Mothers & Providers Perspectives on Cesareans: A *Very* Preliminary Look

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Partnering to Improve Health Care Quality
for Mothers and Babies

Purpose

- To better understand cultural and contextual issues influencing high NTSV cesarean delivery rates
- Results will be used to develop educational materials that effectively communicate with and are sensitive to patients, clinicians and their needs

Methods

- One-on-one semi-structured interviews
- Eligibility:
  - Moms: nulliparous, term, singleton, vertex position (NTSV) cesarean within the last 12 months
  - Providers: hospital-based clinician (physician, midwife, nurse) providing care to pregnant/laboring women
- Gift card offered in appreciation of time
- Preliminary coding consists of grouping response based on question category
- Ongoing analysis will include more detailed coding using MAXQDA software and thematic analysis

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BACKGROUND LITERATURE

Mothers

Listening to Mothers℠ III

Pregnancy and Birth

Report of the Third National U.S. Survey of Women's Childbearing Experiences

Asking Mothers about Cesareans

Eugene R. Declercq
Carol Sakala
Maureen P. Corry
Sandra Applebaum
Ariel Herrlich

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Maternal Requests Remain Rare

- Despite media and professional attention to "maternal request" cesareans, **only 1%** of respondents who had a planned "primary" cesarean did so with the understanding that there was **no medical reason**

- 22% reported asking their providers to schedule a cesarean before labor
  - 87% of those did so believing that it would offer a **health benefit** to them or their babies

LTM III, Declerq et al

Some Pressure from Providers

- 13% of mothers reported experiencing pressure from a provider to have a cesarean

- Discussion about birth when **baby might be getting large** steers many women toward a primary cesarean, even though research and professional guidelines do not support in this case
  - Nearly 4 in 10 of the women in this situation reported the discussion had <u>not</u> been framed as a matter of <u>choice</u>

LTM III, Declerq et al

Uninformed about Potential Harms

- Participants reported "Not sure" about **breathing difficulties** in newborns and **placental problems** in future pregnancies

- Mothers who had a cesarean were:
  - No more likely to be correct about placental difficulties
  - Much more likely to incorrectly agree that a cesarean lowers the likelihood of newborn breathing problems

LTM III, Declerq et al

Prenatal Education Underutilized

- First-time mothers who delivered by cesarean were less likely to have taken childbirth classes (53%) than those who delivered vaginally (61%)
- Hispanic women were least likely to take childbirth classes

- First-time mothers who delivered by cesarean were also more likely to view pregnancy and childbirth websites as very valuable information sources, compared to those who delivered vaginally

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Preliminary Results: Mothers

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Demographics: Mothers (n=25)

Education:

- 24 women had more than a High School diploma/GED

Marital Status:

- Married and living with spouse: 80%

Age:

- Range: 24-45

Income:

- 52% over $100,000

Insurance Type:

- Medicaid: 8%

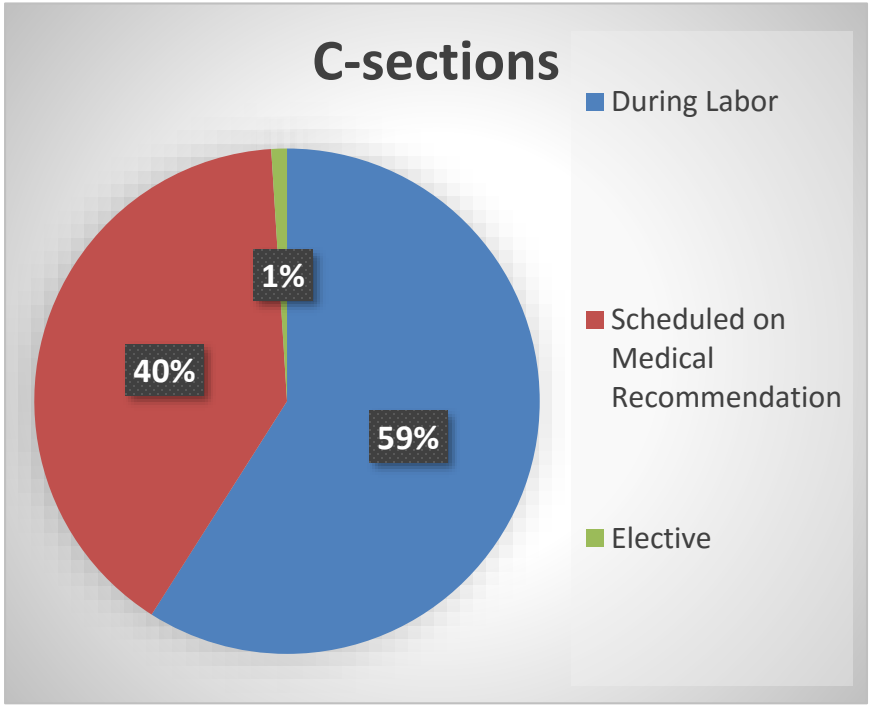
Provider Type:

- OB: 100%

Prenatal Classes:

- Yes: 64%

Induced: 36%



Select Findings: Mothers

- Mothers desire improved communication with providers
- Mixed experiences with nurses
- Suggestions for future education to mothers

Desire Improved Communication with Providers

"I would have wanted to have these talks [about cesareans] before and that way also I would have been more aware, done more research…" (M12)

"Tell the doctor that is going to be on call and the nurses to really be aware because I didn't have the impression that they were aware of what I wanted." (M18)

"I've never given birth before, and I've never had surgery in my life. I have never really been in the hospital, so all of those things compound and then they're asking you to make this very important decision." (M15)

What Nurses Did

- Position changes to promote labor? "nothing" "there was a lot they didn't do" (M1, M7, M21)
- Heart rate monitoring (positioning for HR fluctuations)
- The Pitocin
- The epidural
- Internal exams
- Telling me to push
- "They were not very involved." (M2)
- "The nursing staff was actually very helpful and surprisingly so." (M3)

Suggestions: Future Education to Mothers

Format

- A simple pro/con or comparison list
- Sitting down and talking to them because they may not read a pamphlet
- Have somewhere they can go for more information if they are interested
- A video to watch while you're waiting to dilate

Tone

- Not something that will make women panicky
- No stigma just 'here are all the possibilities'

"I'd rather the information from my doctor than from apps, the internet, things like that." (M12)

Suggestions: Future Education for Moms

Childbirth Education Classes

"I think they should maybe offer them the option to go to a class with an opportunity for one-on-one questions."(M4)

"If they're not telling me I need to take it then I don't really see the point" (M5)

"They didn't really say like, 'well, you should do this class.'" (M17)

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DISCUSSION LITERATURE

Decision-Making

- Women refrain from asking their providers questions due to concerns that they may be perceived as difficult, based on differing preferences for maternity care, or because their provider appears to be rushed
- Among women with primary cesareans, 63% reported that the doctor was the primary decision maker

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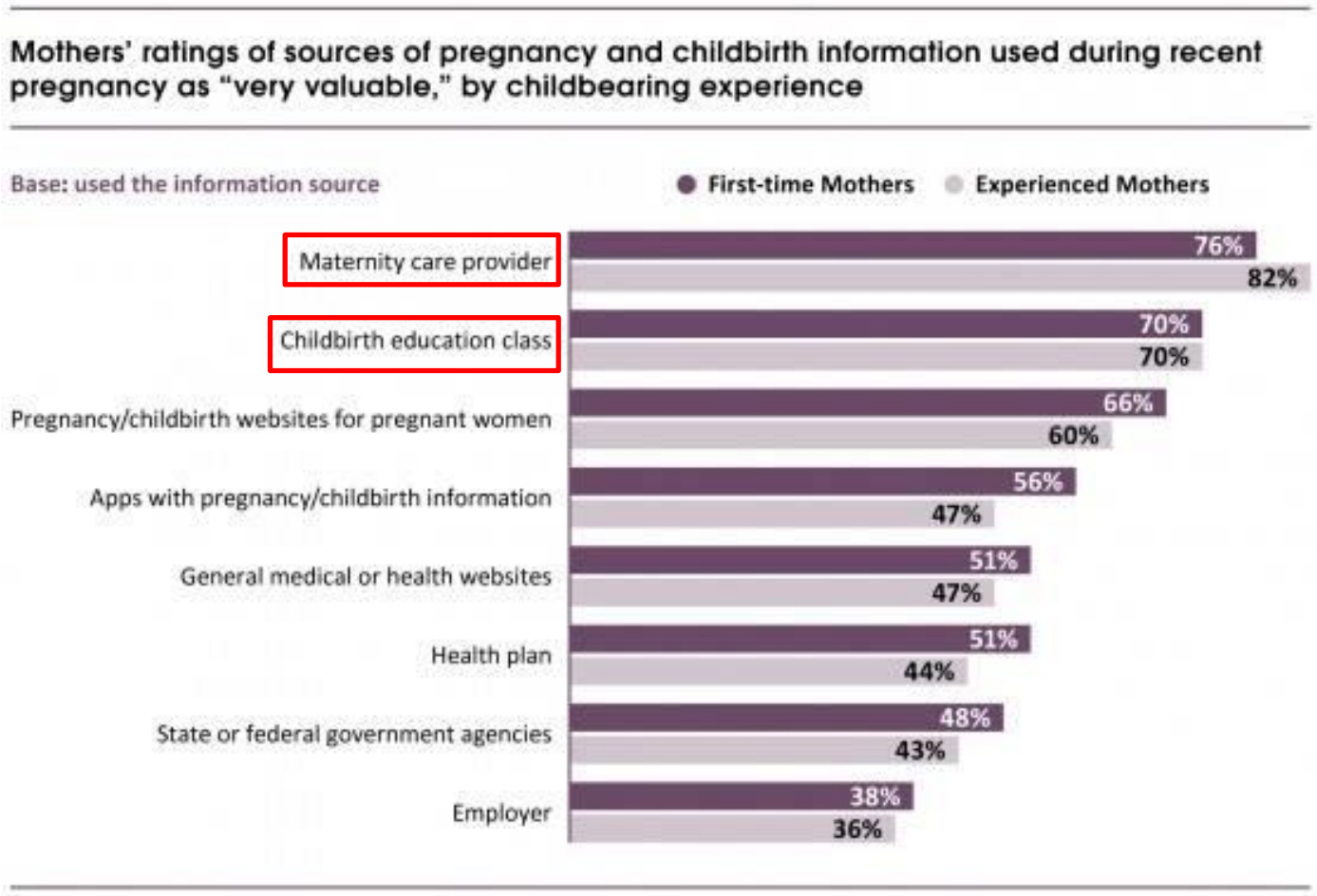
Decision-Making

- A lack of perceived support from nurses is one of the contributing factors to women changing their birth preferences and that laboring women often relinquish decision-making or look to the nurse for advice

- Nurses may subtly influence patient decision making through a lack of support or assistance, without actually expressing preferences

Carlton et al., 2005

"Very Valuable" Sources of Information



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Implications for Practice

- Communication with patients should occur early and often
- First time moms need reassurance
- Provider are trusted; your recommendations matter
- Recommend childbirth education classes

"I honestly thought 'they are going to do whatever is best for the baby' and I'm going to put my faith in them." (M15)

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PROVIDERS

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Preliminary Results: Providers

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Demographics: Physicians

MD (n = 13)	
Degree Location	100% U.S.
Years Practicing	Range: 7-36
Gender	62% Male
Ethnicity	62% Hispanic/Latino
Age	30-39 years: 38% 40-49 years: 31% 50-59 years: 31%
Malpractice Insurance	No: 77%
Practice Type	Group: 10 Academic: 2 Solo: 1

Demographics: Nurses and CNMs

Nurses and CNMs (n= 12)	
Primary Degree:	RN: 62% CNM: 25% ARNP: 8%
Degree Location	77% U.S.
Years Practicing in OB	Range: 2-30
Gender	100% Female
Ethnicity	8% Hispanic/Latino
Age	18-29 years: 17% 30-39 years: 25% 40-49 years: 25% 50-59 years: 25% 70 years or older: 8%

Providers: Our Focus Today

What Aspects of the Practice Environment Contribute to NTSV Cesareans?

- Hospital policies/protocols/practices
- Peers/Practice Group views
- Time constraints
- Nurses
- Electronic Fetal Monitoring
- Liability
- Financial issues
- ACOG/SMFM Guidelines

- Suggestions for future education for nurses and providers

Hospital Policies/Practices that Support Vaginal Birth

- Hospital admission protocols
- Maternal request education/consent form
- Follow AWHONN standards of practice re: Pitocin, monitoring, patient staff ratios
- Needing a legitimate medical reason to do a primary cesarean (like the 39 weeks hard stop, or other form), even a bedside consult

Hospital Policies/Practices that Support Vaginal Birth

- Need a medical indication for elective cesarean w/o TOL or Medicaid won't pay (then why not all insurance?)
- Management open to adopting ideas that work (e.g. peanut ball)
- Whether hospital has and uses a squat bar, a tub for the patient to labor in, aromatherapy, other helpful resources
- Hospitalists

Hospital Policies

- Department must agree on all guidelines
- Peer review with great success
- Notification letter letting you know there is room for improvement

"We'll send them letters and say 'hey, look, there's room for improvement here'… even potentially one fallout will get you a letter" (OB9)

"If it weren't mandated, they would keep doing what they're doing and they would be fine with the 50% C-section rate… I think some people would say 'What's the problem?'" (OB3)

"I think if we start thinking of midwives as the first line of management, or even hospitalists… these things might make an impact in the long run" (OB5)

Peers/Practice Groups

- Really depends on the physician – some will try for vaginal, some are quick to section
- Practice size
  - Logistics of smaller practices can be hard on the physician and be linked to likelihood of doing a cesarean
- Laborists: "There's less of the issue of driving them to do a c-section slightly sooner rather than later" (OB1)

"A lot of physicians, I hear from patients, try to prepare them for a cesarean early in their pregnancy… they talk this kind of nonsense to patients in the middle of their pregnancies to prepare them mentally." (OB5)

"It's like the moral compass of some of these physicians has just been so off lately." (NO11)

"They think its impossible to have a 5 - 7% cesarean section rate, which I know is not true because we have a 7% cesarean section rate… Cesarean delivery has no reason to be higher than 7-20%. This is not a pie in the sky idealism; this is reality. This is achievable." (OB5)

"The genie is out of the bag. We've cut so many patients, and we've seen how good it makes our lives. How are we going to go back?" (OB13)

Time Constraints

- Physician 'Lack of Patience' or for 'Convenience'
- Small practice groups constrained - dealing with the office and the hospital, hard to be *patient*
- Might call a C-section a little bit early because:
  - Want to sleep, have dinner, put kids to bed…
  - Knowing if you wait to call it you're potentially waiting several hours to do a c-section on a very busy operating room day

There's a reason why if you go to the labor floor around 5:00, 6:00, that's the time where all of a sudden everybody that's been laboring all of a sudden magically at that time needs to have a C-section." (OB9)

Nurses: Play an Important Role

…but depends on the nurse (this was said a lot)

- Positive-thinking, motivated to help patient have vaginal delivery
- Communicates with the doctor who isn't there
- Some not educated on how to support to prevent cesarean
- Reinforce position changes and do other things that can help, like pain management, education of patient, emotional encouragement

"The patients that have really good support, the patients are less likely to freak out or say 'I can't do this anymore'" (OB13)

"We are the doctors' eyes and ears" (NO10)

Nurses: Patient Advocates

- "I think most nurses tend to be patient advocates and try and encourage vaginal delivery" (OB14)
- "A good nurse can really make a difference" (OB3)
- "Sometimes they choose not to because maybe they don't feel it is their role. So we've done a lot of work on that. Like, **you're not just here to give medications**, you are here to be a support person, too." (NO4)
- Or, they'll do whatever the doctor says and will not be a patient advocate

Nurses: Room for Improvement

- Don't just come in and adjust the TOCO
- If someone wants a low-intervention birth/has a birth plan and nurse doesn't really want to do that, it has a negative effect
- The feeling that there's not much they can do besides a medical intervention
- Lack of training on how to support a patient who is not on an epidural/doesn't want to be augmented
- How to labor a patient with an epidural to avoid a cesarean
- Nurse influence when they make a face or talk about a concern in front of the patient

Nurses: Barriers to Hands-On Support

- Patient load/Staffing Ratios came up a lot
  - Should be 1:1 per AWHONN, but usually 1:2 or 1:3
  - Can't be there all the time

- Feeling that if the patient has anesthesia, there is a limit to what the nurse can do

"To take care of someone in labor is a one-on-one project" (NO4)

Nurses: Too Much Documentation

"You hear the nurses say it all the time, 'do they want me to take care of the patient, or should I take care of the computer?" (NO9)

"Somebody always suffers, either your documentation or the patient" (NO11)

"Too busy documenting… instead of paying attention to our patients" (NO7)

Electronic Fetal Monitoring (EFM)

"99% of the time when a baby has a bad tracing everything is fine" (OB14)

"It's been well studied that unless the tracing is horrendously bad, it doesn't really predict anything…. I think it has increased the C-section rate but I don't really know what to do about it because it is kind of standard." (OB12)

"I think that the **continuous monitoring provides this illusion that you're giving really good care**, this illusion that you're paying really close attention, when in reality I think it just makes us jumpy and nervous, and removes our requirement to look at the whole picture." (OB10)

EFM Increases C-sections

- "It increases the C-section rate for sure guaranteed….And I want that to be on the record as firm based on my observation and my conversations with several colleagues." (OB11)

- Why?
  - Can't get up and walk around
  - Liability
  - Don't wait and watch a deceleration, or don't want to do intrauterine resuscitation and wait
  - Providers and nurses need more training

"It's just another way for us to cut the patient. I mean most studies will show that it really doesn't do anything to help us truly manage the patient. I mean there's a small population of patients where it's going to make a difference…But **for probably 90 percent of the population** – I mean **intermittent monitoring is just as good**." (OB13)

EFM and Liability

"You practice defensively and you know that the attorney is going to be looking at that trace during the deposition" (NO8)

"Doctors are afraid of litigation and we know that fetal heart tracing, monitoring, has changed nothing for outcomes during labor. The only thing it has done is that it has increased the number of C-sections." (OB14)

Liability

"Liability risk that the doctor perceives of having a vaginal birth and potentially running into complications. But **they don't really perceive the risk of mortality in the patient should things go wrong during Cesarean section**, which to me, is a mistake. There's morbidity and mortality for the Cesarean section which doctors don't address since they're not a common problem" (OB5)

"The second one would be a friend of mine…said that, '**I'd rather receive a letter from the C-section committee than a letter from a lawyer**.'" (OB8)

Financial Issues

- "**Reimbursement is the same** for us whether we're there 12 hours or an hour" (OB9)

- "I could do six vaginal deliveries or six C-sections, and **I go home with the same paycheck**."(OB10)

- "**From the standpoint of financial sense, it makes no sense to sit there with a patient for 20 hours in labor** unless you truly believe in this obstetrics stuff, which most doctors, I don't think do." (OB5)

Financial Issues (cont'd)

- "**If I'm going to get a Medicaid rate, $832.50 for a C-section and $832.50 for a vaginal delivery, why not come in and knock out the C-section, be done with it**, than to get a phone call every 15 minutes from the hospital while this patient's laboring all night and I still have an office full of patients… she's going to deliver in the middle of my office hours, then I have to go do that delivery, and then if she doesn't push well I could be in the delivery for two or three hours trying to push and end up taking her back for another C-section. Now I have a whole office full of patients who are irate or being rescheduled to then come back." (OB13)

- "**Why are we paying the same amount for each? It makes no sense.** It's costing more to the healthcare system to have Cesarean sections, much less for vaginal birth." (OB5)

Incentivize

- Get insurance to pay more to make people more inclined to give a primip a chance at a vaginal delivery

"If you're only making $832.50 and I have to pay somebody to step in and deliver the baby for me, pay them $600.00 or $700.00, then how do I feed my family? **So my incentive at that point is to listen, I got to hold onto this patient. So I'm cutting the patient…** So they need to just incentivize. If…you were getting $832.50 to do the C-section but for the vaginal delivery they were paying you $1,200.00, then you know what, I think there might be some more incentive for people to say, okay, guess what, let's push the vaginal delivery a little bit or let's try to do it." (OB13)

ACOG/SMFM Guidelines

Safe Prevention of the Primary Cesarean

- Majority not yet being incorporated. Participants say that straight-out, or they imply it will help *in the future*
- Some are not aware of them or have not read them

"I think people who come right out of residency, that's something that they are learning and they are aware of and they are recognizing as part of normal care" (OB6)

Agreement with ACOG/SMFM Guidelines

- Gives a standard to go by

"The Prevention of the Primary C-section, **we make our interns carry around in our back pocket**. 'Where on there does it say that your recommendation we give up is okay? Have you given this woman every single chance? Have you given her every single try? Where on this graph does it show you that it's taking too long?'"(OB10)

Disagreement with the ACOG/SMFM Guidelines

- "I think they will have some impact, but actually, I don't agree with some of them… some of the **guidelines of waiting these crazy amount of times while somebody's pushing, I mean I think that's pushing it a little too much**." (OB1)

- "My personal opinion with that guidelines is unfortunately has not passed the test of time. It's too new… Having said that, we are trying to adopt them and then **the problem is all physicians – and I want to include myself into this – we don't buy 100 percent those guidelines**." (OB11)

- "Even as liberal as we may be, that were a bit more aggressive than need be. But I certainly remember when it first came out and just talking about it with my colleagues, I mean people were looking at it and saying, 'Oh, my God, these are crazy things.' But now we've actually implemented some of those, like the time constraints and things like that. But **certainly nowhere have we said that if the baby is asynclitic or OP that you can go in there and internally rotate the baby. Again, those are things that I don't know that I would necessarily even do myself.**" (OB9)

Disagreement with the ACOG/SMFM Guidelines

- "We've got a lot of doctors who been practicing for 20, 40, 15, 20, 30 years and I think it's very hard to get people to say, "**Okay, well, for me, arrested labor is two hours that change not six hours without change.**" (OB6)

- "**Because ACOG says that but that doesn't mean that's what we should do because they're not the ones that are going to be the ones in front of the lawyer.**" (OB14)

- "No, **that's not to our benefit. Our benefit is to cut the patient…We've enjoyed the life of C-sections.** How can we turn our back on that deal? We really can't. It's very difficult to." (OB13)

Suggested Nurse Education Topics

Summary

- Better pushing stage support
- Non-intervention in labor (AROM, Pitocin, IV)
- Admitting people in truly active labor/Sending them home
- Being supportive and open to doulas
- Non-pharmacologic pain management techniques and how to promote labor progress, psychosocial support
- How to effectively schedule/do an induction, or augmentation with Pitocin
- Training on interpreting fetal heart rate tracings
- Physician/Nurse communication (how to appropriately express concerns, how to appropriately advocate for patient)

Suggested Physician Education Topics

Summary

- Why vaginal birth is healthier than cesarean birth (doing the right thing)
- Focus on patient-centered care, patient needs
- If the doctor knows, they can give the order to the nurse
- Could use some up-to-date training on fetal monitoring
- Importance of patient-centered care, shared decision-making
- Prefer speaker presentations from someone outside/independent organization, "show me the data", and prefer it one hour or less
- Show providers their rate compared to their peers
- Get it out over and over and make it the norm

Labor Support Skills to Promote Vaginal Birth

2-Day Regional Workshops

- Learn more about nursing strategies to promote vaginal birth
  - Fetal heart rate monitoring
  - Supporting First and Second Stage
  - And more!

More to Come!

- There's so much more!
- We will be presenting a webinar later with more detailed results
- Developing education materials to help with patient and provider interactions

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QUESTIONS

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