IRLANDA, S., TABIB, M. and CLUBBS COLDRON, B.M. 2023. The role of (mid)wife: the challenges of positive birth experience during VBAC. Human rights in childbearing 7. *The practising midwife* [online], 26(3), pages 13-19. Available from: https://doi.org/10.55975/YWSN4706

The role of (mid)wife: the challenges of positive birth experience during VBAC.

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2023

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The role of (mid)wife: Exploring the challenges of positive birth experience during vaginal birth after c-section

Summary

Vaginal birth after c-section (VBAC) can be physically and mentally challenging. This paper intends to highlight the importance of humanistic care and human rights-based approaches when women are preparing for VBAC. According to the United Nations International Covenant on Civil and Political Rights *(*ICCPU), everyone has the legal right for self-determination. In line with the Human Rights Act 1998 Article 8, and the common law right to self-determination, healthcare practitioners have a duty to provide facilities that allow women to give birth in the manner of their choosing. It also provides suggestions on how to solve disparities of the health system in supporting women's needs, even in pregnancies that identified as 'high risk'. It is argued that empowerment and involvement of women can support positive outcomes and is not antithetical to the expertise and experience of midwives nor a reasonable management of risk. With the practical challenges we would like to invite the profession to discuss and reflect on psychosocial factors contributing to successful VBAC.
The discussion stems from the personal experience of the primary author and aims to add to the debate especially from the perspective of women with the lived experience of VBAC.

Personal experience

Falling pregnant four months after my c-section I have believed that homebirth would support the success of my VBAC the most. Unfortunately, homebirth was suspended. The compromise was made to use telemetry (wireless foetal monitoring device) during labour, to gain informed consent before every examination or diagnostic test and to respect decision but fully document if those declined. Arriving to the labour ward the first midwife looking after me felt that my plan was not in line with the guidelines and promoted more risk averse practice. She proposed baseline vaginal examination, bedside CTG monitoring and to labour out of pool preferably in bed. Having declined that care a second midwife took over who supported the

original birth plan. Under her care I have had a successful water birth, under four hours from arriving to labour suit, without any complications.

Introduction

Repeat c-section rates are relatively high all over Europe.[1] According to the European Perinatal Health Report Scotland has 70-80% repeat c-section rate.[1] This is more than the Netherlands, Norway, Finland and Sweden where this rate is around 45-55%.[1] There are various studies focusing on likelihood and risks of VBAC and researching factors influencing success, but those mainly concentrating on women's medical history or maternal health.[2] Supporting one's health requires more than just physical measures.[3] The Nursing and Midwifery Council (NMC) recognises the importance of psychological aspects of health and how involvement of the birthing person, empowerment, and sensitive care can contribute to this.[4] However, these principles may be subordinated by the prevailing risk aversion culture.

It is pivotal that birth practitioners offer holistic care to women, including the ones undergoing VBAC, and avoid concentrating exclusively on potential risks and liability if those risks materialise.[5] Empowerment and reducing risks are not mutually exclusive aims and empowering women can, under the right circumstances, have beneficial health outcomes.[6]

When not encouraged to actively participate in the process of care management, women may feel that decisions about their care are made remotely, unaware that their involvement is both possible and mandated.[7] Evidence suggests that knowledge is empowering.[8] Empowered women are more likely to give birth naturally and have a more positive birth experience.[9]

After a c-section, pregnancy is more likely to be treated as high risk.[10] An obstetrician is usually involved in the care so that a multidisciplinary approach to the care is ensured.[10] Humanistic care means that women have access to a skilled and passionate multidisciplinary team who provides evidence-based information and respects the decision of women.[11] Inappropriately dwelling on the threat of death of a mother and/or baby can function to frighten women into complying with health professionals' recommendations.[12] Risk-averse practices can be disempowering for both midwives and women because it can take away the control and confidence[12] with also compromising the humanistic approach.[13]

The central theme here will be the contradiction between the rhetoric of women involvement and empowerment and the realities of 'high-risk' births in the contemporary maternity services.

Reflection point 1: Reflect on the care you provide as a midwife during VBAC. Did you ever feel disempowered as a midwife?

Discussion

It is important for all pregnant women to have a can-do attitude, have trust in their body and to go into labour without fear in their hearts.[6;14] During the antenatal care therefore, sensitive communication, use of positive affirmations, relaxation techniques and confidence building approaches are key elements of the holistic approach.[15] For instance, evidence suggests that labouring in water can lower blood pressure, reduce anxiety, and support the release of endorphin hormone and, therefore, can reduce the length of labour.[16;17] Thus, reducing the length of labour reduces the chance of uterine rupture is a reasonable course of action to support the success of VBAC.[18] However, during VBAC water-birth is not supported by guidelines.[19]

Whilst The National Institute for Health and Care Excellence (NICE) guideline supports VBACs, the practice seems to be more concentrated on the 'trial of labour after caesarean (TOLAC)'.[19] The NICE guideline suggests that VBAC would be preferable after c-section, but only supports hospital birth, with immediate access to continuous electronic foetal monitoring, theatre, and blood transfusion.[19] This approach requires midwives to be vigilant and prepared for a possible repeat c-section to prevent uterine rupture.[19]

There are very limited studies investigating the rate of uterine rupture during VBAC due to the rarity of its occurrence. Tanos and Toney[20] suggest that the chance of uterine rupture after c-section is less than 0.23% but, as it is one of the significant possible complications of a VBAC, the care provided revolves around preventing and preparing for this unlikely but fatal outcome.[21]

Prevention of uterine rupture and attempting a successful VBAC are equally important. However, the given care can be too risk averse to support a positive experience with all the benefits outlined above.[22] Unnecessary interventions are justified for preventative reasons.[21] Non-invasive, not medicalised, conservative solutions are too often disregarded.[19]

There is fear over possible life-threatening outcome within health care professionals which might be a contributing factor for the increase of c-section rates,[23] including elective repeat c-sections (ERCS), everywhere in the UK, and particularly in Scotland.[24]

Reflection point 2: How do you promote positive birth experience whilst providing safe and evidence based practice?

Providing relationship-based, humanistic care

Informing a woman of the risks associated with her suggested birth plan is essential. However, once they make an informed choice, they will need to be supported not only physically but psychologically too.[25] The Royal Collage of Midwives (RCM) therefore, advises all midwives to be advocates for women. To ensure that they are heard, their wishes are supported, and that holistic care is provided.[26]

NHS maternity services, encourage midwives to follow guidelines that are set up for specific needs thus, simplifying practice in certain situations. [27;28] However, individualised, and humanistic care encourages service providers to see beyond these guidelines and to always put women first.[5; 29] Midwives are encouraged to use guidelines as tools so the individuum can stay in the centre of care.[30] Achieving this is only possible by avoiding assumptions, exploring backgrounds, plans, fears and actively listening.[31]

Building trust between woman and midwife can support more positive birth experience.[32] Midwives should be cognisant that families have various and complex needs and circumstances. Humanistic care requires them to see beyond pregnancy.[4] Fear driven practice can potentially prevent offering a shared decision-making model in which the wants, needs and previous knowledge of pregnant woman and their families are valued.[4]

The right to self-determination, requires medical practitioners to respect patient autonomy[33]. Women should be supported to practice their autonomy during their childbirth continuum, as they are experts on their own life and needs. Thus, they can participate and even take the lead in decision-making once evidence-based information has been given.[34] The innate knowledge of women should be acknowledged, and their capacity should be recognised by promoting shared decision making.[35]

Informing women is necessary not only for legal reasons, but also for empowering them to adjust to and accept the potential consequences of a given decision. Having to make a decision that can shape care and have potential adverse consequences, can be overwhelming.[36] Therefore, it is of paramount importance that women and their families feel safe and supported to voice their preferences, ask questions, and take time to research.[5;37] Once informed decisions have been made, their choice should be respected without any prejudice or judgement.[4;38] The recent case of Montgomery v Lanarkshire, by rejecting medical paternalism in favour of patient autonomy, signals to health care professionals that medical preference should not override informed consent [39].

To provide humanistic care a human rights-based approach, whereby women are not penalised for their decisions, is fundamental.[4;35;40] Continuity of care provides a good basis for this and makes it easier to build mutual respect and trust to promote shared decision making.[37;41]

The relationship with the community midwife and the quality of antenatal care lays the foundation of the labour experience.[36] Therefore, if continuity of care is not available, effective communication between hospital and community staff becomes even more vital.[27] This sets up realistic expectations for women and their partner. Advocating for women can build their confidence and support positive birth experience.[4;6;14] Having confidence in one's own birthing ability is essential even more so when preparing for VBAC.[42] With effective communication the midwives

providing antenatal care might build the bridge between the woman and the hospital staff.[4] In this way both the antenatal and intrapartum care can be planned with the involvement of the woman.

Midwife means with woman. Involving women and making sure that they are not passive in their care is in the interest of both midwives and women.[35] Building rapport and re-building trust in the woman's own body, are more likely in more egalitarian relationships. Without that, progress of labour and a successful VBAC might be compromised.[43] Positive clinical outcomes and positive subjective experiences of childbirth might not only be compatible but mutually dependent.

Practical implications and Practice challenge questions

Birth plans are not made remotely from professionals' support but coproduced during antenatal care with the community midwife and sometimes with the involvement of a consultant. Therefore, it should be treated as part of the hand over documentation from the community midwife to labour suit.

Reflection point 3: How do you promote effective communication within the multidisciplinary care?

To practice humanistic midwifery, the physiology of labour should not be forgotten.[44] There is a cocktail of hormones being released during labour and this should be supported.[45] Over-emphasising risks and frightening families to comply should never be part of the toolkit, as increased levels of stress hormones can inhibit the oxytocin release.[44] The access to telemetry makes continuous foetal monitoring easier even in water. Women should not be restricted in choosing place or mode of birth.

Reflection point 4: How do you promote the physiological processes of childbirth?

Finally, women have the right both to comply with or reject guidelines during care. The right to choose, without judgement should be remembered.[40] Deviation from guidance or medical opinion should not be deemed negligent as long as the woman has made an informed decision.[39] It is the responsibility of the health care professional to clearly document if decision has been made against professional advice.

Reflection point 5: Have you ever come across with women declining the recommended procedures? If so, how did you approach the situation?
Subsidiary question to reflection point 5: Has it changed the relationship between you and the woman?

Conclusion

Acting with best interest of the woman is necessary but insufficient if women's active engagement in their care is not sought and health care professionals are not upholding the values of the Human Rights Act and the ICCPU. Reaching a mutually agreed care plan requires effective communication and flexibility from both sides.

Providing humanistic care for women attempting VBAC might mean that practitioners should step away from their idiosyncrasies.

The success of VBAC does not only depend on the scar tissue and how well pregnant women physically be able to cope. It also requires emotional and mental strength. Supporting women to be able to cope necessitates their involvement in decision making, effective communication and mutual trust. Guidelines suggest that VBAC is safer in a hospital setting, however, the importance of providing humanistic and women-centred care is also well documented in childbirth literature. These are not exclusive aims. More research in this under investigated area of practice is required.

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