall, McVittie, and Magill (2009) conducted a qualitative phenomenology study to explore women’s perceptions of the role of health professionals in their decision of birth mode for subsequent pregnancy after a Cesarean delivery. Inclusion criteria included 18 years of age,
expecting their second child, and having delivered the first child by Cesarean delivery. Semi-structured interviews were conducted with 10 pregnant women between 20 and 40 weeks gestation. The authors used interpretative phenomenological analysis to analyze data (Smith & Osborn, 2003). Four themes emerged: (a) lacking relevant knowledge to make an informed choice; (b) obtaining probabilistic information; (c) receiving latent communication from health professionals regarding choice of mode of delivery; and (d) relinquishing control over the mode of second birth to the health professional involved.

All participants expressed a lack of personal knowledge or information relevant to their situation. The participants described not understanding the implications of their previous Cesarean on subsequent VBAC or ERCS. Information provided by health professionals was generalized and too probabilistic, as many participants struggled to make sense of the statistical information provided. Many of the participants stated their personal choice of VBAC was in conflict with their providers’ expectations. Participants said physicians’ offered a choice between VBAC or ERCS, yet, expressed personal opinions regarding success rates, without identifying reasons from an exact source. Overall, the participants saw themselves as having little control for the birth of their second child. For some participants, this was welcomed, due to feeling unprepared to make an individual decision without knowing the likelihood of success.

David, Fenwick, Bayes, and Martin (2010) conducted a qualitative study to understand the information needs for women deciding subsequent pregnancy birth mode after a previous Cesarean delivery. Participants were recruited from the Next Birth After Cesarean (NBAC) service. This service is led by midwives in central Australia to provide evidence-based information and support via telephone, internet, informational booklet, and community resources.
to women seeking advice about subsequent birth mode after a Cesarean delivery. The service is offered to women during their postpartum period following their first Cesarean delivery and during the antepartum period of the women’s subsequent pregnancy.

The researchers analyzed a total of 170 calls from a telephone record book and midwives’ field notes. Latent content analysis was used to analyze data. Six categories were identified from the telephone calls: (a) wanting and seeking a VBAC; (b) exploring the possibility of VBAC; (c) cross checking information and advice; (d) checking in/checking out; (e) feeling distressed and disappointed: wanting to talk; and (f) professional inquiry about NBAC service.

The telephone calls categorized under the “wanting and seeking a VBAC” category were from women desiring a VBAC. This group of women had already gathered information from internet and community mother/play groups about delivery mode prior to contacting the NBAC service. The women had decided on VBAC for second birth, were very motivated and contacted the NBAC service to find support and affirmation of their decision.

The telephone calls grouped under “exploring the possibility of a VBAC” described women who had not yet made a decision of birth mode. The calls came from women who had sought out some information and from women who had not done any research. Primarily, the women contacted the service to find out if VBAC was a possibility. The group of women wanted to discuss with a health care professional reasons for previous birth/births and the possibility of having a VBAC. The women were disappointed about not delivering vaginally for their first birth and contacted the service to explore their options.

The group of telephone calls categorized in the “cross-checking information and advice” were from women seeking clarification about information provided to them by their current
health care provider. The “checking in/checking out” group calls were from current NBAC clients checking in about test results and requesting advice about labor and when to come into hospital. Telephone calls categorized in the “feeling distressed and disappointed: wanting to talk” were from women seeking someone they could share their experience with. The women were seeking information and reasoning behind their first Cesarean birth. The “professional inquiry about NBAC service” category was calls from health care professionals inquiring about the service and how to refer a woman. Overall, the group of women requesting service from the NBAC clinics were pleased with the reliable, un-biased information and were grateful to have access to a midwife via telephone.

Godden, Hauck, Hardwick, and Bayes (2012) conducted a qualitative descriptive study to explore women’s experiences in achieving VBAC and contributory factors associated with achieving their desired mode of delivery. Participants were recruited from the Next Birth After Cesarean (NBAC) service in western Australia. Inclusion criteria included English speaking, birthed once by Cesarean in a previous pregnancy, and achieved a VBAC in their recent pregnancy. Thirteen women consented to the study and were tape recorded via telephone interview. A constant comparative method modified from the grounded theory method was used to analyze the data. Each author coded the transcripts independently and final determination of themes was achieved from discussion.

Two major themes emerged: (a) personal environment (4 subthemes), and (b) professional environment (2 subthemes). Previous birth experience was a major factor in achieving a VBAC. Some women reported their first Cesarean was unnecessary and unacceptable, resulting in the desire to have a subsequent vaginal birth. Many of the women
understood reasons for their first Cesarean (i.e. breech, macrosomia), however, indications for their first Cesarean did not predispose them to have another one. All of the women desired to have a natural birth and the decision of VBAC was desired before conception of their second child. Commitment to vaginal birth, determination, support from partners and family members, and personal information gathering about deliveries contributed to achieving VBAC. Maternal actions on the day of labor were a significant factor in achieving VBAC. Many of the women stayed home in early labor, reducing the possibility for medical intervention in the hospital. All of the women stated they were actively involved in their labor, questioning their labor and birth management and rationale for medical intervention if needed.

The second theme, professional environment, characterized how healthcare providers contributed to helping women achieve a VBAC. For the majority of the women, medical and midwifery staff were positive, confident and supportive of VBAC. The participants reported they were given a choice of birth mode and were provided with sufficient, unbiased information about risks and benefits of VBAC and RCS. On top of the information provided by providers, many of the women personally gathered information to enhance their knowledge about VBAC and Cesarean birth. On the day of delivery, having provider support from midwife and physician was a contributory factor to a successful VBAC.

Dahlen and Homer (2013) conducted a qualitative study to examine how women discuss the delivery option of VBAC in English language blog sites and what factors influence their decision making regarding subsequent delivery following a Cesarean birth. The authors used internet alerts from blog sites using the search engine Google and search term VBAC. The majority of the blogs were from the United States, however, because women blogged from all
over the world, the country of origin was not always provided. Thematic analysis was used to analyze the data. A total of 311 blogs were analyzed in a one year time frame. A major theme “motherbirth” or “childbirth” was generated along with six subthemes: (a) surviving the damage; (b) inadequate bodies; (c) choice and control; (d) fearing and trusting birth; (e) negotiating the system; and (f) minimizing or overestimating risk. Women who exhibited a “motherbirth” framework in their decision making about subsequent delivery mode following a Cesarean delivery expressed that a healthy and happy mother was central to a happy and healthy infant and the process of giving birth was important to achieving such. Women that followed the “childbirth” framework in the decision process of VBAC or RCS believed a healthy baby was paramount and a good mother would not expose her infant to any risks. The majority of women in this group elected to have a RCS.

Women reported the decision process was an emotional process and for many women preparing for their second birth meant avoiding a repeat of the previous birthing experience. The women described their bodies as being inadequate to deliver vaginally. For many women, this belief was reinforced from their healthcare providers. Lack of control and choice during their first birth was central to women’s discussions. In the decision process for subsequent birth, the women wanted to regain control attempting VBAC, while others expressed the desire to have an elective repeat Cesarean section to gain control over their birth. Concepts of fear and trust were described by the women, yet, many were able to work through issues. Women described internet Cesarean and VBAC groups/blogs as being very supportive, motivating, and encouraging for each other. Women reported, in general, hospitals are not supportive of VBAC. Risks of both
delivery modes were commonly discussed in the blogs. Women questioned themselves and each other frequently about whether they were underestimating or overestimating the risks of VBAC.

Lundgren et al. (2012) conducted a metasynthesis from qualitative studies to understand women’s experiences of VBAC. Inclusion criteria included peer-reviewed empirical qualitative studies in English from women’s perspectives of VBAC. Health care related data bases were searched and eight studies were included in the metasynthesis. Four of the studies were from Australia, three from the UK, and one from the United States.

The authors concluded women felt uncertain in relation to birth choice after a previous Cesarean delivery and stated the decision of subsequent birth mode after a previous Cesarean delivery is like “groping through the fog” (p. 3). For many women, information from health care professionals during and after pregnancy was unclear and contrasting. Although health care systems claim to advocate for VBAC, many women found it difficult to find a supportive provider. Four themes were identified with sub-themes: (a) own strong responsibility for giving birth vaginally in relation to the women themselves; (b) vaginal birth after a Cesarean birth is a risky project; (c) vaginal birth has several positive aspects mainly described by women; and (d) to be involved in decision about mode of delivery is hard and important.

The women described that giving birth vaginally after a previous Cesarean birth was a personal responsibility. Gaining information and knowledge about delivery modes was crucial in facilitating a vaginal birth. Many of the women stated it was their responsibility to communicate birth desires to healthcare professionals. Some women identified that communication with their providers was difficult.
The women described how they were informed about VBAC risks and for some this meant medically needing a repeat Cesarean delivery. The women described being informed by a physician or midwife about success rates particular to their individual risks. They reported the decision for birth mode after Cesarean was mostly influenced by physicians and previous birth experience. Many of the women sought information from books, internet, television, women experiencing VBAC, partners, family and friends. The women also described that, although risks were provided, benefits of VBAC were not. Overall, there was a lack of support of VBAC from both physicians and midwives as many of the women described feeling pressured to deliver repeat Cesarean section. Yet, several women experienced having a provider against Cesarean delivery, preferring women to deliver VBAC.

The majority of the women reported positive aspects of giving birth vaginally such as bonding, initiating breast feeding, well-being of infant, aid in lung expansion, transition to motherhood, infant-maternal interaction, and reduction of medical interventions and drugs. The women described giving birth vaginally was meaningful to them as a woman. The women desired to experience a natural birth, reporting the female body was meant to give birth vaginally. For some mothers valuing VBAC but needing a repeat Cesarean delivery, feelings of depression, regret and disappointment continued after delivery.

Overall, the women reported lack of information and conflicting, contradictory information from health care systems, negatively influencing decision making about mode of delivery. Having a choice for birth mode was dominant for the women and the majority of women reported health care professionals allowed them to make the decision of VBAC or repeat Cesarean delivery. Being involved in the decision increased trust between provider and patient,
increased confidence and for some women gave them a sense of control. Although, in one study, several women reported relinquishing control to the provider to avoid feelings of guilt over making a decision.

**Decision Making Patient: Quantitative Research**

Martin, Hauck, Fenwick, Butt and Wood (2014) conducted a comparative descriptive study on 47 pregnant women attending the Next Birth After Caesarean (NBAC) service to determine changes in childbirth fear, confidence, knowledge and intention to pursue a VBAC in their current pregnancy, compared to 45 women receiving standard pregnancy care at a hospital clinic. Pregnant women with one previous Cesarean delivery were able to participate in the study. The NBAC antenatal service was conducted by midwives between 14 and 16 weeks gestation. At this time point, the NBAC women received an evidenced based information packet about subsequent birth modes after a previous Cesarean delivery. Women were allowed time to talk through their last birth experiences along with feelings and concerns about current pregnancy. The NBAC women attended two medical reviews later in pregnancy, where options of birth mode were discussed and decision of birth choice was recorded. Both the NBAC and standard care group received a survey packet between 14 and 16 weeks and 36 weeks gestation. All participants were contacted at 6 weeks postpartum and data were collected verbally via phone. Descriptive statistics, chi-square and t-tests were used to analyze data and content analysis was used to analyze participants questionnaire comments at 36 weeks gestation and postnatal telephone interviews.

The researchers concluded by 36 weeks gestation there was a significant increase in knowledge and confidence for the NBAC group compared to the standard care group, however,
there was not a significant difference in childbirth fear and satisfaction between the two groups. Although the NBAC group demonstrated an increase in childbirth knowledge, it did not translate into increased VBAC rates.

Martin, Fenwick, Hauck, Butt and Wood (2015) also conducted a comparative descriptive design (pre/posttest) study to evaluate the effectiveness of a postnatal service provided by the NBAC midwives on women’s birth mode intentions in a subsequent pregnancy after Cesarean delivery and their levels of childbirth fear and self-efficacy at 12 weeks postpartum. Fifty-three women completed questionnaires in the comparison group and 50 in the NBAC postnatal group. Women in the comparison group received routine postnatal care from various different midwives who worked on the postnatal ward according to the hospitals postpartum care guidelines. Information provided to the women concentrated on birth after Cesarean delivery, postnatal depression and anxiety. Women in the NBAC group were visited by the NBAC midwives 3 to 5 days postnatal. The midwives provided each woman with information for reason of their Cesarean delivery and an evidenced-based post Cesarean information package which included a brief overview of the NBAC service, contact details, benefits and risks of VBAC and RCS, information on postpartum depression, anxiety, community resources, and a brochure about making informed choices for their subsequent birth. The women were advised they could contact the NBAC service at any time with questions regarding future pregnancies and birth. Data were collected at 3-5 days postpartum and 12 weeks postpartum. A demographic questionnaire, The Childbirth Experience and Expectations Questionnaire (Version B) (Wijma, Wijma & Zar, 1998) and The New General Self-Efficacy Scale (Chen, Gully, & Eden, 2001) were administered at both time points. At 12 weeks
postpartum, the women were asked for their intended preferred mode of birth for subsequent pregnancy. Descriptive statistics and chi-square test were used to analyze data. The authors reported no significant difference between groups in childbirth fear, self-efficacy and intention to birth VBAC in subsequent pregnancy.

Bernstein, Matalon-Grazi, and Rosenn (2012) conducted a prospective, observational study of 155 (n=87 TOLAC, n=68 ERCS) women admitted to a hospital in New York for delivery. Inclusion criteria included one prior Cesarean delivery and eligible for TOLAC. Data were collected after admission for a scheduled ERCS or admission for TOLAC. Demographic information, prior Cesarean experience, family planning goals, perceived provider preference, factors affecting patient’s choice, and knowledge of risks/benefits of both deliveries were collected from participants. Participants’ knowledge of the risks and benefits of deliveries were assessed from key points noted in the ACOG (2010) VBAC practice bulletin. Chi-square and Student t-test were used for data analysis.

The authors found that women deciding subsequent pregnancy birth mode after a previous Cesarean delivery were not properly informed about the risks and benefits of delivery methods. Particularly in the ERCS group, both TOLAC and ERCS groups lacked awareness, understanding, and showed insufficiencies in the area of comprehension regarding risks and benefits of both delivery methods. Overall, both groups were unfamiliar with successful TOLAC rates, effect of indication of previous Cesarean delivery on success of TOLAC, risk of uterine rupture, increased length of recovery for ERCS compared to TOLAC, and increase of maternal death, neonatal respiratory problems and neonatal intensive care unit (NICU) admission for ERCS. When women perceived their providers as having a preference for ERCS, very few
chose TOLAC. However, the majority of women chose TOLAC if the delivery mode was the physician’s preference.

Konheim-Kalkstein et al. (2014) conducted a quantitative study examining psychological variables that influence women’s decision for VBAC or ERCS. Women were recruited online via social networks. Women who were currently pregnant (n=166) and women planning on being pregnant (n=177) with one previous Cesarean delivery participated in the study. Of the women, 215 were planning TOLAC, 48 were planning elective repeat Cesarean delivery (ERCS), and 48 were undecided. Survey questions were used including women’s birth plans, current, past, and future pregnancies, outcomes and opinions on their previous births, risk perception about VBAC and ERCS, influences of birth plan, influences by others’ birth stories, and the Multidimensional Health Locus of Control Scales for Labor and Delivery (Stevens, Hamilton, & Wallston, 2011). One-way ANOVAs and Chi-square goodness of fit tests were used to analyze data.

The authors found TOLAC women perceive an ERCS as more risky and ERCS women perceived TOLAC as more risky. TOLAC women were less satisfied with their first birth, feeling a sense of failure on part of themselves, their body and their healthcare providers. Women desiring a TOLAC had a higher internal locus of control for childbirth and a lower powerful others locus of control than undecided or ERCS women. More TOLAC women used online sources and support groups as an influence for their birth plan compared to ERCS women. TOLAC women were less likely to rely on healthcare providers as an influence for their birth plan compared to ERCS. The most influential sources of information for TOLAC women were doulas, online information, support groups and educational experiences. Elective repeat Cesarean
delivery women identified their husband/partner/significant other and their health providers as their most influential sources of information.

Konheim-Kalkstein, Kirk, Berish and Galotti (2017) conducted a quantitative study examining the factors that influence women to choose VBAC. A convenience sample of 173 women from the United States were recruited through clinics, internet and word of mouth to participate in the online survey study. Inclusion criteria included women currently pregnant with a singleton pregnancy, one prior delivery via Cesarean, transverse horizontal incision and 18 years of age. Survey questions were used including influences of healthcare providers and online sources, objective knowledge of risks, medical reasons for first Cesarean delivery, subjective influences of birth decision, Positive and Negative Affect Scale (PANS) (Watson, Clark, & Tellegen, 1988), and Multidimensional Health Locus of Control Scales for Labor and Delivery (Stevens, Hamilton, & Wallston, 2011). The authors hypothesized women desiring a vaginal birth will choose VBAC and have a low powerful others locus of control. Hierarchical logistic regression was used to analyze data.

The authors found women having a low powerful others locus of control were more likely to choose VBAC. Women employed in healthcare were less likely to choose VBAC compared to women not in healthcare. Women reporting their healthcare provider as their main source of information were also less likely to choose VBAC. Women having a previous Cesarean for large baby or underlying medical reason, and fear of damage to vaginal area were less likely to choose VBAC. The importance of cosmetic appearance and the desire to experience vaginal birth were factors that influenced women’s decision to VBAC (Kohheim-Kalkstein et al., 2017).
Shorten et al. (2005) conducted a randomized controlled study of the effectiveness of a decision-aid for women with one previous Cesarean birth in making an informed decision regarding VBAC or RCS for subsequent pregnancy. Outcome data included level of knowledge, decisional conflict score, preference for mode of birth, actual mode of birth, and satisfaction. All participants were surveyed at 12 to 18, 28, and 36 weeks gestation and 6 to 8 weeks postpartum. The intervention group (n=112) was given a decision-aid booklet describing risks and benefits of RC and VBAC at 28 weeks gestation. The control group (n=115) received routine prenatal care. The researchers hypothesized the decision-aid would improve levels of knowledge about birth choices and affect rates of VBAC versus RC.

The researchers concluded the intervention group showed a significant increase in knowledge scores between 28 and 36 weeks of gestation, compared to the control group. The intervention group experienced a reduction in their decisional conflict score between 28 and 36 weeks gestation, compared to the control group. There was not a significant effect of the decision-aid on birth preference, actual birth mode, and satisfaction.

Shorten and Shorten (2012) analyzed one segment of data from a randomized control trial (Shorten et al., 2005) to examine women’s postpartum perceptions of planned VBAC and to explore outcomes and experiences of women achieving VBAC, women attempting VBAC but having a repeat Cesarean delivery, and women electing for a repeat Cesarean delivery. A total of 165 women completed surveys 6 to 8 weeks postpartum. Satisfaction with birth was measured using a visual analogue scale (VAS) with a numeric scale from 0 (least satisfied) to 10 (most satisfied). A portion of the Women’s Experience of Childbirth Services survey (Brown & Lumley, 1998) was used to indicate any health problems the mom experienced since the birth of
her infant. The EQ-5D (EuroQol Research Foundation, 2015) was used to measure self-reported state of health. The Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987) was used to measure postpartum depression. Adherence to choice was measured by comparing birth preference at 36 to 38 weeks compared to actual delivery mode.

Findings showed women’s satisfaction with their birthing experiences was significantly related to mode of delivery. Satisfaction scores were higher for women having a spontaneous vaginal delivery and ERCS compared to women having an instrumental vaginal birth or emergency Cesarean birth. Women having an instrumental birth or emergency Cesarean delivery had a higher number of postpartum health issues and were least likely to agree that they would make the same birth choice with a subsequent delivery. Overall, 78% (n=165) of the women in the study would make the same delivery choice for a subsequent pregnancy. The authors found that higher scores on the Edinburgh Postnatal Depression Scale (EPDS) were associated with lower satisfaction scores of women’s birthing experiences. Women having spontaneous vaginal birth had lower incidences of EPDS scores than instrumental vaginal birth, emergency Cesarean birth and elective repeat Cesarean birth.

Shorten and Shorten (2014) analyzed data from the randomized control trial component of the study (Shorten et al., 2005) to empirically examine women’s preferences for TOLAC versus ERCD at different time points of pregnancy. The research questions guiding this quantitative study were: (a) what mode of birth did women prefer during early pregnancy (survey 1 at 12-18 weeks gestation); and (b) what factors influenced adherence to birth preference (survey 1 and 2 at 28 weeks gestation). Two hundred and twelve women completed both surveys 1 and 2. The authors hypothesized that the women’s birth mode preference would not change
between the two survey points. Bivariate analyses and logistic regression models were used to determine preference patterns and degree of adherence to early pregnancy preference.

The authors found TOLAC was preferred over repeat Cesarean delivery by women at both time frames (survey 1- 56.1%; survey 2- 50.5%). Women uncertain of delivery mode represented 17.9% of the study population at 12-18 weeks. At 28 weeks the percentage increased to 25.0% of women being uncertain of delivery mode, particularly for women initially preferring a TOLAC. Adherence to initial choice was slightly greater for women choosing TOLAC (79.0%) compared to ERCS (70.9%). Women who reported problems with their previous Cesarean delivery were more likely to adhere to TOLAC rather than ERCS. Overall, the authors found birth mode preferences change significantly from early pregnancy to mid pregnancy.

Patient decision aids (PtDA) provide clear and informative information to women deciding birth mode after a previous Cesarean delivery (Schoorel et al., 2014). Montgomery et al. (2007) conducted a randomized controlled study to determine effects of two computer based decision aids on decisional conflict and mode of delivery among women with a previous Cesarean birth. Outcome data included total score on a Decisional Conflict Scale and mode of delivery. Secondary outcomes were anxiety, knowledge, and satisfaction. The sample population was women with one previous lower segment Caesarean section, no current obstetric problems, and delivery expected ≥ 37 weeks. Women of all parities were included, however, their most recent delivery must have been a Cesarean birth. Seven hundred and forty two women from England and Scotland participated in the study. Participants were surveyed between 10 and 20 weeks gestation, 37 weeks gestation, and 6 weeks after delivery. After the first contact, the women were randomized to one of three groups (intervention 1, intervention 2, usual care).
Intervention one was a computer based information program about the outcomes associated with planned vaginal delivery, elective Cesarean section, and emergency Cesarean, along with descriptions of possible outcomes for mother and baby. Women allocated to this group could access this information throughout their pregnancy. Intervention two was a decision analysis that included a utility assessment exercise and individualized decision analysis. Usual care was defined as the usual level of care given by the obstetric and midwifery team. The women in the intervention groups also received usual care.

The authors concluded total decisional conflict scores were reduced in all three groups at follow up (37 weeks) compared to baseline (10-12 weeks). However, in both intervention groups the decisional conflict score reduced more than the usual care group. A higher proportion of women in the decision analysis group (intervention 2) delivered vaginally compared to the information program (intervention 1) and usual care groups. Women in both intervention groups reported reduced anxiety compared to the usual care group. The majority of the women (66%) reported a preference for mode of delivery mid-way through their pregnancy (19 weeks) and approximately 57% held the same preference at 37 weeks. Amongst the women who had changed their birth preference between time points (8.1%), 76% had changed from preference of VBAC to RCS. Overall, 65% of the women delivered via mode of preference (Emmett et al., 2010).

Eden, Perrin, Vesco, and Guise (2014) conducted a randomized comparative trial of the effectiveness of two decision aids (two brochures or computerized decision aid) for women with one previous Cesarean delivery in making an informed decision about TOLAC. Inclusion criteria included 18 years of age, currently pregnant with one fetus, low transverse uterine scar, one
previous Cesarean delivery, English or Spanish speaking and option of TOLAC per physician. All participants were surveyed during their antepartum phase at three recruitment locations affiliated with Oregon health systems or at local health fairs. Outcome data included birth intention, decisional conflict score, route of delivery and birth priorities. The authors hypothesized women using the computerized decision aid would experience less decisional conflict about birth priorities compared to women receiving the brochures. The authors also explored the effect of the brochures and computerized decision aid on route of delivery, along with birth priorities for women receiving the computerized decision aid. One hundred and thirty one women participated in the study (n=65 brochure group; n=66 computerized decision aid group).

The researchers concluded that change between pre and post intervention in decisional conflict around birth priorities did not differ between groups. However, the use of both brochures and computerized decision aid significantly improved four decisional conflict measures (feeling informed, having clearer priorities for the birth, feeling supported, overall having less conflict). There was not a significant effect of both interventions on success of VBAC. However, regardless of intervention, the authors found a significant relation between preferred delivery route and actual delivery route.

Scaffidi, Posmontier, Bloch, and Wittman-Price (2014) conducted a cross-sectional, descriptive study on 45 women with one previous Cesarean on their knowledge of the risks and benefits of TOLAC and ERCS, and their degree of decision self-efficacy (confidence in making an informed decision) to their choice of VBAC or RCS. Bandura’s Theory of Self-Efficacy was the guiding framework for the study. The authors hypothesized: (a) women with a history of one
Cesarean delivery who have higher levels of knowledge regarding risks and benefits of TOLAC and RCS will opt for TOLAC for their second birth; (b) women with one previous Cesarean delivery who have a higher degree of self-efficacy will opt for TOLAC for their second birth; and (c) women with higher knowledge regarding risks and benefits of TOLAC and RCS will have a higher degree of self-efficacy and will opt for TOLAC for their second birth. A knowledge and expectation scale (Farnworth et al., 2008) and the Decision Self-Efficacy Scale (O’Connor, 1995) were used to measure degree of knowledge and self efficacy. Data was collected between 10 and 22 weeks of gestation.

The authors found the degree of decision self-efficacy was not associated with the choice of TOLAC versus RCS and there was not a significant interaction between decision self efficacy and degree of knowledge for women choosing TOLAC. A positive significant relation was found between knowledge and decision for TOLAC. This finding is very important to healthcare professionals counseling women. Women that were better informed about birth choices have higher knowledge about risks and benefits about birth choices, understanding that TOLAC is a reasonable alternative to ERCS.

**Decision Making Patient: Mixed Methods Research**

Cox (2007) conducted a mixed method study to explore women’s issues between the choice of VBAC or elective Cesarean delivery, the extent of information received when making the decision, the sources of information and the influence it has on the decision. For the qualitative component of the study the authors used a purposive sample to interview women deciding between ERCS and VBAC in their current pregnancy. Quantitative data were collected in the antepartum period and qualitative data in the postpartum period. Thirty-nine women
completed the surveys in the antepartum period. The most frequent type of information women received during the antenatal period was about pain relief in labor, uterine rupture, length of labor or operation, risks of proceeding to a Cesarean if a VBAC was planned, care for wound, risk of infection, thromboembolism, timing of birth, mobility after birth, pain relief after birth, arrangements for care of other children and driving after birth. The risks of needing a Cesarean if VBAC was planned, uterine rupture, injury to baby, childcare for siblings and length of hospital stay were ranked the most important factors when making a decision of VBAC or repeat Cesarean delivery.

Seven of the 39 women were interviewed during the postpartum period. The main source of information about delivery modes came from the hospital consultant/obstetric team, community midwives and hospital leaflet. Most of the women stated the information was beneficial, although, two of the women reported not having enough information. Several women stated they received conflicting advice between health professionals. Risks were discussed with all of the women, however, the information was provided differently. Some women received factual statistics while others were told it was “a risk” or “small risk.” Several of the women stated information was not freely given, as many of the women had to ask for information or search for information outside the healthcare team. Understanding of information varied for each woman, as some reported the information/terminology was clear while others did not understand information provided to them.

Support of VBAC from healthcare professionals varied on an individual level. Partners/husbands did not have a great impact in the decision of delivery mode. Several of the women stated they lost control of the birth process in previous deliveries and their current
delivery, particularly women delivering via emergency Cesarean delivery. Findings showed that none of the participants had an opportunity to debrief with a healthcare professional about their experiences and feelings of previous deliveries despite their description of experiencing emotional trauma from having an emergency Cesarean delivery. Overall, the researcher found women in this study did not make an informed choice regarding birth mode after a previous Cesarean delivery.

Farnworth et al. (2008) conducted a developmental study exploring the impact of a decision support intervention for women deciding mode of delivery after a previous Cesarean delivery. Qualitative research methods were used to examine women’s experiences of decision-making with the aid of the intervention and without. For a pilot component of the study, quantitative data were collected at 3 time points (11-12 weeks, 28 weeks, 37 weeks gestation). Inclusion criteria included women with a history of one previous Cesarean delivery, no previous vaginal delivery, and understanding of written and verbal English. Thirty-two women consented to the quantitative portion and were selectively allocated to either the intervention or control group (routine care). Eighteen agreed to participate in the qualitative portion of the study (11 from intervention group and 7 from control group). The intervention entailed a take home DVD/video and one-on-one home visit with a health care provider. The video was distributed at 12 weeks gestation to be viewed throughout the pregnancy and the home visit was from a midwife between 30 and 34 weeks gestation. Routine care consisted of an information leaflet about delivery modes at 12 weeks and appointment with an Obstetrician at 36 weeks gestation. During this time frame (36 weeks gestation) decision of delivery mode was discussed and finalized. The Decisional Conflict Scale (O’Connor, 1995), Decision Self-Efficacy Scale (Bunn
and a knowledge and expectations scale generated by the authors were completed by participants. The knowledge and expectation scale consisted of multiple choice questions scored to identify risks and benefits of VBAC and RCS. For the quantitative portion, the researchers used descriptive statistics to observe differences between groups and Students t-tests to compare group means. Qualitative data were collected from audio taped one-on-one interviews. Thematic analysis and the constant comparison method (Glaser, 1965) of interviews were conducted by authors.

For the quantitative component, the authors did not find significant statistical differences between or within groups at each time point. Four themes were identified from the qualitative data: (a) informational support; (b) emotional support; (c) participation and involvement in decision-making; and (d) using decision support. Information support was discussed in terms of amount and usefulness. Some of the women, regardless of study allocation, reported that the information leaflet and or DVD was the only information provided to them, resulting in seeking information from the internet, television and other people. For others, the leaflet and/or DVD was sufficient. The majority of the intervention group did not differentiate from the control group in terms of usefulness of the DVD over the informational leaflet.

Women stated they desired emotional support in the decision process from partners and close family to aid them in making a decision of subsequent pregnancy birth mode after a Cesarean delivery primarily because of a traumatic prior birth experience. However, some women in this study reported the support was not helpful because they described their partners and close family as carrying traumatic memories of the first delivery themselves, unwilling to
provide opinions, or advice. The women in the intervention group praised the home visit as this was a means to communicate their feelings about their previous birth experience.

Participation and involvement in decision making varied. Most of the women reported difficulty making a decision, feeling uncertain throughout the pregnancy. For some women very sure of preferred birth mode at the beginning of pregnancy ended up changing their minds later in pregnancy. Women in the control group reported not having an opportunity to discuss concerns with their provider.

Most noticeably in the intervention group, the women reported that understanding facts about previous Cesarean delivery were crucial in making a decision for second birth mode. Information provided to the women gave them confidence in their decision along with understanding and justifying their decision of birth mode. For women very unsure of their decision, the intervention was a means to provide structure, which guided decision making. For some women, dissatisfaction was reported from lack of communication with provider, conflicting information or doubts about the expertise of the provider.

In summary, the decision making process for subsequent pregnancy after a previous Cesarean delivery is an emotional and difficult experience for women. Participation and level of involvement in the decision varies. Some women want total control of the decision, while others want input from family, friends and provider to finalize a decision. Some women desire a VBAC to experience a natural birth, or to have an easier recovery. While some women desire a RCS because they know what to expect and feel it is the safest route for delivery. Many women remain uncertain of birth mode decision throughout their pregnancy. Lack of information and feeling ill-informed regarding risks and benefits of both birth modes contributes to the
uncertainty women face in making a decision. Women seek information from books and the internet to gain knowledge, yet, information is not always accurate and trustworthy. Decision aids used for the decision process of VBAC or RCS have shown to increase women’s knowledge of risks and benefits of both delivery modes, and decrease decision conflict and uncertainty. Yet, such tools to assist women in their decision remain unavailable to women in the outpatient obstetric clinical setting. Such tools could be used to increase women’s knowledge and understanding that VBAC is a reasonable and safe birth mode after a previous Cesarean delivery, therefore, encouraging more women to attempt TOLAC, ultimately, resulting in increased VBAC rates and decreased RCS rates.

**Summary of Review of Literature**

A summary of the research described above concludes that VBAC is a reasonable birth mode for women with one previous Cesarean delivery. Furthermore, women with a successful VBAC have a lower risk of maternal and neonatal morbidity and mortality. Successful VBAC is more cost-effective than a repeat Cesarean delivery. Many pregnant women prefer to be involved in making decisions to choose between a VBAC or RCS after the initial Cesarean delivery, yet remain uncertain about the delivery mode throughout the pregnancy up to the onset of labor. Information provided to women from healthcare professionals about risks and benefits of delivery modes is inconsistent and scarce. Because physician bias regarding delivery modes exists, along with healthcare institutions not offering VBAC, some women have to shop for a provider willing to comply with their desired decision.

Based on this review of literature of decision making of subsequent pregnancy birth mode after a Cesarean delivery, one concludes that knowledge development related to this
reportedly important process during pregnancy has been impeded by unclear distinction of methodology used in studies and lack of theoretical grounding. In this review, several researchers failed to mention research design in reports. Also, several authors reported using the principles of grounded theory to guide their study and using the constant comparative method to analyze data, yet, reported results as themes and not conceptual categories.

Furthermore, the majority of research studies focusing on women’s decision making for subsequent birth mode after a Cesarean delivery have been conducted outside the United States and from a health care system different than the United States health care system. The Scandinavian countries Finland, Norway, Iceland, & Sweden continue to have the lowest Cesarean rates of 17.3% and under (OECD, 2017). The Netherlands also has a low rate of 15.9% (OECD, 2017). Turkey (53.1%), Mexico (46.8%), and Chile (46%) have the highest Cesarean rates (OECD, 2017). Germany (30.2), United States of America (32.2) and Australia (34%0) Cesarean rates remain relatively high, while the United Kingdom (26.2), Canada (26%), Spain (24.5) and France (20.8) have slightly lower rates (OECD, 2017). To understand why VBAC rates vary widely in different healthcare settings and countries, Lundgren, van Limbeek, Vehvilainen-Julkunen, and Nilsson (2015) interviewed clinicians from three countries with high VBAC rates (Finland, Sweden, Netherlands). The authors found that in these countries women are primarily seen by Midwives throughout their pregnancy and VBAC is considered the first alternative birth mode after a previous Cesarean, unless there is a medical reason for performing a Cesarean delivery. The authors found clinicians (OB and Midwife) work together as a team and build/strengthen women’s trust in VBAC. Clinicians are confident and share the same view on VBAC, encouraging women to deliver vaginally. For women experiencing fear of childbirth,
Sweden uses a “fear team” model where midwives and OBs work closely with each woman and her partner to agree upon a birth plan. The birth plan entails a detailed outline for labor and indications for performing a Cesarean delivery if needed (Lundgren et al., 2015).

The maternal healthcare culture mentioned above is different to that of the United States, where obstetricians are the go-to provider for maternal care. In 2015, MDs attended 84.0% of all hospital births, CNM 8.1% and DOs 7.1% (Martin et al., 2017). For many providers, VBAC is not the first alternative for subsequent pregnancy birth mode after a Cesarean delivery. Cox (2011) found fear of liability and risks associated with VBAC were major concerns for offering TOLAC. In addition, Cox (2011) found Obstetricians and midwives reported scheduling a Cesarean delivery was convenient. Some of the midwives in the study disagreed with such practice and felt marginalized by being excluded from delivering VBAC (Cox, 2011). Furthermore, strict VBAC guidelines issued by ACOG (2010) resulted in many hospital and physicians not offering VBAC, and women having the only option to deliver RCS. Women desiring a VBAC in the United States face tremendous barriers and obstacles in spite of the evidence that VBAC is a reasonable and relatively safe birth mode for subsequent pregnancy after a Cesarean delivery. International research studies have been done in the area of women making decisions regarding a subsequent pregnancy after a Cesarean birth, yet, little is known in the area of women deciding VBAC or RCS in the United States. Therefore, research is needed to identify major influences that affect pregnant women when making decisions about a subsequent pregnancy after a previous Cesarean birth. Since little is known about the phenomena of study in the United States, qualitative research will be the research design for this study. Decision making is a process and grounded theory is a qualitative method used to discover a basic social process (Glaser & Strauss, 1967). Therefore, a theory of women’s decision making of subsequent
birth mode after a previous Cesarean delivery is needed and this theory must be grounded in the experience of women with a previous Cesarean delivery deciding birth mode for subsequent pregnancy. The proposed theory will provide maternal patients and healthcare providers with research based information, regarding individual preferences in decision making of birth option that can lead to enhancing the birthing experience for each individual patient.
CHAPTER THREE
METHODOLOGY

In this chapter, the qualitative approach used to generate a substantive theory of decision making for women deciding subsequent pregnancy birth mode after a previous Cesarean delivery is presented. The classical grounded theory methodology including sampling plan, recruitment, data collection and analysis outlined in Glaser and Strauss (1967) guided this study. Through the process of a constant comparative method (Glaser & Strauss, 1967) the researcher was able to conceptualize the process of women’s decision making for birth mode after a previous Cesarean delivery.

Research Design

The purpose of this study was to generate a theoretical explanation of the decision making process for women as they choose a birth option of VBAC or RCS after a previous Cesarean delivery. For this study, classical grounded theory methodology was used. Decision making is a process and the grounded theory method was used to discover the basic social process of women deciding VBAC or RCS. Grounded theory methodology is the discovery of theory from data. It is the research design of choice when little is known about the phenomena. In grounded theory methodology, a comparative analysis of data generates a set of integrated categories/concepts that produce an inductive theory about a substantive area (Glaser & Strauss, 1967).

The foundation of grounded theory, symbolic interactionism is conceptualized as a
process of humans learning to define their world through an interactional process with others. Symbolic interactionism is based upon three premises: (a) human beings act toward things in their world by the meanings that the things have for them; (b) meanings of such things are derived from social interactions that one has with others; and (c) meanings are defined through an interpretative process used by the individual in dealing with the things they encounter in daily life (Blumer, 1969). Through an interactional process, a theory grounded in the experiences of women deciding upon subsequent birth option after a previous Cesarean delivery was generated.

**Setting**

The study was conducted at a large integrated health system in the Midwest that offers VBAC to women deciding birth option, and through an online social media Facebook page, ICAN (International Cesarean Awareness Network).

**Recruitment**

The recruitment process began by mailing every Obstetrician, Midwife and Doctor of Osteopathic Medicine (DO), practicing in maternal care and affiliated with the integrated health system, an abstract of the study and permission to collect data from their patients. A self addressed envelope was included with instructions to print and sign their name giving approval to collect data from patients. A total of nine signed letters were returned; eight approvals and one disapprove. The outpatient offices were contacted to schedule study information sessions to employees providing care to patients. A total of three information sessions were scheduled. The informational meetings were conducted in the obstetric outpatient clinic offices. The researcher introduced the study and inclusion and exclusion criteria of participants. Healthcare providers were informed of the study and asked to give women meeting inclusion criteria a survey packet
consisting of a study description letter and informed consent (Appendix A), along with a demographic information form (Appendix B). The participants were informed to contact the researcher by phone or email if interested in participating. The researcher was not granted permission to post recruitment flyers (Appendix C) in exam rooms. Five of the total eight approval offices did not return a phone call to schedule the information session. Only one participant from the outpatient offices contacted the researcher, was recruited and interviewed in person during a three month period. With the low recruitment, alternative recruitment strategies were warranted.

Admon et al. (2016) found over a month duration, five times as many pregnant women were recruited for survey research via social media web-based compared to a clinic-based setting. In addition, the pregnant women recruited via social media were more demographically diverse than women recruited from clinics (Admon et al., 2016). Due to low participant recruitment, discussions with the dissertation chair resulted in an additional recruitment area via social media web-based. With a total of 51,191 social media Facebook members, The International Cesarean Awareness Network (ICAN), a nonprofit organization supporting women deciding subsequent birth option after a Cesarean delivery was contacted to request permission to recruit participants via online or at local chapter meetings. The ICAN board of directors granted permission. An amendment to the study protocol was submitted and approved prior to initiating the change in the recruitment process.

Following approval, recruitment flyer information was posted on the ICAN social media Facebook page. Pregnant women interested in the study voluntarily contacted the researcher via university email. Women who were identified according to inclusion and exclusion criteria were
given the option of an in-person or telephone interview. Eleven participants were recruited from social media. All eleven requested a telephone interview. The women requesting a phone interview were sent an informed consent and demographic form to their email of choice. The women were to read, sign and complete the demographic forms. The participants returned all documents to the researcher before each phone interview.

Sample

Twelve study participants with a history of one previous Cesarean delivery were recruited for this study over a 9-month period. Inclusion criteria for the sample was one previous Cesarean delivery, vaginal trial of labor eligible per healthcare provider, 18 years of age and English speaking. Exclusion criteria was a history of uterine rupture or dehiscence, more than one Cesarean section, any medical complication contraindicated for vaginal trial of labor (history of uterine rupture, placenta previa, malpresentation, active genital herpes, severe pregnancy induced hypertension), multiple gestations and women less than 18 years of age. Sample size was determined by the data generated.

Data Collection

Eleven interviews were done as a phone interview and one in-person interview was completed. Before each interview, the purpose and nature of the study, consenting process, and the right to withdraw from the study were explained to participants. The informed consent and demographic forms were completed before the start of each interview. Before each interview, participants were asked if they had any questions or concerns.

All interviews were conducted by the researcher. Each interview was audio recorded. Each interview began with general questions asking gestational week, current provider (OB,
Midwife, GP), and current decision of VBAC or RCS. After each interview, a $25.00 electronic gift card of choice was sent to each participant's email for compensation of their time. An open-ended interview guide was used to structure the interviews and to keep the researcher and participant focused on the substance of the interview (Appendix D). Participants were encouraged to speak freely without interruption from the researcher during the interview. The interview began with an open-ended question by asking the participant, “When did you first start thinking about making a decision between VBAC or RCS?” Probes were used by the researcher to encourage participants to expand on a point, ask for further clarification or to redirect the interview back on topic. The researcher used elaboration phrases such as, “Could you tell me more about that?” or “Could you give me an example regarding that?” At the end of each interview, participants were asked if they would like to share any additional information about their decision of VBAC or RCS.

**Data Analysis**

Following the completion of the first interview, the researcher transcribed the interview. After transcription, the researcher replayed the audio version of the interview and compared it to the transcription to correct any errors. A second copy of the transcription was used for data analysis. Confidentiality was maintained as each participant was assigned an identification number that linked the participant to the data. The original consent, demographic forms, tape recording and copy of the transcription were stored in a locked file in the researcher’s residence.

Consistent with the grounded theory method, the first interview was coded before proceeding to the second interview (Glaser & Strauss, 1967). Then data from the second interview were compared to the first interview codes and this process was repeated until all data
were collected for the study. Data were analyzed using a constant comparison method (Glaser & Strauss, 1967). Two levels of coding were used to analyze the data; open and axial coding.

During the process of open coding, the researcher did line by line coding from the words of the participant, circling key words, sentences and/or phrases to identify initial patterns, and to ultimately verify and saturate individual categories. In this process, the researcher broke down, examined and compared data, coding events into as many categories as possible (Glaser, 1978). During this process of breaking down the data into analytic pieces, the researcher questioned continually; “What is happening in the data? What category does this event or incident represent?” (Glaser, 1978). Substantive codes were highlighted in the margins that corresponded with the specific code in the text. Memo writing was used to provide an immediate illustration of the researcher’s idea, apply a variety of analytical schemes, identify emerging hypotheses, reflect upon hunches in the data, and protect against bias (Glaser & Strauss, 1967). Memo writing was used from the first interview to the final. After each interview was coded, each word, sentence, or phrase was cut and taped to a separate sheet of paper that highlighted the specific code at the top of the paper. As subsequent interviews were coded, the codes were compared to existing codes, or new codes were generated. Text that did not represent an existing or new code were taped to paper that highlighted a miscellaneous category. After the completion of coding the seventh interview, a process pattern became apparent. Theoretical sampling was applied in the remaining five interviews, incorporating participants wanting a VBAC (n=3) and RCS (n= 2) in either their first and second trimesters of pregnancy to enhance the variability of category properties. Study participants gestational weeks and decision of VBAC or RCS at the time of interview are outlined in the findings section, Table 1.
In the second process, axial coding, the researcher reanalyzed the results of open coding and collapsed codes into named conceptual categories. In this process, the researcher compared incidences with properties of each category from the initial coding. Through constant comparison, different categories and properties became integrated. From the researcher’s memos, essential properties and characteristics of categories, relationships/linkages between categories was identified (Glaser & Strauss, 1967). The researcher re-examined all transcripts to confirm that the emergent categories fit the data (Glaser, 1978).

The third process of data analysis is the emergence of a core category. A core category was obtained from the researcher’s memos, properties of categories identified in axial coding, centrality and connectivity to other categories and the recurring nature of the category. All conceptual categories were integrated around the core category (Glaser, 1978; Glaser & Strauss, 1967). The coded data and the connection of categories and memos formed a systematic substantive theory of the decision making process of subsequent birth after a Cesarean delivery.

**Study Rigor**

Study rigor in qualitative research is maintained by the researcher adhering to credibility, dependability, confirmability and transferability (Glaser & Strauss, 1967; Lincoln & Guba, 1985). Credibility was maintained through prolonged, immersed, engagement with each participant to truly understand the process of women deciding subsequent birth after a Cesarean delivery. The researcher adhered to the principles of grounded theory methodology, the constant comparative method of data analysis, and memoing, to generate a credible theoretical process of women’s decision making of subsequent birth after a previous Cesarean delivery. Trustworthiness was established with each participant by the researcher displaying an
understanding and interest of the decision process, in an unbiased manner. The researcher reported events truthfully, with accuracy and transparency, so readers can see the process of data collection and analysis. With maintaining confidentiality, the researcher reported direct quotes from interviews for readers to understand the researcher’s analysis (Glaser & Strauss, 1967; Rubin & Rubin, 2005; Lincoln & Guba, 1985). Dependability of the study was demonstrated by having an experienced grounded theory researcher examine the process and product of the research study (Lincoln & Guba, 1985). Confirmability was adhered to by the researcher keeping an audit trail of each interview, each level of data coding, and the researcher’s memoing that led to the generation and integration of concepts (Glaser & Stauss, 1967; Lincoln & Guba, 1985). Transferability of the study was determined by the researcher thoroughly describing and reporting the research context, analysis and conclusions, so when read by other researchers, the findings having meaning to the decision process of VBAC or RCS and can be transferred to other similar contexts or settings (Lincoln & Guba, 1985).

**Ethical Considerations**

The primary investigator received approval from the Institutional Review Board (IRB) of Edward-Elmhurst Health and Loyola University Chicago before the start of the study. Each participant signed an informed consent before the start of the interview. Each participant was informed of minimal risks and benefits, aware that the interviews were audio-taped, and she could decline to answer any questions, stop the interview at any point and withdraw from the study without consequences. Participant confidentiality was maintained. The transcribed interviews were marked with an identification number and all identifying information (demographic sheet and informed consent) was kept in a secure locked area.
CHAPTER FOUR

RESULTS

In this chapter, the study findings of the basic social process of the decision making process for subsequent pregnancy birth mode after a Cesarean delivery are presented. The study sample, recruitment, data collection and analysis are presented in the beginning of the chapter. The study findings are presented after this section. The final section of this chapter is a discussion of study rigor upheld in this study by the principles of grounded theory and qualitative research.

Sample

Twelve study participants with a history of one previous Cesarean delivery were recruited for this study over a nine month period. All participants had one previous Cesarean delivery, were eligible for a vaginal trial of labor per their healthcare provider, 18 years of age, and English speaking. Sample size was determined by the data generated. The demographic characteristics of the participants and birth mode decision at time of interview are outlined in Table 1.
Table 1. Demographic Characteristics of Women, Decision, Gestation (N=12)

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Findings

In this section, the basic social process of the decision making process of subsequent pregnancy birth mode after a Cesarean delivery are presented. The core category, conceptual categories and their properties will be presented. Properties of categories will be exemplified by direct quotes from participants. The core category is presented underlined, bolded and italicized (core category), the conceptual categories are bolded and italicized (conceptual categories), and the properties of the category are italicized (properties). At the end of each participant quote, a bracket, participant number, and page number of the transcript are provided.

Basic Social Process

The data indicated in the decision making process of subsequent pregnancy birth mode after a previous Cesarean delivery, women want a different birthing experience (core category) compared to their first birth. Based on the data, the decision making process of subsequent pregnancy birth mode of VBAC or RCS after a primary Cesarean birth begins with having a Cesarean delivery for the first birth. This is followed by the women’s judgments of the experience of the first Cesarean delivery. From the experience of the first Cesarean, women seek information about subsequent birth modes, which leads them to know more about subsequent birth modes and aids in getting to a decision of wanting a VBAC or wanting a RCS for subsequent birth. In this process, depending on desired birth mode, women search for a supporting provider. The process is illustrated in Figure 1.
Core Category: Wanting a Different Birthing Experience

The core category is central to other categories, recurrent in the data, and accounts for a majority of the variation in the pattern of behavior (Glaser, 1978). Wanting a different birthing experience emerged as the core category from the data. It was persistent in the data and central
to all seven categories. Both women wanting a VBAC or RCS expressed the need to have a
different birthing experience for their second child. One participant wanting a VBAC stated:

There were some things about the process that were challenging that I wanted to avoid
and have a different birth this time. Actually that was very important, and I think
probably more important than it just be different, like a vaginal birth opposed to another
C section. [1.2]

Another participant verbalized this category with this statement:

That is a big part of why I went with midwives this time but really I just wanted a
different experience this time. They are much more personable and invested in me than
the OBs are and so, yeah, it is 5 minutes from my house, so it doesn’t make sense for me
to switch hospitals, but I definitely wanted a different experience than last time. [7.4]

Another participant discussed **Wanting a different birth experience** by stating:

I actually researched and made sure it was even an option, and once I learned that it was
okay to have a VBAC, I was kind of like I want to do it. I didn’t want to have another
surgery. I wanted to experience birth. I didn’t want to have another surgery. [6.2]

Other participants spoke of this by stating, “I want that experience. I mean that part of it, and
recovery will be easier. Nobody wants to have major surgery and have a 2 year old” [10.2].

Questioning was a Cesarean necessary for her baby and lack of trust in her medical team, one
participant expressed **Wanting a different birthing experience** with this statement:

You know I don’t want to repeat it, but I have made it so far so I feel pretty good about it,
and I do question it constantly was that what we needed to do for my baby? But you do
question it constantly, was it really necessary? You really don’t trust your doctor or your
medical team. You know, did they do what was the best for you? [3.5]

Another participant expressed, “I feel like I was robbed of a normal birthing experience and I
would prefer to not have my stuff cut open again if possible.” [4.2].

One participant, deciding on RCS for her current pregnancy stated:

So, I don’t want to go through that again, and I don’t want to have another 26 hour labor,
and then end up having another C section again after feeling so exhausted and scared. It’s
just difficult to make a decision, because you want what is best for the baby but at the same time, I don’t want to end up in the same situation. [9.1-2]

In addition to the core category, there are seven conceptual categories that represent women’s experiences in deciding VBAC or RCS for birth mode after a primary Cesarean delivery. The categories and their properties are discussed in the following pages.

**Having a cesarean delivery.** The first category of the theory is *having a Cesarean delivery* for the first birth. Participants described *having a Cesarean delivery* for their first birth as a result of *having a cascade of interventions* at the hospital. Participants described *not wanting a Cesarean delivery* for their first birth, feeling unaware and not knowing what to expect due to providers *not talking about Cesarean delivery* during their first pregnancy, and not *knowing how the first Cesarean will affect future pregnancies*. For two participants, the Cesarean delivery was scheduled due to breech presentation and medical or heart condition of infant. Both women were aware they were having a Cesarean delivery for their first birth. The remaining 10 participants presented to the hospital in labor or for a planned induction, yet had a Cesarean section for fetal distress, failure to progress DESCEND, and/or maternal fever. The 10 participants were unaware they would need a Cesarean delivery. Both groups of women expressed *not wanting* a Cesarean section for their first birth. One participant, having a scheduled Cesarean section for her first birth, verbalized the conceptual property of *not wanting* a Cesarean delivery for their first birth with this statement:

I really didn’t want a C section with my first. Umm, I’m a nurse, so in nursing school I had witnessed a few C sections. So I knew what they do and I think it’s one thing when you are a mom on one side of the curtain, not really knowing what they are doing. You know in the US (United States) they say they make a tiny incision and pull the baby out. It’s really much more gruesome than that. In nursing school, seeing one was one of the few times that I felt nauseous. I felt like I was going to pass out in nursing school. So I really didn’t want a C section. And then they found out at 36 weeks my son was breech.
We attempted to flip him and that was unsuccessful. We even bought these Moxa sticks that are supposed to help to turn the baby. I know now there is acupuncture and stuff like that but at that point I knew the decision was made for me. [2.1-2]

Another participant delivering Cesarean for failure to progress, after laboring 16 hours, only dilating to 5.5cm, stated:

My initial goal with my first pregnancy was to have a completely natural birth with no medicine. I honestly would have done a homebirth if my husband was comfortable with it. Um, but he wasn’t. So I didn’t push it and I said that is totally fine I will go to the hospital, but I don’t want to have any interventions. I want to push out my baby. So the Cesarean was like my opposite. Those were my initial wishes for my first birth. [6.2]

One woman stated that Cesarean delivery “was never in my plans” [7.1], and “how horrible it was for me to say okay to the C section” [7.9]. Another stated, “when you go into your first pregnancy and you don’t want a C section. I mean obviously if that is what you need to have a healthy mom and baby that is fine” [10.6]. Two participants unaware of needing a Cesarean delivery, ended up agreeing to a Cesarean delivery, but wished they had not with statements, “I felt exhausted and when he said C section I just agreed to it and I wish I didn’t agree with it that quickly” [6.6]. Another stated, “They did the vacuum three times and that didn’t work and then they told me it was time for a C section and I was so exhausted that I said okay even though I wish I hadn’t.” [7.1] Three participants expressed not wanting to deliver via Cesarean for their first delivery and had discussed their preference with their physician. The first stated, “she knew I wanted to prevent a C section as much as possible” [12.6]. Another stated:

When it was first brought up to me that I might have to have a C section with my first child, um, and then he said there is a good chance I would have to have a C section. I asked would you do a VBAC in the future because I don’t want to sign up for this if just means I have to do C sections. [6.1]

A third stated:
Two participants described having a Cesarean delivery for their first birth was the result of having a cascade of interventions once admitted to the hospital. One participant verbalized this property by stating:

Now that I have done some research on my own I call it a cascade of interventions. I pretty much got an epidural right away. Got an epidural at 2cm and I have read if you get them before you are 6cm you are 2/3rds more likely to have a C section. I think it was the Pitocin or what not. I was stuck at 8cm for 5 hours. My son was also sunny side up and I had my membranes scraped on my due date, so I know that can sometimes bring on early onset of breaking of your water. So once they knew that I was already bedridden and we couldn’t get him to turn. So yeah, that is what happened with me. [4.2]

Another participant stated, “You know when you go to a hospital you are on a time table and one intervention leads to another intervention which leads to another. It’s like the domino effect” [2.2-3].

Not talking about Cesarean section is another property of this conceptual category. One participant described knowing that Cesarean was a delivery option, yet expressed an option that is not talked about in first pregnancies. Her words were, “I do feel like when you're pregnant the first time people don't talk about C sections a lot although it happens to so many people” [1. 15-16]. Another participant, hospitalized during her antepartum period verbalized:

So I was hospitalized and on bed rest for 3 weeks, so I didn’t even know C section was even on the table, because no one talked to me about it, and I was on a lot of medicine and they were just talking to me about making it to 37 weeks. [5.8]

One participant expressed the need for providers to discuss and talk about Cesarean delivery with their patients. Her words were, “honestly, like bringing it up at the end of your first pregnancy,
just bringing it up, because the idea of a C section had not crossed my mind. I was thinking I
won’t have one of those” [8.6].

One participant having an emergency Cesarean expressed:

But because I had an emergency, I feel like it would have been nice to have someone to
come and debrief me about what had happened and why and to talk about future
pregnancies at that time, because when I was in the hospital and after the baby was born I
didn’t even get, the doctor did come check on me, but he didn’t talk to me about why it
happened. He didn’t even talk about why at my 6 week postpartum visit. We didn’t even
discuss the C section at all. It was kind of left in a lurch. [9.5]

Participants described the importance of knowing how the first Cesarean will affect future
pregnancies. One participant verbalized this property with the statement:

If anything in your first pregnancy could affect your second pregnancy, which is why I
liked that my doctor was very willing to talk to me about options for VBAC and what I
could do differently while I was still pregnant with my first. Of course this was towards
the end of my first pregnancy when we first started discussing potential for a C section.
Umm, I think that was really important to me that I knew how my decision was going to
affect my future pregnancies and future family, and all that. [6.8]

The same participant continued stating:

So I think that would be important for a doctor to tell you if a C section comes up. So my
doctor went into my first C section knowing I wanted a VBAC in the future. So he said
he did the incisions and all that in a certain way so that I could VBAC in the future. [6.9-
10]

Another participant stated:

You know when you decide to have a C section the first time you should know how it
affects subsequent pregnancies if you plan on having more, and I remember that was a
question I asked. Would I have to have one next time? And they said no, depending if
you have a healthy pregnancy you should be able to VBAC, but once you have two C
sections in a row that is where it gets risky. So, I think knowing that from the get go is
important. [10.5]

One participant having an emergency Cesarean expressed this property by stating:

Well, I didn’t know ahead of time that I was going to need a C section. I guess, if I knew
ahead of time when they were discussing that it would be required I would like to have
known more about repeats at that time, but because I had an emergency I feel like it
would have been nice to have someone to come and debrief me about what had happened
and why and to talk about future pregnancies at that time. [9.5]

One participant, having a planned Cesarean expressed, “I think as soon as C section is on the
table with your first pregnancy, and the complications, and the reason for that C section, then
someone needs to talk about subsequent birth in that same conversation” [5.8]. Another
expressed similar words with this statement:

I think women should be as informed as early as possible. About all the factors, cause
some women might elect to have a C section and not realize that they are kind of limited
with their second child as what they can do. [12.5-6]

Lastly, one participant stated, “It’s sort of like, they don’t talk to you about the later children
consequences” [1.16]. As a result of having a cascade of interventions, not talking about
Cesarean delivery, and not knowing how the first Cesarean will affect future pregnancies, some
women expressed having a negative experience with their first Cesarean delivery. Yet, two
women expressed having an acceptable experience with their first Cesarean delivery, leading to
the second category of the process, judging the experience.

Judging the experience. The second category of the theory is judging the experience of
the first Cesarean delivery. The women’s judgments of their first Cesarean experience varied
widely. The majority of the women expressed having a negative experience, yet, two women
expressed having an acceptable experience.

The negative feelings and experiences varied widely as some women expressed not
having an ideal experience and not having a good recovery with their first Cesarean, while
others expressed experiencing a traumatic life event, wanting to talk to a counselor about their
previous delivery and current decision. One participant verbalized the property not having an
ideal experience with the statement, “The C section was not what I would have considered an ideal experience” [8.1]. Another participant, referring to her husband in the statement, spoke of the property by stating, “He knows how much the C section affected me and how much I hated it. I have an 18 month old and I am still not even close to being over the fact that I had a C section the first time” [6.7]. Other women verbalized this property with statements of having a “very unpleasant Cesarean” [5.3], and “the entire C section experience did not feel safe” [5.3].

For some women, their Cesarean delivery birth was more than an unwanted experience. It was a traumatic life event, resulting in emotional distress, postpartum depression, and the desire to never experience the psychological trauma from a Cesarean delivery again. The property of experiencing a traumatic life event was verbalized by this statement:

Because I had postpartum depression and all kinds of stuff from just it not turning out how I thought it would be. I felt like it was the worst day of my life and the best day of my life in the same day. It was so stressful, traumatic, and scary, but I also got a healthy baby out of it. [9.5]

Another participant stated:

Umm, when I have talked to several women after birth about C sections, and I said we don’t talk about how bad this is, the shaking. You kind of feel like you are on a gurney and it is an awful, awful experience. We had no idea it was going to happen and I was upset about it for a long time. [4.1].

Although needing a Cesarean delivery for a healthy outcome, one woman stated:

I think the C section was really scary for me. I know it was necessary and I chose it, but it was a little bit scary and during the surgery I ended up, my epidural failed and they had to put me under general anesthesia because I could feel the surgery. So, that was really scary, and I didn’t get to see my son for several hours until I had woken up and come out of recovery [8.2].

Others spoke of personal feelings of anger about their negative Cesarean experience. One participant stated:
But more I am just angry I didn’t get to comfort him or get pictures when he was first born. I heard him crying but I couldn’t comfort him, and then thinking about future children and how it like effects birthing then. Those are the parts I get angry about [12.7].

Several women described experiencing feelings of grief and sadness over their Cesarean section. One participant states, “I just had to go through with it. I had to make peace with it. It was just hard for me to know what was going on in my body” [2.2]. Others state, “I feel a lot of women have much more grief over their C section. There was definitely a period of that, but I have overcome that” [3.5], and “I know a lot of ladies who have ended up having an emergency C section have a lot of guilt and sadness about what happened” [9.7].

Some women spoke of wanting to talk to a counselor about their Cesarean experience and birth mode decision for current pregnancy. The women described wanting someone educated about both delivery modes, risks of VBAC and RCS, yet not their OB. One participant verbalized this property with this statement:

I think it will helpful, you know, my OB is great, but he is definitely an OB, and I do think in the process it would be helpful if someone was available that had more of a counselor position. I don’t know if there are special classes nurses do, I don’t know, but just because it is not as cut and dry as it seems and it is a lot of guilt in the decision. Even though nothing has gone wrong or if something does goes wrong, am I prepared for that? You know? An OB is not necessarily the person to work through that. Maybe there are OBs that can, as supportive as my OB is, he is definitely more medical. I would like a place that I could pop in and talk to someone and work it out. That would be very helpful. [5.9]

She continues to state:

We do go to a therapist once a month but he doesn’t know the risks of VBAC or anything else. So I have talked to him about finding my own peace with the decision, but, I guess it is just not the same. I think if there was someone who could facilitate that with practices, and just not that decision, but also decisions like if you chose to co-sleep or not, or there are so many decisions that come with pregnancy in general. If they could counsel on all of that and to counsel on is this that important to me that I am willing to take on the accountability if something goes wrong. To counsel me on at being at peace with the
decision I made if something goes wrong. You know, someone that understand the risks, understands the literature, someone that understands the information you are getting from the OB but is there to sort out like what a counselor does. That would be helpful. [5.10]

Another participant spoke of wanting to talk to a counselor by stating:

I definitely think that would help. Yeah, that would be helpful, yeah, it’s a good idea, because it took me awhile to even talk about my C section experience with anyone. It made me feel pretty emotional and I didn’t feel really comfortable talking about that with my doctor. Umm, so I think that would be helpful to a lot of women and I think in general. This doesn’t have anything to do with a C section but I have read stories in regards to women struggling with postpartum depression. Women go back to their doctor and their doctor says it has been more than 6 weeks you need to see someone else about this. So they feel lost with it because they don’t have anybody to support and listen to their feelings. So I think that is definitely lacking for a bunch of postpartum issues. [8.7]

Another participant experiencing grief from her Cesarean delivery stated:

Yeah, I think that would be helpful. When you go into your first pregnancy and you don’t want a C section, I mean obviously if that is what you need to have a healthy baby and mom that is fine, but in a perfect world it is kind of hard to flush out all those feelings. Especially after you have the baby and you are so hormonal. Yes, just having the option to talk to someone would be helpful. It’s just deep feelings and you really don’t know you have them until they surface and you are like oh my god I am so upset about that. It was hard to process needing a C section and then letting go of the dream you had about how you were going to have your baby. It’s hard. It would be nice to talk to someone. [10.6]

One participant, working as a mental health counselor stated:

I would say, actually I am a mental health counselor. Honestly, I would say I am definitely not over my C section. Yeah, a lot of that for me personally, the best experience has been talking within about it because that is what eases my anxiety is talking to people that have a lot of knowledge about it and having a lot of information about it. So the best person for me to talk to about it would personally be my peers, who would have a lot of information about that. In regards to a social worker, or counselor, or psychologists, honestly that doesn’t make any difference to me just as long as they are licensed and credentialed and specialize in birth trauma. [12.7-8]

Another participant stated:

I am a big proponent of therapy and think everyone needs it, but, like even though I don’t have ill will towards the OB that delivered me there are still moments that I think about it and move past it, because I am a grown up and don’t need to dwell on it, but some people
have a really hard time moving past, especially a traumatic C section, but don’t want to seek help. I think it is so needed for so many women, especially because a lot of women don’t have supportive husbands. [7.8]

For some women, having a negative experience resulted from *not having a good recovery* after the Cesarean delivery. One woman stated:

> It was horrible. I couldn’t walk or drive. Well, I could walk a little bit around the house, but I basically sat in a chair at home all day until my husband came home, and I couldn’t drive for 2 weeks, and the worse thing was when they taped me up in recovery from the C Section. They taped me up with tape that I am allergic to. So you don’t know until you take the tape off and I took it off and I instantly knew that it was the wrong tape. Then they told me to take Benadryl, which you can’t take when you are nursing, so then my milk took longer to come in and my girl was groggy for days. Ummm, and so it was all just compounding on each other. It was awful [7.2].

Another participant stated, “Yeah, and the recovery was not a good experience either. My family has a history of addiction so I don’t take any narcotics. So it was very painful getting through the recovery with just Ibuprofen” [5.1]. Although the majority of the participants expressed having a negative experience, two participants expressed having an acceptable experience with their first Cesarean delivery.

The women’s judgments of having an acceptable experience were verbalized with properties of *having a good recovery* and *not experiencing any bad outcomes*. One participant verbalized these properties by stating, “My recovery went great. I felt great. All went well” [2.2]. She continued to state, “My incision healed very nicely. I didn’t have really any bad outcomes” [2.8]. Another participant spoke of *having a good recovery* stating, “I mean I feel like I had a pretty good recovery from the C section” [11.2]. One of the participants having an acceptable experience with their Cesarean delivery was planning to deliver repeat Cesarean delivery for their current pregnancy and the other participant was leaning more towards RCS.
Participants’ judgments of their first Cesarean delivery were described as either having a negative experience or an acceptable experience. Regardless of Cesarean experience, all participants wanted more children. To get a better understanding of reasons for their first Cesarean delivery and options for birth mode after a Cesarean delivery, participants actively sought out information.

**Seeking information.** The third category of the theory is *seeking information*. In this category, from their experience of their first Cesarean delivery, women seek information from several avenues to understand reasons for having their first Cesarean and options for future pregnancies. The first property of this category is *seeking information on their own*. Most of the women sought information on their own via online, through social media groups, and web search engines. Participants also received information from other women experiencing a previous Cesarean delivery, women attempting and/or having a successful VBAC, women having a RCS, and Doulas. Participants spoke of receiving minimal information from their providers about subsequent birth modes after their Cesarean delivery. One participant verbalized this property by stating:

I have had to do it all pretty much myself. My OB from my first birth at my follow up appointment did say I would be a good candidate for one. But she didn’t really go into detail about what a VBAC was or what makes you a good candidate. So after she said that, that is when I started doing more research and I found the ICAN group. So I started reading online and another person in ICAN in another city started pointing me in the right direction of some stuff that I could read. [8.2]

Another stated:

Yeah, from online and in person from friends and from people who have had VBACs before and from people who have had RCS. Umm, like my brother and sister-in-law are both doctors, so from talking to them, just talking to people too, but a lot online. [12.3]
Others spoke of seeking information on their own stating, “a lot of the research I did on my own” [10.3]. She continued by stating, “it was mostly online, articles” [10.3]. Another stated she sought information, “from the internet and from other women. Other women on the site and then ICAN has monthly meetings, so I have been to a few of those. Like support group meetings” [3.2]. This was echoed from other participants stating, “I did do more research online in the beginning” [2.6]. Another participant stated:

Yeah, through the internet or through word of mouth. So we have attended a couple meetings for ICAN and talked to them. So talking to people from ICAN, which has been some online and some in person, and then the Doulas. And I have a friend who has a friend that just had a VBAC. So I have talked to her a little bit about it. So some of it has been through word of mouth, but most of it has been online. [6.6]

Another participant spoke of receiving information from her Doula stating, “a lot I got from the Doula” [7.10]. One woman sought information via social media requesting VBAC providers. She stated:

So what I did, I posted on Birth Circle, it’s a Facebook page in the Jackson area of women who prefer natural birth, and lots of birth education and doulas, that kind of things. I posted on there asking for recommendations and I probably got a list of 6 or 7 doctors. [12.4]

Participants welcomed and credited ICAN as a source of information and support, as many women found hearing other women’s stories encouraging. One participant verbalized this property by stating, “I give a lot of credit to the ICAN group. That has really helped me and opened my eyes to birth” [4.1]. Others spoke stating:

I joined ICAN on Facebook page which has been interesting to hear different women’s experiences. I think that has been supportive and a great way to hear other peoples experiences and what happened. It has been helpful because it is real life experiences [2.6]
Another stated, “I relied a lot on ICAN information and stories from other women, that sort of stuff for getting information” [3.2]. Another participant verbalized this property by stating, “I have seen so many stories with successful VBAC and just how reclaiming the birth experience really helped you feel at peace with previous experiences. So that really helped me again” [5.7]. One participant described the support she received from ICAN after an OB appointment and being informed her provider would not deliver her by VBAC. She stated, “ICAN facebook website people were very helpful after that OB appointment. They kind of helped build me back up because I was very defeated when I left there” [7.7]. Another described how information posted on the ICAN Facebook page was helpful with this statement:

Someone posted a website about checking your OB Cesarean rate. I checked my practice Cesarean rate and it is 38%. Most C sections happen between 4pm and 10pm. Mine happened at 5:30pm on a Saturday, so it’s those types of things I think are so important [4.7].

One participant stressed the importance of having a support group like ICAN by stating:

I think giving a way for women to talk to each other and find a supportive community if they don’t already have one, because I can’t imagine having a VBAC and no one around you is supportive. I am lucky to have a supportive group but I am sure there are women that don’t have that. Everyone just tells them you should have a C section, why are you doing this? You know? So, I think giving the women resources rather it be ICAN or I don’t know, local moms that have been through the same thing. Just a support group. [10.7]

One participant found other women’s stories on the ICAN Facebook page encouraging, yet favoring VBAC. She verbalized this by stating:

I think some of the stories I read on ICAN were encouraging, but I will say those can be a little bit super militant. Like a little VBAC or nothing, and I don’t think that I am quite that. You know, I think there is definitely a place for a C section [1.3].

One participant, deciding on a RCS, sought out information from ICAN. She stated:
I sought out information from ICAN. So I talked to the local chapter leader from here and we met for coffee a couple times and that is when I got the information about how it is safer and healthier to try for a VBAC. [9.3]

Another stated, “And I think someone mentioned it, like a part of a Facebook moms group. Someone mentioned it on ICAN. They have a Facebook page, Chicago chapter and I went and checked them out and got some information” [1.1].

Participants described seeking information by reading more. Participants read books and online articles, aiding in the decision to have a VBAC or a RCS. One participant verbalized this property by stating, “I have done a lot of reading, like Pushed and The Baby Catcher. Both have been very instrumental in solidifying my decision” [3.2]. She continued to state:

Reading birth experiences has been the most helpful this time around too. Feeling confident about having a vaginal birth and reading all those stories in The Baby Catcher. Like, she had one pretty bad story but for the most part she had pretty much all normal homebirths that you are like, yeah, I can do this, my body can do this and my baby will come to greet me. My baby wants to come out. I think that was helpful to read more stories in a normal setting. [3.4]

Another states, “I saw the documentary of the Business of Being Born and now I am reading the book Pushed. Again it is dated in 2007, but it is very eye opening and everyone is saying the same thing” [4.7].

Others spoke of reading more with statements:

So this time I have definitely read more, I think, the specifics, like different hospitals and just different, I think, like the decisions that you make in labor that end up impacting the outcome of the labor. So after reading more about that I decided to hire a Doula. [8.7]

Lastly, one participant stated, “I am also a Biologist by training. I have my masters in biology so I love research, statistics, all that stuff, so I know from a lot of my own readings” [10.3].

Participants also sought out information about subsequent pregnancy birth modes by receiving information from their providers. Information provided varied, from participants
receiving no information from providers, to participants receiving take home reading material describing risks for both delivery modes. Many participants received information verbally in exam rooms during office visits. Information provided to participants from providers mostly consisted of risks of VBAC and individual success rates for VBAC. For some participants, uterine rupture was the only risk mentioned throughout their entire pregnancy. At 40 weeks gestation, one participant stated:

So when I first went in and said I was interested in VBAC, that first doctor that I saw said that’s great, but there is potential of rupture. He said something like you know a half percent or percent or something. In that kind of low range. [1.5]

When asked by the researcher, was uterine rupture the only risk mentioned throughout the pregnancy regarding VBAC, the participant responded, “yes, the only risk for VBAC” [1.8]. When asked if risks for repeat Cesarean were discussed she verbalized, “No, no, and I know that I was aware of some of that but they didn’t. They pretty much acted like that was the safer alternative” [1.8]. At 22 weeks gestation, one participant stated, “She really hasn’t given written information or verbal information except when I ask” [2.3].

Another participant, 40 weeks gestation responded:

Actually the midwife a few weeks ago told me that my uterine rupture risk was greater because I have an odd incision, longer than normal uterine incision, so that was concerning, that was something she talked to me about. She said she had talked to the surgeons and it wasn’t, still a standard risk, nothing to be too worried about. And then this last week when I went back and saw another midwife she said she didn’t read that at all and my risks were no different than anyone else. Other than that I really haven’t been given much. [3.1]

Others verbalized receiving similar information about the risk of uterine rupture with statements, “So we talked about all that in my first appointment. And I got all the scare tactics of like uterine rupture and all that, and also how you can die of natural childbirth” [4.3]
Another stated:

The midwife that I first started to see when I first got pregnant talked a lot about uterine rupture and would go over the percentages of uterine rupture, like 1% but she was very clear, like 1% was 1 out of 200 women. So when you are delivering babies all the time 1% is a lot because you see 200 women often, and when you see that 1 time, that one time is enough to be the one, and you don’t want to be that. [5.3-4]

Only two participants stated receiving information from their provider of risks for both VBAC and RCS. When asked by the researcher if the provider discussed risks for both deliveries the participant responded:

Yes, yes, because there are risks to both and it shouldn’t be just getting the risks of VBAC opposed to RCS. You need to have all the information because major surgery is major surgery and they also understand recovering from major surgery and having a 4 year old is not optimal. [7.5]

The second stated:

Sure, well initially my doctor said with a healthy pregnancy and healthy baby there are risks to VBAC and there are also risks to RCS too. He said as long as everything would work out he really didn’t think the risk would be any different. Either way, so there is always the risk of uterine rupture, like .5% or like 1%, something like that, low but it’s not that low either. It’s something that I keep in mind, and like there are risks for RCS too. [6.2-3]

One participant, deciding to have a RCS, was the only participant that verbalized the risk of infection. Hearing the risk hindered her decision of having a RCS. She stated, “yeah, when he did go over the risks of the surgery and he tells you that it is major surgery and there are definitely risks with that like infection, things like that” [9.4].

Several participants described their providers using VBAC percentage/calculators to provide them with an individual VBAC success rate percentage. One participant stated:

But I guess it was helpful when he got out the chart and did that. I don’t know. He originally said it was a sixty to eighty percent chance of VBAC early on but now it’s less and when I was at my last appointment that I had on Monday when I was 40 weeks and a
day, umm, my doctor got a piece of paper from a study and did some math and found a probability and suggested 42 or 45% or something. [1.6]

Another stated, “She did tell me my chances of having a VBAC were 85%” [2.5]. Two participants did not welcome this information by stating:

To be honest it pissed me off because my first doctor, you know, the one that doesn’t do VBAC pulled up the calculator online of my chances of having a VBAC and that just takes your age, weight, why you had first Cesarean. But no other factors like I had an epidural at 2cm, nothing like that, I don’t like that test. [4.4]

Another stated, “And the OB that I had a consult with told me if I was her patient she would not even let me VBAC because my percentage/calculator thing said I have a 30% chance” [7.3].

Several participants verbalized wanting resources from providers to take home. Participants were referring to information comparing pros/cons and risks/benefits of both VBAC and RCS. Participants described wanting resources from providers to take home because “resources would've been nice so that I could take home and read and spend more time at home as opposed to the exam room” [1.17]. Another wanting information in Spanish and English stated:

The more information that we could physically have in our hands would be better because you know the internet has a lot of personal experiences, but if you trust your OB it would be helpful to get as much information straight from the practice. I would love as much information as straight from the practice, and it has been an issue because my husband speaks Spanish and we haven’t had any luck finding an OB or midwife that speaks Spanish. I feel like I it would be much easier because I am just translating everything. And it is easy for information to get lost in translation so it would be easier to have that printed material in both languages to take home. And in our situation it is Spanish, but in other situations it could be Polish or whatever because also when we looked online I found a lot of information we came across was specific to Mexico and not here, practices are different, protocols are different. [5.8]

One participant described wanting resources from their providers to take home by stating:

I’m probably old school and would like to have something on paper. They do have a little bit of stuff on their website, personal website about VBAC. I read through that, but that
wasn’t super helpful because every woman’s story was different. A piece of paper, yeah, my doctor is open to conversation but I do feel like I have to be the pro active one with all the questions. I know they don’t have all the time to sit with me but it would be nice to hear what other women have experienced. What are their pro/cons on a provider level? It would be helpful. [2.6-7]

Another stated:

I think for me I had made my decision to VBAC so I don’t think there was a lot they could provide me. It doesn’t hurt, though. I am a researcher and I like to see studies and numbers and results so I would have appreciated that type of thing. [3.5]

Participants sought out information from books, online, providers, doulas and support groups to educate themselves on subsequent birth modes after a previous Cesarean. As a result of seeking information, participants described knowing more about pregnancy, labor and birth their second pregnancy compared to their first.

**Knowing more.** The fourth category of the theory is knowing more. From seeking information on their own, receiving information from their providers, hearing other women’s stories and reading more, the women were more knowledgeable with their second pregnancy than first pregnancy. The properties of this category are being more educated and not knowing enough the first pregnancy. One participant verbalized the property being more educated with the statement:

I am trying to be more educated about the situation this time” [4.2]

She continues to state:

I think it really goes back to us, being educated. I have a girlfriend who is getting ready to go through her first birth. And I know I scared the hell out of her, but it’s important that I tell her. Here are things you should know and articles that have been written about inductions and the risks of that, and things like scraping your membranes. That can lead to other things. The knowledge of the first pregnancy. If we can get that out there it will potentially help on our own to bring down the Cesarean rate. Just being more educated. [4.8]
Another participant articulated the property of *being more educated* by stating:

Yeah, so with the first birth you don’t know what to ask, you feel so overwhelmed. So with my first pregnancy, even though we had been married for 5 years, it still wasn’t planned. Honestly, I learned more, I nursed my first child for a year and I would read stuff on my phone while I was nursing him in the glider. [12.9]

Another spoke of this property by verbalizing:

If I wasn’t so set on a fully natural birth and researching all I could with that, I likely would have never even knew that a VBAC was an option, because I always thought once a C section, always a C section. [6.9]

Another verbalized, “I think I have definitely learned more that the benefits versus the risks of a VBAC versus a repeat Cesarean. Seems like there could be more complications from repeat surgery” [8.3].

Participants described *not knowing enough their first pregnancy*. One participant verbalized this property by stating, “I definitely feel like I didn’t know enough about labor was concerned” [4.1]. She continued by stating:

I wasn’t knowledgeable the first time around on things. [4.7] I didn’t even know what a midwife was last pregnancy. One came around during rounds with my first delivery and helped me turn in a different position. My mom made a comment like I didn’t know there were still midwives. So I didn’t even know what one was, and since reading Baby Catcher it’s like I would like to start seeing a midwife for my normal GYN appointments. [4.9]

Another participant stated, “I have done a lot more reading this time on. The first, I thought you just go in and it happens and this time I know a lot more on hypnobirthing and natural child birth” [3.5].

Participants described *seeking information*, which resulted in *knowing more* about subsequent birth options after a Cesarean delivery. *Knowing more* about risks and benefits of
both VBAC and RCS lead women to either want a VBAC or RCS for their second birth experience.

**Wanting a VBAC.** The fifth category of the theory is **wanting a VBAC.** This category represents the women who had a primary Cesarean delivery for their first delivery, had a negative experience from their first Cesarean, sought out information, became knowledgeable about subsequent birth modes after a Cesarean delivery, and want a VBAC for their second birth. The properties of this category are *missing out, seeing my child for the first time, spending less time in the hospital, wanting an easier recovery, and wanting more kids without having three or four C sections.*

The initial property of *missing out* is articulated with participants describing losing the experience of birthing vaginally for their first delivery. Birthing vaginally was described by women as birthing naturally. Not being able to have a vaginal birth for their first delivery resulted in feelings of failure. One participant verbalized this property with the statement:

The feeling that I missed out on natural birth. The feeling that I missed out on being a female, women, I guess. I was wanting to have that natural pregnancy, natural birth. I didn’t want to feel like I was failure in birthing my own child. [3.1]

Another participant stated, “I mean, it was a no brainer. I really felt like I missed out on something” [4.1]. She continued to state, “I was robbed of a normal birthing experience”[4.2]. One participant stated, “Those were my initial wishes for my first birth. So I think when that was taken away from me last time made me want to do it as close to normal this time” [6.2].

Two participants described *missing out* by verbalizing:

Um, I don’t know, even after the first one I still, even though he was premature, I felt like my body wanted to give birth as weird as that is, like my body was still having a lot of contractions. I didn’t know if that was normal but I felt like something was missing. I felt like he was still in me. [5.2]
Another stated, “I would love to VBAC because that is how it should be, you know, your body should work, you should be able to birth your baby traditionally” [10.2]. One participant, leaning towards having a RCS stated:

I guess what is holding me back, all out choosing RCS is the feeling like I missed out on experience as a mom of birthing a child. I think that is the only thing holding me back, not getting that feeling. [2.2]

Two participants described wanting to VBAC because they missed out on seeing their child for the first time. One participant stated, “I think the decision mostly is wanting that experience of seeing my child for the first time. Um, so I think that is the biggest influence” [8.3]. Another stated:

So that was another reason, huge reason for choosing a VBAC and this doctor, because for my first birth I was not able to hold my child or nurse my child for 2 hours after delivery. That was kind of tough and I don’t want to go through that again. [12.4]

Spending less time in the hospital was a reason one woman wanted a VBAC. This property was verbalized with this statement, “I wanted to spend less time in the hospital. That was a big part. I wasn’t looking forward to spending four, three nights in the hospital when I could spend maybe one” [1.2]. Wanting a VBAC to have an easier recovery was desired by several women. This property can be verbalized by these statements, “And then the healing process, the healing process was awful with a C section. I think it would be better if I could achieve a VBAC” [12.2].

Another stated:

I want that experience. I mean that part of it and recovery will be easier. Nobody wants to have major surgery and have a 2 year old. There is like the practical aspect of it like the recovery will be easier and I just would rather want my body do what it should be able to do. [10.2]
Another participant had a similar response stating:

Well you know a few things. One, obviously having a toddler at home and not being able to pick him up for 2 plus weeks because of the abdominal surgery. Also, the pain I went through last surgery. I could not even sleep in a bed because I wasn’t able to get up. Nursing is very important to me. That is very challenging to nurse overnight when you have had a C section.[4.2]

In a similar response one stated, “and for me I have more been wanting to VBAC because the Cesarean hurt a lot and I am not looking forward to recovery along with having a toddler” [5.2].

Several women verbalized wanting more kids without three of four Cesareans. This property can be verbalized by this statement, “I wanted more than two kids and I know with more C sections it gets dangerous. I didn’t want 3 or 4 C sections. So that was a huge part” [12.2]. Another stated:

I know I want to try this, at least, because part of it is we want more kids and I don’t think I can handle going through 3 or 4 C sections. So that is why I really want to do this and have more kids vaginally. [7.2]

**Wanting an RCS.** The sixth category is **wanting a RCS.** The majority of the women in this category had an acceptable primary Cesarean birth experience, sought out information, became knowledgeable about subsequent pregnancy birth modes after a Cesarean delivery, and are **wanting a RCS** because they know what to expect and fear of attempting a vaginal birth. One participant had a traumatic experience with her first Cesarean and is **wanting a RCS** due to fear of attempting a vaginal birth and ending up in the same situation. She stated:

He basically made me feel like it was okay to go with a repeat C- section. I felt like initially I should definitely try for a VBAC, but because the first birth was so traumatic physically and emotionally he said that it basically okay to go with the repeat C section. So that helped me feel comfortable with that decision. [9.3-4]

Another stated:
Everyone is always saying the recovery is much easier for vaginal and VBAC, but I’m scared to even attempt to do that. I mean I have firmly wanted to do a C-section, but from the group and some of the support and everyone is talking about the recovery. I mean I feel like I had a pretty good recovery from the C-section. [11.2]

Another participant having an acceptable Cesarean experience stated:

I didn’t have any really bad outcomes from it, so, like the big unknown. This might be my third reason for not wanting to do a VBAC. What if I attempted it and ended up getting a C-section and have a worse recovery because I had been in labor and had surgery. Those are my top reasons I am hesitant to attempt VBAC. [2.8]

She continued to explain other fears for delivering vaginally by stating:

I have some pelvic floor issues that I have had to go to physical therapy for and there is a big fear in me that having a vaginal delivery would exacerbate and make it worse and have to go to more physical therapy. So there is a big fear in me if I did try for the VBAC it would be more successful but other things could happen like urinary incontinence. [2.7]

The property of knowing what to expect was verbalized from a participant stating, “I am leaning more towards RCS because it’s like now I know what to expect and I am comfortable with, and with labor, it can go any way” [2.2]. Another stated, “I thought the recovery wasn’t that bad and I feel like now I’m sticking to something I know. I had one” [11.2]. She continued by stating “even the C-section, before I didn’t have it, and now that I have experienced it I know what to expect, so that is what I am comfortable with right now” [11.6]. Another having an emergency Cesarean for her first delivery stated:

Just the comfort of knowing I will be able to avoid a long labor and not end up with an emergency C-section again. This way, even though I know that it is not a traditional birth I will go in there and have that C-section and hopefully have a quicker, it will be a quicker process, and hopefully a little bit easier to recover with a repeat. [9.2]

She continued to state, “if they are going to treat it like a condition anyway, I feel like going there and having a C-section will probably be easier, because I kind of know what to expect”
Participants described wanting a VBAC or wanting a RCS for their current pregnancy, which lead to the final category of finding a supportive provider.

**Finding a supportive provider.** The final category of the theory is finding a supportive provider. This category represents when women are planning another pregnancy or pregnant again, and have in mind desired birth mode for their second child. Participants expressed wanting acceptance and support from healthcare providers of desired birth mode. One participant moving from Virginia to Illinois started searching for a VBAC supportive provider before she got pregnant a second time. She verbalized:

> We moved out here and didn't have an OB out here yet. So I remember picking. It's not like Elmhurst has a huge variety of doctors but I remember thinking that I wanted to find a practice that was very VBAC supported. When I got my IUD out and we started trying to get pregnant again. Umm, that was one of the factors that I considered when picking my practice. At least on their website that they said they do. [1. 1-2]

The same participant picked a practice of five doctors. Acceptance and support for wanting a VBAC was not welcomed by all five providers. She stated, “so I was optimistic throughout most of my pregnancy to VBAC and my providers were sort of more or less. It’s a group of five. Some of them are more, some are less” [1.3]. She went on to say, “I would say there are three that I would personally say are pro VBAC and two that I would say aren’t” [1.6]. “There were two in particular that seem to be very supportive. They were actually supportive, not just accepting but actually supporting. They were like yeah, let’s do this, I got your back on this” [1.11]. Due to several of the providers not supporting her wishes to VBAC, she started “strategically making appointments with the doctors that were pro VBAC” [1.6], and “one of them I only saw twice and then I avoided seeing them” [1.12]. She expressed her preference of single provider practices and not wanting to be in a practice with multiple providers with this
statement, “yeah, like two physicians that were very supportive and being more open. It wasn’t my preference. I had one last time and she knew my pregnancy better and she knew me better” [1.12]. Another described her healthcare providers accepting her wishes to have a VBAC by stating:

When I said I wanted to try for a VBAC, they said, okay great and they haven’t really mentioned it again. I think they assume moving forward that is the plan assuming everything else continues to go well. So, I think they were pretty accepting of what I wanted to do. They have been pretty accepting to my wishes. With me, I guess that seems more important that they are willing to go ahead and let me plan on a VBAC. [8.4]

One participant talked about feeling support and acceptance from her OB with this statement:

The OB that did my C section, I remember this in recovery. She said I know this is not what you wanted, and I know you want to have more kids, so I put your incision in the very best spot for a VBAC and I double stitched you. So from there I was like okay. My health group is generally supportive. [10.3]

She went on to talk about seeing a Nurse Practitioner for her first appointment and stated, “Yeah, you could tell she couldn’t say much because they have all their legalities of what they can say but, yeah, she was supportive” [10.5]. One participant talked about important factors that impact having a successful VBAC. She stated, “Like there are Doulas and Midwives and what are the most important things that can impact you on having a VBAC. First and foremost everyone is saying the provider. So having a VBAC friendly provider” [4.7].

For some participants, finding a supportive provider for desired birth mode was difficult. As a result, some participants ended up switching providers and hospitals to achieve a VBAC. One participant, having been with her OB for 12 years was getting a second opinion and potentially switching providers to achieve a VBAC. Happy with her provider for the twelve years and saddened of potentially switching, she verbalized this property with this statement, “I’m actually heartbroken at the thought of potentially switching doctors but at this point, like
my birth experience, as stupid as that might sound, is very important to me” [6.7]. This participant was diagnosed with transient hypertension at 26 weeks gestation. To achieve her VBAC she decided to get a second opinion. She stated:

So my BP was pretty high on Wednesday. He said now, not necessarily a higher risk for uterine rupture, but now he is saying he won’t do a VBAC. So I am going to get a second opinion and see if that’s really what I should go off of, because he said the uterine rupture risks wouldn’t necessarily go up, but if there was an uterine rupture then outcomes would be way way way worse than if I would have had a healthy pregnancy that didn’t have any blood pressure issues. So I going to get a second opinion to see, cause I still want to VBAC if I can still do it. [6.3]

Another participant, wanting a VBAC had to switch providers and hospitals. Her previous OB and hospital did not do VBACs. Living in Mississippi, she stated, “this is super common in Mississippi. There aren’t many doctors that do VBACs” [12.3]. She stated, “I had to switch doctors and that was part of the decision making process too, and I had to switch hospitals too, actually because the hospital I am at does not do VBAC” [12.2]. Another participant had a similar experience stating:

So, my practice with my last pregnancy, I didn’t really approach them with the VBAC conversation when I first got pregnant and I found out they don’t even attempt VBACs. So I knew I shouldn’t have been with that practice to begin with since they are not really with it with the time. So I then tried to change. [4.3]

She continued to state, “if I would have done my research and been in the know, per se, I probably would have changed practices before I got pregnant” [4.6]. One participant, wanting a VBAC, started her second pregnancy with a midwife but switched to an OB. Her first child was delivered early due to a heart condition. She stated, “with my first baby’s history she said you would need to be with an OB” [5.4]. She continued by stating, “I switched to an OB that sees over the midwives. I think the midwives weren’t comfortable because of my baby’s first heart condition” [5.2]. The same participant also, “switched back to the hospital that is close to my
husband’s work that we originally wanted to deliver with my first child” [5.6]. One participant, wanting a VBAC, but understanding she may need a RCS, didn’t get VBAC support from all providers. She thought about changing providers and provided this statement:

It was something that I did think about but I don’t, you know, and so by the time I was in my third trimester, I was like do I really want to try to research another provider, especially if I'm in the place where I'm not, like, this is what I want regardless of anything. You know I'm fine if I need a repeat C section and it needs to be done. [1.11]

One participant, desiring a RCS, switched OBs after her first delivery and before her second pregnancy. She stated, “We were interviewing a new OB at the time because I was not happy with my original OB” [9.2].

For some women wanting a VBAC, seeking out/switching to a Midwife was the course of action to achieve, or have better chances of having a VBAC. The property of seeking out/switching to a Midwife was verbalized with this statement, “I knew with me in order to do a VBAC I would need to seek out a Midwife. So going for a midwife in the beginning made, I was more confident in making that decision of having a VBAC over a C section” [3.1].

Another participant had a similar response:

My husband and I talked about it even before I got pregnant that I wanted to try for a VBAC, and that is why I switched to midwives, and the whole reason I did that was because I knew I had better chances with a VBAC and less interventions with the midwives than OB. [7.5]

Another participant, 25 weeks gestation, spoke of switching from strictly an OB practice to a Midwife/OB practice in hopes to have a successful VBAC. She verbalized this by stating:

I never thought I would travel. I live a mile from Prentice. It’s 18 miles, an hour sometimes in traffic, but I feel having a midwife will better my chances of having a VBAC. So to answer your question, I am seeing an OB, but might be changing to a midwife/OB group. [4.3]

One participant sought out a midwife practice for her second pregnancy, hoping to deliver
VBAC. She stated:

I am seeing a midwife practice that operates out of a hospital. So I did like my OB last time, but the hospital that I delivered at has a high C section rate, and so when I was doing my research on the possibility of doing a VBAC, I would probably have a best shot if I went to a hospital with a lower C section rate or went to providers that had a low C section rate. This practice has a high rate of successful VBAC. [8.1-2]

Seeing a midwife for their second pregnancy was welcomed and a positive experience for participants choosing midwifery care for their second pregnancy. Several participants spoke of their negative experience with their OB for prenatal and labor care for their first birth, compared to the positive experience seeing a midwife for prenatal care in their second pregnancy. This was verbalized with this statement:

Actually that was one of my biggest regrets was not having a midwife for my first delivery. You just don’t know with your first and you think having a doctor is the best route and for me it wasn’t. I think I just needed a different approach and I was scared with my first one. There was a lot of things happening that prevented my labor from progressing at a faster rate. You know having all those interventions just went against my body, so, I think having a midwife and having that approach and reading Baby Catcher, like, having a long labor is normal. You know really it has been the whole approach to the pregnancy. There hasn’t been a lot of ultrasounds, appointments seem really standard. Just the general level of care and the approach to pregnancy. It feels more like not medicalized. You know, women have babies and this is the way things should go compared to a doctor treating you, I suppose. Just this approach makes it feel different. [3.4]

She continued to state:

You just never know what is going to happen, but I feel a lot better this time and I have been reassured by my midwives. You feel a connection with your midwives. One other thing with midwives, is you never feel rushed when you are in there. I know we are on an appointment schedule, but I always felt like they always looked me in the eye or they were taking notes. You know I felt like they felt I am a person and not just a time slot. [3.5]

She praised the entire practice by stating, “the whole practice I should say feels good. From the
ultrasound tech to the person that greets you at the door, the receptionist. Everything just feels really good this time” [3.5]. Switching from an OB group to a midwifery group for the second pregnancy was a positive step for one participant. She stated:

I definitely feel I have more time, they provide more explanation than I experienced with my first pregnancy, the OB at the different practice. So I definitely feel they have more time and they are listening to my questions. It depends, I have met several different midwives and I feel some take more time than others, but generally I still feel like I am being heard. [8.6]

Another stated, “they are much more personable and invested in me than the OBs are” [7.4]. She continued stating:

During the OB appointment, no, she didn’t want to hear what I had to say, but I expressed it anyway. But with the midwife they are great. They have got to know my daughter since I brought her to every appointment. They actually want to know what is going on with me as a person, and they have started a new program. It hasn’t started yet, but I wish it had. It is starting I think this month or maybe June. It is an after hours clinic for people that are due around the same date so they can come together and talk. I don’t think group therapy is the right word but it’s just a support group kind of thing for patients of the midwives, and the midwives are taking their own time in the evenings to have this group. I think twice a month to support their patients and to build a community of support among patients. I could forward you an article about it if you would like. It just shows how they are invested in getting to know their patients and how supportive they are on a personal level instead of being a number. [7.7-8]

She continued to state:

They have signs all over their area because they are separate from the OB area. They have signs all over about empowering yourself during birth and like how good their VBAC rate is and like their commitment to their patients and not the numbers, and like everyone that you talk to is realistic but also like, why wouldn’t you try this? I just feel they are very supportive. [7.5]

Another participant spoke of similar feelings stating:

I had a girlfriend that delivered last month. Her baby was breech. Luckily they were able to turn it, but she was telling me she felt like just a number at her OB. Like they weren’t spending the time with me and answering my questions and I feel with midwives they do. [4.9]
In summary, the results of this study defined the process of women’s decision making of subsequent pregnancy birth mode after a previous Cesarean delivery. *Wanting a different birth experience* emerged as the core category. The basic social process begins with *having a Cesarean delivery* for the first birth. The women’s *judgments of their experience* of their first Cesarean delivery leads women to *seek information* about subsequent pregnancy birth modes, resulting in women *knowing more* about birth modes. Following, women make a decision of either *wanting a VBAC* or *wanting a RCS*. Depending on birth mode decision, women *find a supporting provider* to ultimately deliver birth mode desired. In the following section, the researcher’s adherence to study rigor will be discussed.

**Study Rigor**

Study rigor in grounded theory is guided by four specific principles, which are discussed below. These include, the theory must fit the substantive area that it will be used, the theory must be understood and clear to individuals utilizing the theory, the theory is general enough and can be applied to several situations within the substantive area, and the theory must allow individuals utilizing it partial control in everyday situations (Glaser & Strauss, 1967).

The generated theory fits and will work in the substantive area, as it was developed from data from pregnant women deciding subsequent birth mode after a previous Cesarean delivery. The theory was inductively developed from individuals that have lived the experience and illustrated by individual examples of data (Glaser & Strauss, 1967). Categories that emerged from the data were compared to other categories, forming broader categories. As the theory developed, transcripts were re-reviewed, to confirm that the theoretical structure and categories fit the data. The theory is reported in a clear manner and comprehensible to study participants,
pregnant women, health care providers, and all individuals with experience in the substantive area of study. To understand the researcher’s analysis, direct quotes from participants were provided supporting conceptual categories and their properties (Glaser & Strauss, 1967; Rubin & Rubin, 2005; Lincoln & Guba, 1985). The developed conceptual categories are clearly defined, making the theory applicable to a variety of contexts and situations related to the substantive area of study (Glaser & Strauss, 1967). The theory is transferable to women deciding VBAC or RCS, postpartum women with a previous Cesarean delivery, and women considering pregnancy after a Cesarean delivery. For women currently pregnant and deciding VBAC or RCS, the theory can be transferable at different time frames, which would include first through third trimesters, and in different outpatient and inpatient settings. The theory is relevant to various maternal care health care providers, such as Obstetricians, Midwives, Nurse Practitioners, and maternal care nurses.

**Summary**

This chapter provided a theoretical model of the basic social process of the decision making process for women deciding subsequent pregnancy after a previous Cesarean delivery. The theory consists of a core category and seven conceptual categories. Properties of each conceptual category were provided from participant quotes describing the decision process of women deciding subsequent pregnancy birth mode after a previous cesarean delivery. An illustration of the linear process of conceptual categories was provided in this chapter. The chapter concluded with a discussion of study rigor applied in qualitative research and grounded theory.
CHAPTER FIVE
DISCUSSION

The purpose of this chapter is to discuss the key findings of this study, which investigated the decision making process that women undergo with the decision of subsequent pregnancy birth mode of VBAC or RCS after a previous primary Cesarean delivery. The chapter begins with a discussion of the theoretical model and core category, followed by the seven categories and the properties of each category. The study findings will be compared to previous research findings. Following this section, the unique finding of this study will be discussed. In conclusion, the limitations of the study will be discussed, along with implications for nursing practice, education, administration and research.

The decision making process of subsequent birth mode of VBAC or RCS after a primary Cesarean birth begins with women having a Cesarean delivery for their first birth. Several participants were aware of needing a Cesarean delivery for their first birth, due to abnormal fetal position or the medical condition of the infant. These participants had a planned or scheduled primary Cesarean delivery. Other participants presented to the hospital in labor or for a planned induction, yet, had a primary Cesarean for fetal distress, failure to progress, and/or maternal fever. The process is followed by the women’s judgments of the experience of their first Cesarean delivery. Apart from opposing primary Cesarean birth experiences, women seek information about reasons for their first Cesarean delivery and options for subsequent
pregnancy birth mode. By seeking information from various avenues, women know more about subsequent birth modes, aiding in their decision of wanting a VBAC or wanting a RCS for subsequent birth. Depending on desired birth mode, women search for a supporting healthcare provider in hopes to achieve their desired birth mode. The core category that emerged from the data was wanting a different birth experience. The core category was central to all seven categories and represented the participant’s desire to have a different birthing experience for their second child. In the next section, the core category and seven conceptual categories will be discussed, in relation to extant literature.

Core Category

Wanting a different birthing experience emerged as the core category in the process by which women, regardless of wanting a VBAC or wanting a RCS expressed the need to have a different birthing experience for their second child. Women wanting a VBAC expressed wanting a different birthing experience with phrases such as “wanting to avoid and have a different birth this time,” “wanting a different experience than last time,” “not wanting to repeat it,” and “not wanting to go through that again.” For this group of women, “wanting to experience natural birth” was a desire. These findings are similar to reports in the literature.

Emmett et al. (2006), exploring women’s decision making regarding mode of delivery after a previous Cesarean birth, found the experience of having a natural delivery was a factor that influenced women’s decision to plan for a VBAC. Phillips et al. (2009-2010) explored the process of decision making for subsequent birth after a previous Cesarean delivery, and found mothers wanting a VBAC decided on birth route with the belief in the significance of natural birth. Wanting a normal and natural delivery was a factor affecting the decision making process
regarding mode of delivery after a previous Cesarean birth (Moffat et al., 2007). Fenwick et al.
(2007) found a major influence for women wanting a VBAC after a previous Cesarean delivery
was a deep belief and importance of experiencing a natural birth. Participants described giving
birth naturally was a vital part of being a woman and mother. Meddings et al. (2007) explored
women’s lived experiences of previous Cesarean delivery that elected to attempt VBAC for
subsequent pregnancy, and found wanting a normal birth, which was defined as experiencing the
function of a female body, was a factor for deciding VBAC. Desiring to have a natural birth was
a major factor associated with achieving a VBAC after a Cesarean delivery (Godden, Hauck,
Hardwick, & Bayes, 2012) Shorten, Shorten and Kennedy (2014) found the need to experience
natural, normal labor were reasons women decided to have a VBAC. Lundgren et al. (2012)
found women who gave birth vaginally after a previous Cesarean delivery expressed birthing
vaginally was meaningful and a significant part of being a woman and mother. The women
desired to experience natural birth, expressing the female body was made to give birth vaginally.

Dahlen and Homer (2013) explored factors that influence women’s decision making
regarding subsequent delivery following a Cesarean birth. The authors found for many of the
women preparing for their second birth meant avoiding a repeat of the previous birthing
experience.

In this study, one woman, wanting a different birthing experience and wanting a RCS
expressed “not wanting to end up in the same situation” due to her first birth being 26 hours of
labor and ending in an emergency Cesarean delivery. Philips, McGrath and Vaughan (2009-
2010) found women choosing RCS desired the delivery to avoid trauma of a repeat Cesarean
delivery if needed for their second birth. Fenwick et al. (2006) found women who experienced a
Cesarean birth for their first delivery, and who preferred a Cesarean birth for their subsequent pregnancy decided birth mode due to fear, anxiety, and trauma experienced from their first Cesarean birth. Shorten, Shorten and Kennedy (2014) found women with one previous Cesarean delivery deciding ERCS for subsequent pregnancy did so for reasons such as avoidance of risks and avoidance of emergency Cesarean delivery.

In this study, two participants, wanting a different birthing experience and wanting a RCS, described having an acceptable experience with their first Cesarean and decided to schedule a RCS and avoid labor. The participants described having no bad outcomes with the first Cesarean and decided RCS because they are familiar with delivery mode. Munro, Janssen, Corbett, Wilcox, Bansback, and Kornelsen (2017) researched women’s decision making for subsequent birth mode after a Cesarean delivery and found women that had a planned Cesarean delivery (breech presentation and placenta previa) for their first delivery expressed positive experiences with their Cesarean, and leaned towards repeat Cesarean delivery for a subsequent delivery.

Wanting a different birthing experience emerged as the core category as all participants, regardless of desired birth mode for subsequent pregnancy, expressed the need to experience a different labor and delivery for their current pregnancy. The core category closely aligns with previous research studies in the decision making process of VBAC or RCS after a primary Cesarean delivery. In the next section of this chapter, the seven conceptual categories and their properties will be discussed, and how the categories relate to previous scholarly work.
Having a Cesarean Delivery

The basic social process of the decision making process of subsequent pregnancy birth mode of VBAC or RCS after a primary Cesarean birth begins with a woman *having a Cesarean delivery* for her first birth. Participants in this study told of their reasons for needing a primary Cesarean delivery. Several women understood the medical reasons for needing a primary Cesarean and had a scheduled/planned primary Cesarean. Other women in this study presented to the hospital in labor or for an induction, in hopes of having a vaginal delivery, yet, ending up delivering via Cesarean for reasons such as failure to progress or fetal distress. All of the women understood the need for their primary Cesarean in order to have a healthy infant and outcome, yet expressed *not wanting* a Cesarean section for their first delivery. The conceptual property *not wanting* a Cesarean delivery has been previously found in research works on women’s birth mode preferences. Researchers found most women reported a preference for a vaginal delivery (Gamble & Creedy, 2001; Lavender & Kingdon, 2009; Stoll, Fairbrother & Thordarson, 2018; Arcia, 2013; Liu et al., 2013; Angeja et al., 2006). Donati, Grandolfo, and Andreozzi (2003) found primiparous Italian women delivering vaginally preferred this birth mode for their first birth. The authors found over 70% of the women delivering Cesarean for their first birth would have preferred a vaginal delivery. Li, Tippawan, and Babill (2014) found nulliparous Chinese women preferred a vaginal over a Cesarean delivery for their first birth. Pang, Leung, Lau, and Chung (2008) found nulliparous women at 37 weeks gestation preferred vaginal delivery over a Cesarean. After delivery, a significant proportion of the women changed their birth preference from vaginal to elective Cesarean for a subsequent pregnancy due to fear of vaginal birth (Pang et al., 2008). David et al. (2010), exploring information needs for women deciding VBAC or
RCS, found women preferred to give birth vaginally and felt disappointed about not delivering vaginally for their first birth.

*Having a cascade of interventions* emerged as a conceptual property as participants described *having a Cesarean delivery* for their first birth due to the number of interventions performed during their first labor. Participants spoke of various interventions such as membrane sweeping, getting an epidural in the early stages of labor, being bedridden after the epidural, and Pitocin as causes for their first Cesarean. Participants expressed the interventions went against their bodies and delivering vaginally.

Researchers have found women delivering via Cesarean experienced more interventions during labor and birth compared to women having a vaginal birth (Chalmers et al., 2010). Rossignol, Chaillet, Boughrassa, and Moutquin (2014) found obstetric interventions such as continuous electric fetal monitoring at admission versus intermittent auscultation were associated with Cesarean delivery and epidural analgesia. Epidural on request was associated with Cesarean delivery, instrumental delivery and oxytocin use (Rossignol et al., 2014). The authors found the earlier such interventions begin, the greater the probability of needing other interventions, cascading down to a Cesarean delivery (Rossignol et al., 2014). Fenwick et al. (2007) found women who had experienced a VBAC or stated a preference for VBAC for their subsequent pregnancy felt ill-informed and unprepared for their first birth, resulting in a number of interventions performed during their first birth, resulting in delivering via Cesarean delivery. The women expressed changing hospitals and/or providers to avoid interventions such as induction or epidural for a subsequent birth.

*Not talking about Cesarean section* emerged as a conceptual property as participants
described knowing Cesarean section was a delivery option, yet, not discussed with them by healthcare providers during their first pregnancy. Despite being in the hospital for three weeks in her third trimester, one participant described Cesarean delivery birth mode was not discussed with her by providers during the hospitalization. Participants described the need for providers to “bring it up” at the end of the pregnancy, because many women go in the hospital thinking they will deliver vaginally, and end up delivering Cesarean. Participants also described the need for healthcare providers to debrief them in the postpartum phase on the reason for needing a Cesarean delivery. Participants described having a Cesarean delivery, yet, being “left in a lurch” because no one debriefed them on the reason of their first Cesarean and how it will affect future pregnancies.

David et al. (2010), exploring the information needs for women deciding subsequent pregnancy birth mode after a previous Cesarean delivery, found some women contacted the Next Birth After Cesarean (NBAC) service (midwife led group assisting women deciding subsequent pregnancy after a Cesarean delivery) to discuss with a healthcare professional reasons for their previous Cesarean birth and to find out if VBAC was a possibility. In contrast, Farnworth and Pearson (2007) found women deciding subsequent pregnancy birth mode after a previous Cesarean were provided clarity for the reasons of their previous Cesarean birth from Obstetricians.

In this study, women having a planned, scheduled primary Cesarean delivery for a medical indication were aware of the need and reason to have a Cesarean delivery. This is recognized in previous work done by Godden et al. (2012), stating women having a scheduled
Cesarean delivery for medical indications such as breech presentation or macrosomia understood reasons for needing their first Cesarean.

Another property of having a Cesarean delivery that emerged from the data is knowing how the first Cesarean will affect future pregnancies. Participants described a need for providers to discuss Cesarean delivery birth mode in their first pregnancy, and how the first Cesarean delivery could affect future pregnancies and deliveries.

In previous research work, Farnworth et al. (2008) found women reported understanding facts about previous Cesarean delivery as crucial in making a decision for second birth mode. Goodall, McVittie, and Magill (2009) found women deciding subsequent pregnancy birth mode after a Cesarean lacked personal knowledge and information particular to their situation to make an informed decision of VBAC or ERCS. The authors found women did not understand the implications of their previous Cesarean on subsequent birth mode after their Cesarean. Previous work by Bernstein, Matalon-Grazi, and Rosenn (2012) found women were not properly informed by providers of the risks and benefits of VBAC and ERCS. The authors found both groups (VBAC and ERCS) were unfamiliar of the effect of indication of previous Cesarean delivery on success of TOLAC.

The first conceptual category, having a Cesarean delivery and its properties, having a cascade of interventions, not wanting a Cesarean delivery for the first delivery, providers not talking about Cesarean delivery, and knowing how the first Cesarean will affect future pregnancies, led to the next stage of the process of the women’s judgments of the experience of their first Cesarean delivery.
Judging the Experience

In this process, participants described their feelings and experiences of their first Cesarean delivery. The majority of the women expressed having a negative experience with their first Cesarean delivery, yet two participants described having an acceptable experience. Conceptual properties that emerged from the data from women judging the experience as negative were; not having an ideal experience, experiencing a traumatic life event, wanting to talk to a counselor, and not having a good recovery. The participants expressed the gratitude of a healthy infant for their first birth, but also expressed how the Cesarean delivery took a psychological toll on their mental well being.

Previous work by Munro et al. (2017) found women having a previous unplanned Cesarean delivery expressed negative “out of control” feelings for their first birth and felt like a “failure” for not delivering vaginally. Fenwick et al. (2006) found women with one previous Cesarean having a planned RCS and/or opting for a planned RCS for their subsequent pregnancy, desired mode of delivery due to fear and anxiety from the impact of their first Cesarean delivery. Some of the women expressed uncertainty of getting pregnant a second time due to their traumatic experiences of their first birth. Women with one previous, non-elective or emergency Cesarean delivery desiring a VBAC for their subsequent birth decided birth mode because their first Cesarean delivery physically and emotionally hindered their state of health (Fenwick et al., 2007). This group of women expressed feeling powerless, hopeless and never wanting to repeat the experience.

The decision process of subsequent pregnancy birth mode after a previous Cesarean delivery is emotional, and for many women means simply avoiding a repeat of the previous
birthing experience (Dahlen & Homer, 2013). Despite their description of experiencing emotional trauma from a previous Cesarean delivery, women do not often have the opportunity to debrief with a healthcare professional about their negative feelings and traumatic experience (Cox, 2007). In addition to women, their partners and close family friends carry traumatic memories of the first birth (Farnworth et al., 2008).

*Experiencing a traumatic life experience* linked to the next property of wanting to talk to a counselor about their previous birth experience and decision of VBAC or RCS. The property wanting to talk to a counselor, is a unique finding. Participants described wanting someone other than their maternal/child provider, with more of a counselor position to “work through” emotional issues of having a Cesarean delivery for their first birth and subsequent pregnancy birth mode.

One participant wanted someone;

> To counsel me on being at peace with the decision I made if something goes wrong. You know, someone that understand the risks, understands the literature, someone that understands the information you are getting from the OB, but is there to sort out like what a counselor does. [5.10]

Researchers have found women having an emergency Cesarean delivery or operative vaginal delivery experience had increased symptoms of PTSD, compared to women having a spontaneous vaginal delivery or elective Cesarean delivery (Gamble & Creedy, 2005). Women having an emergency Cesarean delivery experienced increased emotional distress compared to women having a vaginal delivery (Gamble, Boorman, Creedy, & Fenwick, 2011). In the decision making process of subsequent birth mode after Cesarean delivery, Farnsworth and Pearson (2007) found women feel uncertain of their decision and have fear of blame if their
infant has a bad outcome. To avoid feelings of guilt over making a decision of VBAC or RCS, some women relinquish control of the decision to their provider (Lundgren et al., 2012).

*Not having a good recovery* emerged as a conceptual property as participants described the negative, physical experiences after the Cesarean delivery. One participant described having several issues that “just compounded on each other.” She described having to “basically sit in a chair all day until her husband got home from work” because she could only “walk a little bit around the house.” Other participants described the recovery as very painful and longer than expected.

When compared to a vaginal delivery, Cesarean delivery requires a longer recovery period (Thompson, Roberts, Currie, & Ellwood, 2002). Previous work from Eden, Hashima, Osterwell, Nygren, and Guise (2004) found women deciding subsequent birth mode after a Cesarean delivery decided VBAC for an easier recovery and for a shorter recovery period (Emmett et al., 2006; Romero et al., 2012; Moffat et al., 2007; Farnworth & Pearson, 2007; Fenwick et al., 2007; Meddings et al., 2007; Wittman-Price, Fliszar & Bhattacharya, 2011; Shorten, Shorten & Kennedy, 2014; Lundgren et al., 2012). Meddings et al. (2007) found having a Cesarean delivery negatively affected maternal/infant bonding and strained family obligations in the postpartum period.

Although not wanting a Cesarean delivery for their first birth, two participants judged their first Cesarean delivery as acceptable. One participant had a planned scheduled Cesarean delivery for breech presentation, and the other participant had a spontaneous rupture of membranes (SROM), labored all night, but failed to progress in labor. Neither experienced an emergency Cesarean delivery. Conceptual properties that emerged from the data from women
judging the experience as acceptable were having a good recovery and not experiencing any bad outcomes.

In previous work, Munro et al. (2017) found women having a previous elective Cesarean delivery for breech presentation and placenta previa described their Cesarean as friendly, predictable and calm, and planned to deliver RCS for subsequent birth. Shorten & Shorten (2012) found women’s satisfaction with their birth experience was related to mode of delivery. Women experiencing spontaneous vaginal delivery and elective repeat Cesarean delivery had higher satisfaction scores than women experiencing instrumental birth or emergency Cesarean delivery. Women experiencing instrumental vaginal birth or an emergency Cesarean delivery were least likely to make the same delivery choice in a subsequent pregnancy (Shorten & Shorten, 2012).

This stage of the process is followed by the third category of seeking information. In this next phase, women seek information on their own and from their providers to get an understanding of their first birth and options for future pregnancy birth modes.

Seeking Information

Seeking information emerged as the third category of the process. At this point of the process, women are seeking information on their own via online, social media groups, other women, and Doulas to get clarification and reasoning of their first delivery and options for future births. For some women, seeking information began in the postpartum phase of their first birth, and for others during their second pregnancy. Many of the women described seeking information on their own because they received minimal information from providers about subsequent birth modes after a previous Cesarean delivery.
The conceptual property of *seeking information on their own* has been articulated in previous work regarding decision making for subsequent pregnancy birth mode after a Cesarean delivery, as women seek information for reasons behind their first Cesarean (David et al., 2010). Women reported feeling ill-informed to make a decision (Emmett et al., 2006), and not being informed about risks and benefits of delivery methods (Bernstein et al., 2012; Shorten, Shorten & Kennedy, 2014). McGrath, Phillips and Vaughan (2010b) and Lundgren et al. (2012) found women were not given sufficient information about risks for both deliveries and sought information on their own through books and the internet. Lack of information from healthcare providers explaining why their first Cesarean occurred made women seek information online to understand risks and benefits of VBAC and RCS (Munro et al., 2017). Yet, sources of information online were not always helpful to some women (Goodall et al., 2009). Godden et al. (2012) found personal information gathering about subsequent birth mode after a previous Cesarean delivery contributed to women achieving a VBAC.

Women sought information on their own by joining online social media support groups and attending support group meetings. One particular support group, ICAN, was a positive source of information for the women as many found *hearing other women’s stories* encouraging. Participants described women’s “real life experiences” as helpful and uplifting. However, one participant described the stories as encouraging, but “a little bit super militant” towards VBAC.

Lundgren et al. (2012) found women sought information about subsequent birth mode after a Cesarean delivery from women experiencing VBAC, partners, family and friends, books, internet and television. Previous work done by Fenwick et al. (2007) found women deciding VBAC were emotionally supported by support groups for VBAC mothers, as hearing other
women’s experiences provided positive reinforcement for choosing VBAC. Women reported internet Cesarean and VBAC support groups and blogs as encouraging, supportive and motivating (Dahlen & Homer, 2013). However, with conflicting results, Goodall et al. (2009) found women felt the internet and support groups were unhelpful in providing information about VBAC and RCS. Konheim-Kalkstein et al. (2014) found more women planning TOLAC used support groups and online sources as an influence for their planned birth compared to women deciding ERCS.

Women also sought information by reading more. Reading more emerged as a conceptual property as women described reading more online and books. The books Pushed and The Baby Catcher were described as instrumental in aiding in the decision to VBAC. Reading about birth experiences helped women gain confidence in delivering VBAC. One participant described reading more her second pregnancy about hospitals and decisions in labor that ultimately impact the labor outcome. As a result, she decided to hire a Doula to assist her in labor to have a successful VBAC. One participant described reading more research and statistics.

As a result of receiving insufficient information, McGrath, Phillips, and Vaughan (2010b) and Lundgren et al. (2012) found women sought information from books and the internet to gain knowledge about subsequent pregnancy birth modes after a Cesarean delivery.

In addition to reading more, participants sought information by receiving information from their providers. The participants described receiving information from providers verbally during appointments. Some participants received take home materials to read, while another participant in her second trimester of pregnancy, had not received verbal or written information from her provider about birth modes. Providers primarily discussed uterine rupture as a risk for
VBAC. For one participant, 40 weeks gestation, the risk of uterine rupture was the only risk conveyed during her pregnancy, and risks for Cesarean delivery were not discussed the entire pregnancy. Two participants described their provider discussing both risks for VBAC and RCS. Only one participant, deciding RCS, verbalized the risk of infection. Participants also described providers using a percentage/calculator to predict success rate of VBAC.

Lundgren et al. (2012) found information about VBAC and RCS from health care professionals to patients was unclear and contrasting. In previous work, Emmett et al. (2006) found information provided by providers to women deciding VBAC or RCS varied. Some women received information verbally, others received a general leaflet about Cesarean birth, and some women had to request information due to providers not routinely providing information about birth modes. Moffat et al. (2007) echoed this as information provided to women from healthcare providers ranged from minimal to sufficient information. Some women in the study desired information specific to their individual situation rather than general information about birth modes (Moffat et al., 2007). Philips, McGrath and Vaughan (2009-2010) reported women desiring or achieving a VBAC were mostly informed by providers of the risks of VBAC and the benefits of RCS. The women reported information provided was biased towards RCS. Women reported feeling rushed and feared to ask questions during verbal discussions with physicians regarding previous Cesarean delivery and subsequent pregnancy birth modes (Munro et al., 2017).

Fenwick et al. (2006) found women preferring RCS for subsequent pregnancy after a Cesarean delivery reported Cesarean birth was the safest birth mode compared to VBAC. In the study, women reported providers negatively discussed VBAC and they felt obligated to comply
with their doctor (Fenwick et al., 2006). Women stating a preference of VBAC for subsequent birth mode after a Cesarean reported feeling a lack of communication and understanding with their providers, and felt providers were rude and aggressive (Fenwick et al., 2007). Bernstein et al. (2012) reported women were not properly informed of risks and benefits of both delivery modes. In contrast, Godden et al. (2012) and Wittman-Price et al. (2011) found most women reported receiving sufficient and unbiased information about VBAC and RCS. However, some of the women desiring VBAC felt obstetric appointments were discouraging when faced with a medical professional not supportive of VBAC. Konheim-Kalkstein et al. (2014) found women desiring a RCS reported their husband/spouse/significant other and healthcare provider as the most influential source of information compared to TOLAC women who were less likely to rely on healthcare providers for information. Women reported information from medical personnel was the most trusted source of information, however, researchers found women were not adequately informed of risks and benefits of TOLAC versus RCS (Shorten, Shorten & Kennedy, 2014). Cox (2007) found the main source of information about subsequent pregnancy birth modes after a Cesarean delivery came from obstetric team, midwives and hospital leaflets. Several women in this study received conflicting information from healthcare professionals. Risks were discussed with the women, but information was provided differently. Most of the women found the information beneficial, however, two women (2/7) reported not having enough information (Cox, 2007).

Participants described waiting resources from providers to take home and read. Participants described information comparing risks and benefits of both delivery modes would have been beneficial in making a decision. Being able to take information home would allow
women to spend more time thinking about their decision at home “opposed to the exam room.”
Take home materials in different languages was expressed by one participant, as she expressed having to translate everything to her husband. She stated, “it is easy for information to get lost in translation.” Information provided on practice websites was not always helpful as participants described wanting “a piece of paper” with “pros/cons on a provider level” to take home. For some women, although their decision was made, take home materials with “studies and numbers, and results would have been appreciated.”

In previous research work, Emmett et al. (2006) found some women felt ill-informed in making a decision and would have liked facts and figures to assist in the decision making process after their first Cesarean delivery.

Decision aids provide women deciding birth mode after a Cesarean delivery with clear, accurate and informative information (Schoorel et al., 2014). Information provided to women in the form of a decision-aid booklet, describing risks and benefits of both VBAC and RCS was found to increase knowledge scores and decrease decisional conflict in women deciding subsequent pregnancy birth mode after a previous Cesarean delivery (Shorten et al., 2005). Montgomery et al. (2007) found computer based decision aids reduced decisional conflict scores in women deciding subsequent pregnancy birth mode after a previous Cesarean delivery. Women receiving the decision aid reported the quality and depth of information decreased their uncertainty and helped in making a decision (Frost et al., 2009). Eden, Perrin, Vesco, and Guise (2014) found the use of informational brochures and computerized decision aids significantly reduced decisional conflict in women deciding subsequent birth mode after a Cesarean birth. Farnworth et al. (2008) exploring the impact of a decision support intervention (take home DVD
and one-on-one home visit with a healthcare provider) for women deciding mode of delivery after a previous Cesarean delivery did not find a significant difference between routine care and the intervention on decision conflict and self-efficacy measures, along with knowledge and expectations of birth. Qualitative measures were used to examine women’s experiences with the intervention and without. The authors found in the intervention group women were provided facts about their previous Cesarean, which helped in making a decision for subsequent birth. Information provided to the women increased their confidence in their decision. For women unsure of decision, the intervention provided structure and helped guide them in the decision process.

From seeking information from different avenues, participants described knowing more their second pregnancy compared to their first pregnancy.

**Knowing More**

Seeking information on their own through online readings and books, hearing other women’s stories, and receiving information from their providers, lead women to feel more knowledgeable about their second pregnancy. Participants described knowing more their second pregnancy by being more educated as many participants described not knowing enough the first pregnancy. Participants described not knowing enough their first pregnancy regarding labor and birth and/or maternal care providers, as one participant stated, “I didn’t even know what a midwife was last pregnancy.” Not knowing enough their first pregnancy, led women to take a personal initiative of researching and reading more and being more educated their second pregnancy. Participants described the importance of being educated about inductions and risks associated with them.
In previous research, Fenwick et al. (2007) found women deciding subsequent pregnancy birth mode after a previous Cesarean delivery felt ill-informed and unprepared for their first birth. As a result, seeking knowledge and information was prominent to achieve a VBAC for their second pregnancy. Lundgren et al. (2012) found women described having a VBAC as a personal responsibility. Personally gaining information and knowledge about birth modes was prominent in facilitating a VBAC. Godden, Hauck, Hardwick, and Bayes (2012) found information provided by providers and information the women personally gathered to enhance their knowledge about VBAC and Cesarean birth contributed to their VBAC success. Investigating if women were making active decisions about delivery choices, Wittman-Price et al. (2011) found personal knowledge was the strongest predictor of satisfaction with delivery decision.

By seeking information and knowing more, women make an informed decision of wanting a VBAC or wanting a RCS for subsequent pregnancy birth mode after a previous Cesarean delivery.

**Wanting a VBAC**

*Wanting a VBAC* emerged as a conceptual category as many participants described having a negative experience from their first Cesarean, sought out information about subsequent pregnancy birth modes, became educated, informed and knowledgeable about birth modes, understanding that VBAC is a reasonable and safe delivery mode after a previous Cesarean delivery. The conceptual properties of this category are *missing out, seeing my child for the first time, spending less time in the hospital, wanting an easier recovery, and wanting more kids without having 3 or 4 C sections.*
*Missing out* was described by participants as not being able to birth vaginally their first pregnancy. Participants described birthing vaginally as the natural/traditional mode of birthing and wanted a VBAC for their second pregnancy to have that experience. Participants described how the female anatomy is created to birth vaginally/naturally. For some women not being able to birth vaginally/naturally their first pregnancy, resulted in personal feelings of failure. One participant, leaning towards RCS, described the only thing holding her back from all out choosing RCS is the “feeling like I missed out on experience as a mom of birthing a child.”

The conceptual property *missing out* has been articulated in previous research work in women’s decision making for subsequent pregnancy birth mode after a previous Cesarean delivery. Women desire a VBAC to have the experience of having a natural delivery (Emmett et al., 2006; Phillips et al., 2009-2010; Moffat et al., 2007; Farnsworth & Pearson, 2007; Fenwick et al., 2007; Meddings et al., 2007; Godden, Hauck, Hardwick, & Bayes, 2012; Wittman-Price et al., 2011; Konheim-Kalkstein et al., 2017; Shorten et al., 2014; Lundgren et al., 2012).

*Seeing their child for the first time* is another conceptual property as women described not having this experience with their first birth. Being able to hold, bond and breastfeed their infant immediately after birth was a major influence for wanting to birth vaginally. One participant described not being able to hold or nurse her child for two hours after her Cesarean delivery. Munro et al. (2017) found all of the women in their study expressed being separated from their infant after their first Cesarean was a negative experience regarding their Cesarean. In the same study, women that valued immediate bonding wanted a VBAC for subsequent birth (Munro et al., 2017). Farnworth and Pearson (2007) found post birth bonding and breastfeeding (Shorten, Shorten & Kennedy, 2014) were two major influences for wanting a VBAC. Women
experiencing a VBAC or preference for, reported bonding between mother and infant was an advantage of having a VBAC (Fenwick et al., 2007; Lundgren et al., 2012). However, Meddings et al. (2007) found influences on bonding differed, as some women reported no difference between bonding with Cesarean or VBAC. In the same study, some women reported their Cesarean negatively affected bonding. In contrast, one woman reported a decrease in bonding after her VBAC due to anesthetics during delivery (Meddings et al., 2007).

*Spending less time in the hospital* emerged as conceptual property from the data. One participant described not being away from her child for more than one night, and if she had a RCS she would be in the hospital three or four nights, compared to one night if she had a vaginal delivery. Cox (2007) found length of hospital stay was an important factor when making a decision between VBAC or RCS.

*Having an easier recovery* emerged from the data as participants described wanting a VBAC because the healing process was painful with their first Cesarean, nursing was challenging, and the practical aspects of having a toddler and newborn will be easier with a vaginal delivery. Previous work by Moffat et al. (2007) and Lundgren et al. (2012) found family obligations, daily life (Lundgren et al., 2012) and maintaining an independent role within the family (Farnworth & Pearson, 2007) were reasons women decided to have a VBAC, as caring for a newborn and their first child on a daily basis would be difficult after a Cesarean delivery compared to a vaginal delivery. Having a shorter/easier recovery time has been found in previous work as a major reason for wanting a VBAC (Emmett et al., 2006; Moffat et al., 2007; Farnworth & Pearson, 2007; Wittman-Price et al., 2011; Shorten, Shorten, & Kennedy, 2014; Lundgren et al., 2012).
The last conceptual property of this category is wanting more kids without three or four Cesareans. The participants described wanting more children and knew as the number of Cesarean births increased, so did the risks. Participants described how their bodies could not physically handle three or four Cesarean deliveries. Farnworth and Pearson (2007) found the plan for future pregnancies was an influence in the decision process of deciding VBAC.

Wanting an RCS

The sixth conceptual category of the basic social process is wanting an RCS for subsequent pregnancy birth mode after a previous Cesarean delivery. In this study, two women deciding RCS judged their first Cesarean delivery experience as acceptable and have decided birth option because they know what to expect. Munro et al. (2017) found women having a planned first Cesarean expressed a positive experience with their first Cesarean, and often lean towards having a repeat Cesarean delivery for subsequent birth. One participant, having a traumatic experience decided RCS due to fear of attempting a vaginal birth.

Knowing what to expect and fear of attempting a vaginal delivery are conceptual properties that have been identified in previous research regarding decision making of subsequent pregnancy birth mode after a previous Cesarean delivery. Phillips et al. (2009-2010) found women deciding RCS for subsequent pregnancy after a previous Cesarean did so for reasons such as fear of childbirth, knowing what to expect for a second delivery reducing anxiety, avoiding trauma of a repeat emergency Cesarean, knowing the process of Cesarean delivery, having a calm environment with staff ready at check in for their scheduled Cesarean, and avoiding the induction process. Fear of having a vaginal birth and having a sense of control and plan were influencing factors for women to decide RCS (Emmett et al., 2006). Avoidance of
an emergency Cesarean delivery, prior delivery experience and fear of danger to baby were several reasons women decided on RCS after a previous Cesarean delivery (Shorten, Shorten, & Kennedy (2014). Fenwick et al. (2006) found after experiencing a Cesarean, women decide RCS for subsequent pregnancy because Cesarean delivery has a sense of certainty compared to vaginal birth with many uncertainties. For this group of women, knowing what to expect was a benefit of having a RCS.

The final stage of the basic social process is finding a supportive provider. This stage represents when women are planning another pregnancy or are pregnant again and have in mind desired birth mode. Women search for a provider supporting their desired birth mode.

**Finding a Supportive Provider**

In the final stage of the basic social process, participants find a supportive provider supporting their desired birth mode. For some participants, finding a supportive provider began before getting pregnant a second time, and for others during the antepartum phase of the second pregnancy. Many of the participants wanting a VBAC described wanting to find a supportive provider that accepted and supported their desired birth mode. Wanting acceptance and support from healthcare providers emerged as a conceptual property as participants described wanting to find a practice that was VBAC supportive. Having multiple providers in a practice was described as a negative experience in finding a supportive provider. One participant described in her practice of five, only two of the providers were supportive of VBAC, which lead her to “strategically make appointments with the doctors that were pro VBAC.” Providers accepting and supportive of participant’s wishes to try for a VBAC gave the participants feelings of confidence to successfully have a VBAC. Midwives were described as more VBAC friendly than
Obstetricians. Participants also mentioned having the support from a Doula as an important factor on having a successful VBAC.

In previous research work regarding women’s decision making of subsequent pregnancy birth mode after a previous Cesarean, Emmett et al. (2006) found most of the women reported their healthcare providers allowed them to make their own decision of birth mode. However, two of the women in the study felt their decision of birth mode was ignored, being forced to deliver birth mode not desired. Godden, Hauck, Hardwick and Bayes (2012) found the majority of the women in their study reported their medical and midwifery staff as positive and supportive of VBAC and were given a choice of birth mode. Farnworth and Pearson (2007) found all participants in their study reported their Obstetrician respected birth mode choice and allowed each woman to make their own decision of birth mode for subsequent pregnancy after a precious Cesarean delivery. Philips, McGrath, and Vaughan (2009-2010) found women achieving or wanting a VBAC reported their healthcare providers felt VBAC was the most risky birth mode compared to RCS. Obstetricians not supportive of VBAC informed participants of the increased risks of having an emergency Cesarean delivery, uterine rupture and possible maternal and/or infant death (Philips et al., 2009-2010).

Women desiring VBAC find it difficult to find a supportive provider (Lundgren et al., 2012). Kelly et al. (2013) found a contributing factor to women not achieving their desired VBAC was the uncertainty and doubt from medical staff during antepartum visits. For this group of women, having unsupportive staff depleted their confidence in having a VBAC. Fenwick et al. (2006) found women having a previous Cesarean and preferring RCS for subsequent pregnancy identified the primary care provider as the major influence in the decision to have a planned
Participants in this study reported not having an option or choice to deliver VBAC because it was not possible, or their doctor only believed in Cesarean delivery. Participants described their providers talking negatively about VBAC and due to this, participants felt obligated to comply with their doctor. Women feel pressure from providers to deliver by RCS (Fenwick et al., 2007). In their study, exploring childbirth expectations and knowledge of women who had experienced a VBAC or preferred VBAC, researchers found communication between patient and provider was poor and wishes for a VBAC was neglected. Participants felt health care professionals were insensitive, rough, rude and aggressive (Fenwick et al., 2007). Goodall, McVittie and Magill (2009) reported women felt their personal choice of VBAC was in conflict with their providers, as the women expressed their providers offered a choice between VBAC or RCS, but gave personal opinions regarding success rates without providing exact sources. The majority of the women in the study felt like they had little control over birth of their second child. Shorten, Shorten and Kennedy (2014) explored women’s values and expectations during their decision process of VBAC or RCS. The authors found a major factor that influenced the decision process was the lack of medical practitioners support of TOLAC. Lundgren et al. (2012) conducted a metasynthesis from qualitative studies to understand women’s experiences of VBAC and found the majority of women felt a lack of support delivering VBAC from doctors and midwives, and felt pressured to deliver RCS. Yet, some women experienced having a provider against RCS and preferred to deliver VBAC.

For some women, finding a supportive provider for desired birth mode meant switching providers and/or hospitals to achieve desired birth mode. Switching providers and/or hospitals emerged as a conceptual property as participants described having to switch providers due to
their first pregnancy provider not offering VBAC. One participant described switching providers to get a second opinion to achieve a VBAC. One participant described having to switch both providers and hospitals to achieve a VBAC. Participants also discussed the possibility of switching providers later in pregnancy due to being in a practice of five providers that weren’t all VBAC supportive. One participant, wanting a RCS, switched providers after her first delivery due to experiencing a traumatic birth.

Fenwick et al. (2007) found women who had experienced a VBAC or preferred a VBAC reported the need to change hospitals and specialists to avoid interventions such as induction or epidural for a subsequent birth. Women reported hospitals, in general, are not supportive of VBAC (Dahlen & Homer, 2013).

For some participants, switching providers meant seeking out/switching to a midwife to achieve or have a better chance of achieving a VBAC. Participants spoke of switching to a midwife from an Obstetrician at the beginning of the second pregnancy to have less interventions during labor and to increase chances of a successful VBAC. One participant, in her second trimester, living a mile from the hospital she delivered her first child, spoke of switching to a midwife and traveling an hour in traffic to have a better chance of having a VBAC. Finding out that her previous hospital had a high Cesarean rate, one participant decided to switch hospitals and providers to have a better chance of a successful VBAC.

Munro et al. (2017) found women reported switching to midwifery care for their second pregnancy or have an unattended homebirth to increase their chances of having a successful VBAC. Seeking out/switching to a midwife was a positive decision made by participants. Women cared for by a midwife during their pregnancy are more likely to choose VBAC (Metz et al.,
Managing care by a midwife is associated with increased rates of VBAC compared to traditional Obstetrician care (White, le May, Cluett, 2016).

*Seeing a midwife* for their second pregnancy emerged as a conceptual property as women described the positive experience of choosing midwifery care for their second pregnancy compared to their obstetric care during their first pregnancy and birth. Participants described regrets for not knowing of or having a midwife for their first pregnancy. Several participants described wanting a different approach to the second pregnancy. Participants described feeling connected, empowered, supported and reassured by their midwives compared to their OBs in their first pregnancy. Participants described not feeling rushed during antepartum appointments with midwives compared to OBs in their first pregnancy. One participant not only praised her midwife, but the entire practice, including the receptionist and ultrasound tech. She described how the entire practice “feels really good this time.”

Researchers reported women are more satisfied with antepartum care delivered by a midwife compared to an Obstetrician (Wilson & Sirois, 2010). Munro et al. (2017) found women reported discussions with physicians about their previous Cesarean delivery and subsequent birth were rushed and brief, and many women feared to ask questions. In contrast, midwife patients did not feel rushed and appointments often lasted over an hour. Participants consulted with a physician at 36 weeks gestation. This visit was not positive as many left feeling pressured to make a decision, questioning their decision and regretting signing the informed consent for a RCS if needed (Munro et al., 2017). However, Kelly et al. (2013) found women not achieving a VBAC was a result of individual provider practice and hospital policies. Restrictions such as continuous fetal monitoring and intravenous infusion impacted their delivery. The women
reported their midwife was more concerned with hospital protocols rather than facilitating and helping them deliver VBAC.

**Unique Findings**

A unique finding emerged from this study. The conceptual property of *wanting to talk to a counselor*, highlighted under the conceptual category *judging the experience* with the first Cesarean delivery, was a unique finding from this study that has not been previously described in literature focusing on women’s decision making of subsequent pregnancy birth mode after a previous Cesarean. The majority of participants in this study described having a negative experience with their first Cesarean, experiencing feelings of grief, sadness, and anger. For some participants, the negative feelings remain ongoing and unresolved. Participants described *wanting to talk to a counselor* about their previous Cesarean delivery and current birth mode decision. Participants described the decision making process to have a VBAC or RCS “is not as cut and dry as it seems and it is a lot of guilt in the decision.” Participants desired someone other than their Obstetrician, with more of a counselor position, to discuss such matters with. Participants described not feeling comfortable talking about emotional issues with their Obstetrician, as Obstetricians were described as being “more medical.” Participants described wanting someone knowledgeable of risks and benefits of both birth modes, but also someone with a counseling background that could counsel participants struggling with “finding peace” with the decision, along with “being at peace with the decision made if something goes wrong.”

Current ACOG (2017) VBAC practice guidelines state risks and benefits of both VBAC and RCS should be discussed and documented with each patient. Individual characteristics that may increase risks associated with both VBAC and RCS should be discussed and documented,
“so that a woman can choose her intended route of delivery based on data that are most personally relevant.” (ACOG, 2017, p.e224). The guidelines state discussion should start in early pregnancy and a VBAC calculator should be used to provide individual percentages of VBAC success rates. Women deciding VBAC should be counseled about resources available at intended delivery site. Future reproductive plans should be discussed with each patient providing information of risks as the number of Cesarean births increase. In addition;

“After counseling, the ultimate decision to undergo TOLAC or a repeat Cesarean delivery should be made by the patient in consultation with her Obstetrician or other obstetric care provider. The potential risks and benefits of both TOLAC and elective repeat Cesarean delivery should be discussed. Documentation of counseling and the management plan should be included in the medical record” (ACOG, 2017, e224).

Checklists are provided on ACOG’s web page to guide obstetric care providers in terms of counseling and management for women deciding subsequent pregnancy birth mode after a Cesarean.

The results from this study highlighted the inability of providers to counsel and provide information to patients deciding VBAC or RCS according to current ACOG (2017) guidelines. Participants described receiving insufficient information from their Obstetrician before and after their first Cesarean, resulting in unresolved emotional issues and questions regarding subsequent pregnancy birth modes. For many of the participants in this study, risks and benefits of both deliveries were not discussed.

Unanswered questions, traumatic experiences, grief, sadness and anger about their first Cesarean delivery lead women to have unresolved emotional feelings about the first delivery, distrusting providers and desiring someone other than their Obstetrician in their current pregnancy to aid in the decision process of VBAC or RCS. The results of this study and the
unique finding of participants wanting to talk to a counselor highlight the need for providers to start counseling and providing sufficient information to patients in their first pregnancy, continuing into their subsequent pregnancy.

**Limitations**

A limitation of this study is the purposeful sample was primarily Caucasian, married, mean age of 31, well educated, with household incomes over $70,000 a year. A more diverse ethnic sample may produce different results, as non-Hispanic black women have the highest Cesarean rate (35.9%), with Hispanic women following at 31.7% (Martin et al., 2018). All interviews and transcriptions were conducted in English, limiting the understanding of cultural differences in the decision process. A more diverse socio-demographic sample with younger women, lower income and educational levels may produce different results, as Cesarean rates are higher for college educated women and women 40 years of age and older (MacDorman et al., 2011; Martin et al., 2018). An additional limitation of this study is the sample consisted of women having access to a facility offering VBAC. It did not include women currently deciding subsequent pregnancy birth mode with limited resources/access to a facility offering VBAC. To get a better understanding of the decision process, future studies could include women deciding subsequent pregnancy birth mode living in rural communities with limited access to maternal care. In addition, future studies could include health insurance ownership and the effect it may have on the decision process. A final limitation of the study was the online social media recruitment site ICAN. ICAN is a non-profit organization whose mission is to advocate for VBAC. The majority of the women following ICAN on Facebook desire a VBAC. In this study, at the time of the interview, more women had decided VBAC. Having a balanced sample of
participants deciding VBAC or RCS could have produced different data compared to the current study results.

**Implications for Nursing Practice**

The basic social process of the decision making process of VBAC or RCS has implications for nursing practice. The findings of this study indicate the decision making process for VBAC or RCS begins with the first Cesarean delivery, and for some women, preferences of subsequent pregnancy birth mode are formed at this time. This study found women received insufficient information in the postpartum phase after their first Cesarean delivery regarding reasons for their Cesarean, recovery, and effects of the Cesarean on subsequent pregnancy birth modes. Participants in this study expressed wanting information about subsequent pregnancy birth modes during the postpartum period. This study also highlights that women received insufficient information in their current pregnancy on clinical risks and benefits of both VBAC and RCS. The women desired information to take home and look at explaining up-to-date evidence of risks and benefits of both VBAC and RCS. Due to lack of information provided by their providers, women sought out information on their own and relied on information from the internet, support groups, books and their experiences from their previous Cesarean.

Obstetric registered nurses (RN), obstetric and gynecologic nurse practitioners (NP) and Certified nurse-midwives (CNM) all serve an educator role by providing information to women during pregnancy, labor, birth, and after birth. The generated theory is useful to understand the process of women’s decision making of birth mode after a Cesarean delivery. Findings from this study indicate the need for obstetric care providers to provide sufficient information, acknowledge issues and concerns, and to clarify questions regarding their patient’s individual
situation during the postpartum phase of their first Cesarean and subsequent pregnancy. CNMs and NPs provide care to women in the interpregnancy period. It is essential care providers address any postpartum issues, mental well-being and plans for future pregnancies. Women experiencing psychological/emotional issues from their first Cesarean should be referred to a healthcare provider specializing in birth trauma.

The findings from this study indicate participants gained knowledge about their first birth and subsequent pregnancy birth modes from hearing other women’s stories and attending support group meetings. To assist women in the decision, obstetric practices could incorporate nurse led birthing/support Cesarean and VBAC/RCS educational classes.

Implemented in the 1990s in the UK by midwives, Birth Afterthoughts Services provide postnatal debriefing services to women having unanswered questions and/or emotional and psychological distress following a birth (Bailey & Price, 2008). The service provides a confidential session between the mother and midwife. During the session, the midwife reads through their birth notes, giving mothers an opportunity to discuss and understand what happened during their labor and birth. A service of this nature could be implemented in the United States to help women experiencing a traumatic birth. The needs of the service could be identified in the patient’s electronic medical record (EMR) before hospital discharge.

CNMs provide direct patient care to women during the antepartum and labor/birth for subsequent pregnancy after a Cesarean delivery. Per ACOG (2017) VBAC guidelines, the decision of VBAC or RCS should be made by the patient in consultation with an Obstetrician or other obstetric care provider. Both risks and benefits should be discussed and documented in their medical chart, along with any individual characteristics increasing the risks of either birth
mode. ACOG (2017) provides checklists for providers to follow when counseling a patient deciding VBAC or RCS. It is essential for CNMs to follow such checklists to provide sufficient information of risks and benefits of both delivery modes. Hospitals and outpatient offices should implement EMR checklists to ensure women receive necessary information of risks and benefits of both delivery modes. By supplying sufficient information, women can make an informed decision to ultimately enhance their birthing experience for their second birth.

**Implications for Nursing Administration**

Registered nurses work as nurse managers in hospital maternity units and are positioned to work with other staff and management to make informed decisions regarding maternal/child healthcare policies, procedures and practices on their units. Maternity units have specific policies for Cesarean deliveries and for TOLAC, where offered. The findings of this generated theory have implications for nursing administration. There is a need for nurse managers to implement policies regarding comprehensive patient education on antepartum units for mothers possibly needing a primary Cesarean delivery. The policy could include an in-house nurse led education class informing soon to be mothers standard procedures for a Cesarean and information about the actual surgical procedure and postpartum phase. For mothers having a scheduled Cesarean, hospitals could offer birthing classes specific to mothers having a primary Cesarean delivery. For mothers unaware of needing a Cesarean for the first delivery, regular hospital birthing classes could incorporate a section of the class to give a detailed description about Cesarean deliveries.

In the postpartum phase after the first Cesarean, before discharge, units could implement a discharge class providing women with take home information about the postpartum period, available resources for mental well being, and up-to-date information about subsequent
pregnancy birth modes. Hospitals should implement EMR checklists to ensure women attended a discharge class and received take home resources.

For women entering a subsequent pregnancy after a Cesarean delivery, hospitals could offer nurse-led VBAC/RCS classes to aid women in subsequent pregnancy birth mode decision. The classes would include current ACOG (2017) guidelines for VBAC, candidates for VBAC, and risks and benefits of both delivery modes. Take home materials should be provided to reiterate information provided in class.

**Implications for Nursing Education**

The basic social process that emerged from this study has implications for nurse educators. Findings from this study indicate patient teaching and information provided to women to assist in the decision of VBAC or RCS was insufficient. Associate, bachelors and masters prepared nurses provide direct care to women in the antepartum, intrapartum and postpartum phases. The developed theory is useful to clinical nurse educators as they are responsible for mentoring and preparing nursing students planning careers in maternal child nursing. Clinical experiences are a core element to nursing programs and nurse faculty are responsible in assuring every student has the ability to perform comprehensive physical and psychological patient assessments upon graduation. Healthcare decision making is a process that is uncertain, difficult and emotionally taxing at times. Information provided to patients from their providers is the foundation to any healthcare decision. Clinical nurse educators must instill in students the necessity of patient teaching, communication and educational handouts, so patients can make an informed healthcare decision.
The study findings have implications for nurse educators in a hospital setting. There is a need for maternal-child nurse educators to implement a variety of on-site childbirth education classes so women can make informed pregnancy, labor, and birth decisions. Childbirth classes should be offered to in-patient antepartum patients via television, online, or in a classroom setting. Information packets particular to each class (e.g. Cesarean as first birth class, VBAC/RCS class) should be provided to each patient.

**Implications for Nursing Research**

The results of this grounded theory study indicated the need for further research of the decision making process of women deciding subsequent pregnancy birth mode after a previous Cesarean delivery. Further studies are needed incorporating diverse socio-demographic groups of women to confirm or modify the theoretical model. The model generated in this study revealed women’s decision making process of subsequent pregnancy birth mode after one previous Cesarean delivery. Women with two previous low transverse Cesarean deliveries should be counseled and offered TOLAC (ACOG, 2017). Also, women with a twin gestation are candidates for TOLAC (ACOG, 2017). Further studies could determine if the decision making process of VBAC or RCS differs between various maternal populations.

Results from this study indicate information provided to women is a major factor/influence in the decision process of VBAC or RCS. Yet, the information provided by providers was scarce, resulting in women seeking information on their own. Nurses serve as an educator role by providing VBAC and RCS information and advice to women in the postpartum phase after their first Cesarean, interpregnancy at routine GYN visits, and during the antepartum and labor phase of a subsequent pregnancy. From this study, future research is needed to
operationalize conceptual categories and develop an empirical tool to test the process in practice. The theory could be used with specific nursing interventions, such as a nurse lead VBAC/RCS educational class to help women make an informed decision for birth mode. From this study, participants described wanting to talk with a counselor about their previous Cesarean delivery and subsequent pregnancy birth mode decision. A future nursing intervention study, incorporating appointments with a psychiatric nurse or nurse practitioner could potentially help women work through their emotional issues from their previous delivery and decrease conflict in making a decision of VBAC or RCS.

**Conclusion**

The theoretical model of the basic social process of the decision making process for women deciding subsequent pregnancy after a previous Cesarean delivery consists of a core category and seven conceptual categories. The core category and seven conceptual categories provide an explanation of the decision process. In this final chapter, study findings to previous scholarly research findings were compared and key/unique findings were discussed. The chapter concluded with how this substantive theory provides unique implications to nursing research, education, administration and practice. The generated theory in this study will provide a research based theory for healthcare professionals to use to guide them in counseling women as they make the decision of subsequent pregnancy birth mode after a previous Cesarean delivery.
APPENDIX A

DESCRIPTION OF THE STUDY AND CONSENT FORM
**Introduction:**

Dear Participant,

You are being invited to participate in a research study through the Nursing Department at Loyola University Chicago. The study is a research project being conducted by Melinda Dixon, MSN, RN and under the supervision of Dr. Lee Schmidt. Ms. Dixon is currently a PhD student at Loyola University of Chicago.

You are being asked to participate in this study because you are deciding birth option of Vaginal Birth after Cesarean (VBAC) or Repeat Cesarean Section (RCS) of subsequent pregnancy after a previous Cesarean delivery. Before you decide to volunteer for this study, please read this form and ask any questions you wish before agreeing to be in the study. You must be willing to give signed consent in order to participate in the study.

**Purpose:**

The purpose of this study is to discover, understand, and learn more about the experiences of women deciding birth option of VBAC or RCS after a previous Cesarean delivery. This information will increase the knowledge to participants and healthcare professionals about the decision making process, ultimately enhancing women’s birthing experiences.

**Participant Involvement:**

You will also be interviewed by the researcher, Melinda Dixon. I will ask you to fill out a demographic survey describing yourself. During the interview you will be asked to discuss and explain your thoughts and experiences in deciding birth option of VBAC or RCS. You are free to skip any questions that you do not wish to answer. The interview will be conducted by phone or in person at a location and time convenient to you. The interview will take approximately one hour. In addition I may call you for a short 5-10 minutes to review the findings with you. The interview will be audio taped for accuracy. You are free to decline to answer any questions and stop the interview at any point if you are feeling uncomfortable. You will asked to provide your current address, contact phone number and email address. This information will not be shared and will only be used for purposes of the study.

**Risks:** No more than minimal risk is involved in this study. The risks consist of emotional feelings of an unexpected or undesired birthing outcome from your last birth and/or current pregnancy. There is a possibility that you may experience uncomfortable feelings regarding making the decision for VBAC or RCS. You may also feel nervous about being audio taped. If any questions make you feel uncomfortable, you do not have to provide that information.

**Benefits:** There is no direct benefit for participating in this study, however, you may benefit from receiving an abstract of the findings and better understanding what you are going through. Results from the study will benefit healthcare professionals responsible for informing pregnant women deciding subsequent birth mode after a Cesarean delivery.

**Compensation:** You will receive a $25 gift card after the completion of the demographic survey and interview.
Voluntary: Your participation in this study is completely voluntary. You are under no obligation to participate. You have the right to refuse to answer any questions and the right to withdraw at any time.

Confidentiality: Your information is confidential. The survey and transcribed interviews will be marked with an identification number and all identifying information will be removed after your interview. All taped data will be kept in a secure locked area. Only members of the research team can have access to your information. The audio tapes will be disposed of after completion of the study. You name will not be used in any publications.

Contacts and Questions: For further information and questions about this study, please contact Melinda Dixon or Dr. Lee Schmidt at 773-508-3466 or mdixon3@luc.edu

Statement of Consent: In signing this consent, you have thoroughly read and understood the information provided to you regarding the research study, had an opportunity to ask questions, and agree to participate in the research study.

Participant’s Signature ___________________________ Date ________________

Researcher’s Signature ___________________________ Date ________________
APPENDIX B

DEMOGRAPHIC FORM
Please circle the response below that applies to you.
This general information will help interpret the results of the study. Please circle the appropriate information and fill in the blanks.

1. Age ____________

2. Your current marital status
   - Single, never been married
   - Married
   - Separated
   - Divorced
   - Widowed

3. Your ethnic group
   - White/Caucasian
   - Black/African American
   - Hispanic
   - Asian/Pacific Islander
   - Native American
   - Other ____________

4. Are you currently employed?
   - Yes
   - No

5. If you are currently employed, do you work?
   - Full time
   - Part time

6. What is your total household income?
   - Less than $15,000
   - $15,000 to $34,999
   - $35,000 to $70,000
   - Greater Than $70,000

7. How many children do you have?
   ____________________
8. What is your educational level?
   High school diploma
   Associate Degree
   Bachelor Degree
   Masters Degree
   Doctorate
   Other ____________

9. How many times have you been pregnant?
   ____________

10. In what month and year was your first Cesarean delivery?
    ____________

11. What was the reason for your first Cesarean delivery?
    ____________________________________________

12. Where was your first Cesarean performed?
    ____________

13. For your first Cesarean delivery, was your provider an Obstetrician, Midwife or General Practitioner?
    ____________

14. Is your current obstetric provider an Obstetrician, Midwife, or General Practitioner?
    ____________
APPENDIX C

RECRUITMENT FLYER
Deciding Between a *Vaginal Birth After Cesarean* or a *Repeat Cesarean Section*?

- **WHO:** Mothers deciding on a subsequent birth option after a previous Cesarean section.
- **PURPOSE:** To explore women’s experiences in their decision making process of birth option after a Cesarean section.
- **WHY:** To help nurses and other health professionals to understand how to help women decide subsequent birth option after a Cesarean section.
- **HOW:** Phone or One-on-one interviews (approximately 1 hour)
- **COMPENSATION:** Each participant will receive $25 GIFT CARD
- **CONTACT:** If interested, please inform a healthcare professional at your appointment or contact Melinda Dixon, MSN, RN at 773-508-3466 or by email mdixon3@luc.edu
Thank you for agreeing to participate in this study. The information provided from you and other mother’s experiences of the decision process of subsequent birth after a previous Cesarean section will provide nurses and healthcare professionals with an increased understanding of the decision process. It is important for healthcare professionals to understand the decision making process to help women who have experienced choosing the option. Your participation and input is very valuable and I thank you again for taking the time to express your thoughts about your individual experience in deciding VBAC or RCS. The interview will take approximately one hour.

Please read the informed consent form and ask me any questions you wish before signing it. Remember, your participation in this study is voluntary and you are under no obligation to participate. You have the right to withdraw at any time. Confidentiality will be maintained. The taped interviews will be kept in a locked secure area and identity to your data will only be revealed between the research team. Do you have any questions or concerns before we start the interview?

The interview will begin with an open-ended question;

1. When did you first start thinking about making a decision between VBAC or RCS? (Ask probing questions about timing, e.g. prior to getting pregnant or during the pregnancy.
2. What was it like for you to decide between VBAC or RCS?
3. Can you describe what influenced your decision of VBAC or RCS?
4. Please describe the information your doctor and or nurses gave you about VBAC and RCS.
5. Were there things your doctor or nurses told you that helped in making a decision….
6. Where there things your doctor or nurses told you that hindered in making a decision….
7. Please describe how family and/or friends informed or prepared you for your decision?

8. To date, have you decided on a birth mode?

9. Is there anything else about your decision of VBAC or RCS you would like to share?
REFERENCES


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VITA

Melinda Dixon earned a Bachelor of Science in Nursing from Old Dominion University in 2001. She began her nursing career at Inova Health System on an inpatient medical-surgical unit. In 2005, Ms. Dixon received her Master of Science in Nursing from George Mason University. Ms. Dixon thrives on learning new things and has enjoyed a nursing career filled with new challenges and opportunities. She has enjoyed working as a staff nurse in maternal/child nursing and pediatrics, preceptor to new graduate nurse students and later a maternal/child clinical educator for Loyola University Chicago. Ms. Dixon is currently a pediatric home health nurse.