

A Qualitative Study Exploring Women's Experiences of Unplanned Cesarean Surgery and Their Suggestions for Improving Care

Étude qualitative explorant les expériences des femmes en ce qui a trait à la césarienne non planifiée et leurs suggestions pour ce qui est de l'amélioration des soins

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ABSTRACT

The rate of unplanned cesarean birth is increasing and there is a growing body of evidence regarding the associated psychosocial harms. A phenomenological study exploring eight women's lived experiences of intrapartum cesarean birth in Nova Scotia was undertaken. Two groups of women were recruited, three receiving care from a midwife with transfer from a planned home birth and five women under the care of a physician. Semi-structured interviews were tape-recorded and transcribed. These data, combined with participant diaries and e-mails, were analyzed using Colazzi's method. Three major themes emerged: 1) Immediate and lingering emotional reactions, which were wide ranging, the majority negative, particularly fear, disappointment and self-doubt, 2) Mediating factors, most significantly, continuous contact with the baby and provider support, especially from midwives, and 3) Participant suggestions for improving care which included prenatal operating room (OR) tours, family-friendly OR policies, postnatal medical review with extended follow-up and peer support. This study adds to the already substantial evidence of associated psychosocial harms which can be mediated by concurrently reducing unnecessary cesarean surgery and implementing measures to improve the quality of cesarean care.

KEYWORDS

unplanned cesarean, midwifery care, childbirth experiences, fear, disappointment

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RÉSUMÉ

Le taux de césarienne non planifiée est en hausse; en parallèle, nous disposons de plus en plus de données semblant indiquer des torts psychosociaux connexes. Une étude phénoménologique explorant les expériences vécues par huit femmes en ce qui a trait à la césarienne intrapartum en Nouvelle-Écosse a été menée. Ces femmes ont été réparties en deux groupes : trois d'entre elles ont bénéficié des soins d'une sage-femme et ont vu leur accouchement planifié à la maison se solder en un transfert, tandis que les cinq autres ont bénéficié des soins d'un médecin. Des entrevues semi-structurées ont été enregistrées sur bande magnétique et transcrites. Ces données, conjointement avec les journaux personnels et les courriels des participantes, ont été analysées au moyen de la méthode de Colazzi. Trois thèmes majeurs en ont été dégagés : 1) Réactions émotives immédiates et persistantes qui s'étendaient sur un large spectre (la majorité d'entre elles étant négatives et comptant, en particulier, la peur, la déception et la remise en question); 2) Facteurs atténuants, dont les plus saillants étaient le contact continu avec l'enfant et le soutien du fournisseur de soins, particulièrement de la part des sages-femmes; et 3) Suggestions des

participantes pour ce qui est de l'amélioration des soins, dont des visites prénatales de la salle d'opération (SO), des politiques de SO qui tiennent compte des besoins des familles, une analyse médicale postnatale s'accompagnant d'un suivi prolongé et le soutien des pairs. Cette étude s'ajoute aux données déjà substantielles qui démontrent la présence de torts psychosociaux connexes pouvant être atténués en assurant, de façon concomitante, la diminution du nombre de césariennes superflues et la mise en œuvre de mesures qui visent l'amélioration de la qualité des soins entourant la césarienne.

MOTS CLÉS

Césarienne non planifiée, soins offerts par des sages-femmes, expériences d'accouchement, peur, déception

Cet article a été évalué par des pairs.

INTRODUCTION

A phenomenological study exploring eight women's lived experiences of unplanned cesarean delivery in Nova Scotia (NS) was undertaken as part of a Master's Degree in Midwifery Practice through Thames Valley University, London, UK.¹ The purpose of the study was to document women's experiences of primary intrapartum cesarean surgery, to compare and contrast the experience when women have a midwife or physician and, to seek their suggestions on how to improve the experience for others. The study was completed in 2007, following the introduction of midwifery legislation in NS but prior to implementation.² Midwives at the time were unregulated, providing primary care only during home births but offering key elements of Canadian regulated practice, including informed choice, continuity of carer and advocacy for physiological birth.^{3,4} Typical for the out-of-hospital practice context,⁵ NS midwives' rate of intrapartum cesarean was low at 5%,⁶ whereas the provincial rate was higher. In 2008/2009 19.5% of all NS births were primary cesareans, an increase from 18% in 2006/2007.⁷ Approximately 75% occurred during labour, with dystocia as the most common indication.⁸ Cesarean section rates continue to rise in tandem with the body of evidence suggesting there are negative psychosocial effects for mothers and babies.

To date, there have been two extensive reviews of the literature on cesarean related psychosocial outcomes. In 1996, Dimatteo et al.,⁹ performed a meta-analysis of 74 quantitative studies which showed diminished maternal satisfaction and

changes in mother-infant attachment which was more pronounced for unplanned versus planned cesareans. In 2007, Lobel et al.¹⁰ reviewed the psychosocial sequelae of cesarean surgery, verifying Dimatteo et al.'s⁹ findings while incorporating newer evidence on psychological injury. Lobel et al.¹⁰ and Border¹¹ found the link between cesarean delivery and postnatal depression "inconsistent" but an association to post traumatic stress rather more compelling.¹²⁻¹⁵ Lobel et al.¹⁰ concluded, "Studies of women who have had a cesarean paint a picture of disappointment, distress, and dissatisfaction with this method of delivery."

Qualitative surveys demonstrating comparatively more dissatisfaction and negative experiences with unplanned cesarean have been conducted in Sweden,¹⁶ the UK¹⁷ and closer to home, in PEI.¹⁸ A survey of 6421 postpartum women across Canada, found the least positive ratings of labour and birth for unplanned cesarean versus other modes of delivery, along with less optimal early parenting and breastfeeding outcomes.¹⁹

Added to the recent quantitative evidence are two qualitative studies published in 2010. Somera et al.²⁰ interviewed nine Montreal women, one to five days following an 'emergency' cesarean. Somera et al.'s²⁰ population was ethnically diverse while Fries²¹ looked specifically at the experiences of seven African American women. Fries²¹ participants had an unplanned cesarean within the preceding year, mostly for non-urgent indicators. Both studies describe disappointment, distress and the need for improved emotional support and validation from

providers.

The research on intrapartum cesarean surgery has not yet examined the effects of different primary providers or models of care on the experience. It has captured immediate or intermediate reactions rather than the longer-term aftermath and most recommendations have been researcher, rather than participant-generated. This study addresses those gaps.

METHODOLOGY

Qualitative methodology is the most appropriate design for examining human experiences²² and useful in constructing pertinent, valid theories for testing by quantitative means.²³ Phenomenology was chosen as a long-established and rigorous 'experiential' science particularly suited to midwifery research involving complexity of experiences and sociopolitical context.²⁴ Phenomenology seeks to examine everyday lived experiences in-depth, from the participants' own perspective, in order to uncover universally shared understandings.²⁵ Ethical approval was obtained from Thames Valley University. Confidentiality was assured using standard conventions. Identifiers have been removed and quotes coded by pseudonym initial, data source and page number.

Eight women who had intrapartum cesarean surgery for a first birth and were parenting a healthy cesarean-born child, aged four months to five years, were recruited in two groups. One group of three participants (Irene, Jill and Debra) had cesarean surgery following transfer from a planned home birth. A total of four women meeting the criteria were identified by NS midwives. One was excluded for unrelated health reasons as were the author's clients. The second group had physician-led care for planned hospital birth, four with obstetricians (Kate, Nancy, Frances and Olivia) and one with her family practitioner (FP) (Lynn). These five were recruited through diverse community organizations using purposeful sampling. Telephone pre-screening in this second group was used to capture the widest possible range of experiences, cultural views and ages (19-43 years). Participants in both groups were Caucasian but from diverse social, economic and

geographic circumstances.

With the participants' written consent, data were collected via semi-structured interviews using a memory-aid guide. Interviews, lasting an average of two hours, were conducted, according to participant preference, in either their home (n=6) or a public venue (n=2). The interviews were tape-recorded then transcribed verbatim by the author. Along with transcripts (T), data were collected using participant diaries (D) and e-mail exchanges (E). Diaries were mailed to participants two weeks before their interviews and collected two weeks after. Only four diaries were returned but all participants provided post-interview comments. These data were analyzed using Colazzi's²⁶ method involving repeated reading, extraction of meaningful phrases, building themes from the phrases, returning to participants for validation and finally, describing the phenomenon.²⁴

Scientific rigor was carefully attended to throughout the research process. Credibility was ensured through participant feedback, reflexive journaling by the author and triangulation using three sources of data. Confirmability is seen in the link between the findings and participants' quotes. These quotes were selected from all sources of data to represent a cross section of views. Dependability was established by detailed documentation of the research process and through internal audit by two dissertation supervisors. Transferability has limitations as outlined below, but is bolstered by the findings' resonance with previous research.

FINDINGS

Theme 1: "This whole cascade of feelings"

The first of three major themes describes participants' immediate and lingering feelings about their experiences. Initial reactions to the decision for surgery varied. There was guarded anticipation and "relief", as Nancy explained, "...I might not be happy with the decision but it's made, my [baby] is going to be born." The decision was "a bit of a shock" for Lynn and a "surprise" to Irene, whereas Kate described sad resolve, "The tears ran down my face. I said, 'okay, I need a healthy baby, you do what you need to do.'"

All of the participants experienced fear in spite of

having non-emergency indicators for surgery. Debra found her spinal anesthetic initially "distressing", being "short of breath ... like I couldn't feel breathing happening". Her fear resolved with reassurance. Nancy was also frightened by a last minute rush to the operating room (OR), coinciding with a hospital shift change. Her fear settled and in fact, Nancy was the only participant who described feeling "more cared for" in the OR. For everyone else, the OR was "strange" "intimidating" or "scary" which Kate explained, "It was a scary thing for my husband and I ... there were all these people and machines and lights and noises. Neither of us had been in the OR before and so we were just like - abhh!"

Four participants experienced frightening events:

- 1) Lynn described exhaustion and a disassociated state, "at one point, certainly, I thought I was going to die ... it was like an out of body experience sort of thing, I remember seeing myself on that table..."
- 2) Jill also described exhaustion and a loss of reality related to clinical hypotension, "... like I was sort of moving away"
- 3) Frances had a conversion to general anesthetic for epidural failure discovered after her surgery began, at which point her partner was removed from the OR. She wrote in her diary, "The last thing I remember was the sawing scalpel, tears on my face going in my ears and some stranger's hand in mine instead of [partner]."
- 4) Olivia reported rushed and insensitive pre-operative care during which she developed a high spinal block. Olivia could not move her arms or talk yet her anesthetist remained unaware until informed by a nurse once Olivia regained speech in the recovery room, "I remember being so upset at the time and even that first night afterwards, all I could do was cry because I had been so scared to death." Olivia reported postnatal avoidance behaviours, invasive memories, and arousal states typical of an adaptive Post Traumatic Stress Reaction.²⁷ Her symptoms resolved without treatment by three months postpartum. Debra was unique. She recounted her intrapartum cesarean as, "over-all, a very positive experience". She felt primarily "grateful" on behalf of her baby who required urgent corrective surgery. Debra was the only participant who did not express feelings of sadness, regret, anger, guilt or disappointment.

Seven participants felt "disappointed" or even "devastated" about missing out on some aspect of vaginal birth and/or "bonding". Five expressed anger towards a provider. Olivia was "really annoyed" with her anesthetist, "that none of the policies and procedures had been followed." Jill was "appalled" that, without any previous discussion, the surgeon performing her second unplanned cesarean asked, on the operating table, for her consent to do a tubal ligation. Kate felt "pressured" into an epidural she did not request when her nurse advised she might, otherwise, become too tired to push effectively. However the "thing that really sticks out" for Kate was her obstetrician's "jump to the section", "I really got the feeling that she would have put me off her case load, if she could have done my section and then moved on to the next patient ... and that's not good!"

Participants' disappointment and anger were often tempered by guilt as Lynn offered, "I don't want to sound like I'm complaining or feeling like I had a negative experience because it could have been a lot worse... the most important thing to me is that I have a healthy baby." Kate made a similar comment but identified the defense mechanism as a "rationalization". When this rationalization was used by providers, family members or others, participants felt "silenced" as Nancy expressed, "Almost every conversation will end with, 'But at least you and the baby are healthy'... because that is a way of distancing the whole subject without exploring it further, without asking how you really feel about it." Six participants described feeling "sad" or "pretty low" for a few months but only Frances reported treatment, "I breastfeed for three months until I was overwhelmed with sadness and had to start anti-depressants ... I'm through it now but it still makes me sad that I wasn't able to really be there for the birth."

Regrets were common. For instance, all three participants receiving narcotic analgesia "regretted" that decision because, as Irene explained, "it didn't actually help". Six participants voiced self-doubt, poignantly described by Nancy as "the feeling that you have failed at something so fundamental". Kate, Jill and Frances lost confidence in their "pelvic bones", Irene in her "cervix". Doubts went especially "deep" for Jill and Nancy who had subsequent intrapartum cesareans. Jill said, "I feel de-sexed, less female because there is a scar across my feminine core... its like I am not whole..." By contrast, Debra trusted that, "... things went as they did because the

baby did not want to be born at home ...there were no obstructions to labour". Olivia was the other participant who did not express self-doubt. She had a cesarean for an undeliverable breech then all subsequent births vaginally, at home. Olivia talked about how healing this was for her, "If I had been unable to have the [other] births that I had, I don't know how over the first one I still would be."

Participants' fears lingered and influenced their decisions about future reproduction. Five described deliberately delaying or forgoing additional pregnancies. Two had no second child after five years. The reasons were diverse but often involved concerns around physical recovery, not surprising since seven of the eight participants had post operative problems. Frances, for instance, continued to have "sharp pains" at the incision site and wrote, "I'm pretty thoroughly scared of surgery and it's after effects now." Nancy's fears were more encompassing, "If I'd had two vaginal births we might well have had a third baby. It just changes things altogether ... apart from the physical aspects, it is very difficult emotionally to recover from a c-section."

Theme Two: Mediating Factors

Participants outlined numerous factors which mediated their intrapartum cesarean experiences, including self-efficacy, partner support and social support. The quality of provider support and contact with the baby, however, were most significant.

Provider Support

Accounts of provider support or its absence dominated participants' descriptions. While seven participants offered positive comments about various providers, only midwives were consistently described as supportive. The elements of midwifery care that participants singled out most for praise were informed choice, control and continuity.

Participants in the midwifery group detailed more care choices. For instance, Jill's midwife explained suturing techniques, "...she knew all about it. They didn't

give me the option but I said... 'This is what I want.' And she backed me up and I ended up getting it." Shared decision-making was associated with a better sense of control as Debra explained, "It became clear that [cesarean surgery] was what we needed to do ... but there was that time to say, 'Okay' which was a big deal I think and looking back, I didn't feel pushed or rushed or directed by anyone." Like Debra and Jill, who felt they had "really, really tried" "everything" during labour to facilitate a vaginal birth, Irene could conclude, "... it seemed obvious to me that the c-section was necessary."

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By contrast, four of the five participants having physician-led care expressed doubts about the necessity of their cesarean and/or the interventions they believed contributed to having a cesarean.

Kate said it most simply, "I just question whether different care could have resulted in a vaginal birth." Doubts were linked directly to a lack of informed choice which Nancy expressed this way, "I said okay, fine, we'll have the c-section... [but] I didn't feel like I was being handed all the options, I didn't feel I was given all the information."

Continuity of care provider enhanced the positive mediating effect of provider support, as Debra spelled out, "That's the whole point ... to have the same midwife I'd gotten to know over my pregnancy, to be there ... as my care giver, the person whose knowledge and experience I trust." According to McCourt and Stevens,²⁸ a meaningful level of continuity involves not just 'knowing' the midwife as 'a familiar face' but 'being known' as a distinct individual. Having this kind of two-way connection seemed especially important in the OR. Lynn had intrapartum care with her long-time FP and stated, "I wanted [FP] to be there because I have a rapport with him and I trust him". She recalled tearfully, "... it was only the people who I really recognized that I was able to kind of connect with ... I remember actually looking at my GP, thinking, oh god, I don't know if I'm going to make it through this ... and he was just totally understanding. Jill also valued 'being known', "When [Midwife] saw me sort of losing ground, my blood pressure was coming down, she was keeping me going ... She was able to read me and what I needed..." Conversely, participants having obstetric

care identified discontinuity as a problem. Nancy offered, *"These are some of the biggest decisions you have to make and you have no rapport with these people, you have no kind of relationship..."* Kate questioned the effect discontinuity had on her experience and care, *"I wonder if I would have felt differently if the delivering doctor had been the OB who had done my prenatal care... Would she have better understood my desires and encouraged a vaginal birth?"* Often, discontinuity resulted in fragmented "task" oriented care. For Nancy, the overall feeling *"...was all very much like a factory ... you feel processed ... at someone else's pace"*.

The positive mediating effect of support was enhanced when providers behaved collegially as was the case for Debra, *"I keep saying this, but its true, people behaved themselves well ... I don't think anybody was blaming anybody for anything. I hope not. That would be really unhelpful..."* For the other two midwifery-care participants, inter-professional tensions were obvious. Jill described the obstetrician's criticism of her midwife and FP in the OR as a personal affront, *"I don't want my choice in support to be chastised ... I'm in surgery ... at that point I don't need invasive attacks ... He attacked me through them."* Within the midwifery group there was a longing for "more positive" collaboration, which according to two successive provincial midwifery reports, remains a challenge following implementation in NS.^{2,29}

Midwifery participants also reported having contact beyond six weeks and detailed review of birth events. Irene commented on the positive effect, *"It helped me realize why and gave me peace of mind... and an acceptance of it."* After hospital discharge, seven participants did not have follow-up care from the obstetrician who performed their cesarean. Two had a discussion and medical records review with their prenatal obstetrician, however, both felt the visit did not answer their questions. Nancy said, *"I felt like they just pulled this report out of a file of standard reports. I couldn't see anything of my experience in it."* Without benefit of review from a provider actually present at their birth, participants in the physician group had more "gaps" in their understanding and memory of events. "Muddled" memories were especially problematic for Frances who had general anesthetic with no partner present, *"Nobody talked to me so nobody would know that's*

how I put the experience together. It's like a jigsaw puzzle, the pieces fit together but the picture doesn't look right."

Separation from Their Baby

For the five participants who had delayed contact with their baby, separation was one of the most negative factors mediating their experiences. Irene was clear on the point, *"The most disappointing part of the whole birth for me was that I had to go to recovery ... the baby had to go get [a diagnostic test] ... and it was most of an hour before we were back together."* Irene felt separation contributed to her child's reticent personality, while Kate questioned the initial "connection" with her baby and whether it was *"as strong or the same as it could have been..."*

Theme Three: Participant-Generated Suggestions for Improving Cesarean Care

Beginning with care choices, participants suggested that funded midwifery and doula services are "patient-centric" options which *"better support natural childbirth."* Nancy felt situating midwives in "free standing birth centers" would be an "appealing middle ground" for NS families. In terms of prenatal preparation, Lynn asked that childbirth educators emphasize *"a c-section can happen to very healthy pregnancies"*. Lynn and Irene suggested including the operating room on prenatal hospital tours as the best setting for explaining cesarean procedures and available choices. The OR tour and discussion concept was validated by all participants.

Many suggestions revolved around improving women's autonomy. Olivia wanted providers, *"to increase the level of respect by simply asking my permission to proceed ... Is it okay if we get your blood pressure, etc?"* Frances noted she *"wasn't in the frame of mind to ask the right questions"* during labour so, like Lynn, wanted more information *"beforehand."* Topics raised were eating in labour and the risks of membrane sweeps, induction, narcotics and epidural anesthetic. The latter included conversion to general anesthetic and high spinal blocks since neither are especially rare events, occurring in the range of 5% and 1% of cesareans respectively.³⁰⁻³²

Participants suggested fear might be reduced by offering more anticipatory guidance about *"what was going on and what things may or may not happen"*. Debra

asked providers to pre-warn women receiving spinal anesthetic "that you can't feel yourself breathing". Olivia wants the OR checklist to include "asking for standard responses" from women so high spinal blocks can be diagnosed promptly.

Participants suggested ways to make the OR experience more "welcoming", "maternally friendly" and "baby friendly". Frances asked that when conversion to general anesthetic becomes necessary, partners be allowed "to stay in the [operating] room" so those women can have a family-witnessed birth too. Olivia asked that hospital OR policies be changed to accommodate two supporters. For Olivia, having her mother stay when her partner needed to leave with the baby, "made a big difference". Since "all the masks and hats that match" meant many of the participants found it "hard to tell who is who", they wanted OR staff to "wear a name tag" or otherwise, identify themselves. When the baby is in good condition, participants asked that partners have the "opportunity" to "cut the baby's cord" and relay the gender. As with a vaginal birth, they wanted mothers to "see and hold their babies immediately after birth" and for families to have time "alone" in the recovery room "to bond". In the postnatal period, Olivia suggested providers routinely "check with you after your surgery to see if you were satisfied with your treatment". She asked that providers offer "validation ... whenever anything goes wrong" and perform "routine screening tests to make sure that there isn't any undue anxiety or depression."

In terms of medical review, Nancy suggested, "In an ideal world, you would get a copy of [your medical records] ... at your six week appointment, discuss it with the [surgeon] then take it away, think about it ... go back again in three months or so and talk about it and try to get answers to those questions so you have a more complete picture ... it would change care if [obstetricians] felt they had to be more accountable to women." Frances suggested "the hospital should have some kind of support group or follow-up for women who gave birth by c-section." Participants wanted to "share experiences" with other women in ways that validated cesareans as "scary

things that heroines survive [rather than] an easy way out." Nancy suggested providers find a "happy medium" between treating cesarean surgery as a "birth" and still "work to make sure there aren't as many unnecessary c-sections."

Limitations

As with all qualitative research, the findings of this phenomenological study cannot be generalized.²⁴ The population is small, lacks ethnic diversity and therefore may not represent all views. It is probable that the physician-care participant group were self-selected as a result of bias, particularly their willingness to collaborate with a midwife-researcher. The relevance to regulated midwifery practice may also be questionable, especially for clients planning a hospital birth, or where informed autonomy and continuity are not featured in the model of care.

DISCUSSION

The findings of this phenomenological study closely parallel previous research. The range and intensity of emotional reactions are consistent with qualitative studies examining intrapartum cesarean experiences,^{12,13,20,21,34} planned and unplanned cesareans combined³⁴, and complicated childbirth with mixed modes of delivery.^{17, 36-39} The study had the same proportion of intense fear and disassociation as Ryding¹² and like Fries',²¹ only one participant who was not disappointed.

Disappointment with cesarean birth has been reported for decades^{9,40} despite rising cesarean rates and therefore, as Lobel et al.¹⁰ surmise, is unlikely to change with further rate increases. By contrast, fear is less well-accepted as endemic to the unplanned cesarean experience. In this study, fear was universal and particularly concerning with respect to the four participants experiencing frightening events in the OR. Surprisingly, one participant in this group had pre-screened with very positive views and two of the four had never spoken to any health care provider about their fright. Among these four were two reports of psychological injury. Olivia had short

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duration PTSD and Frances had clinically-treated postnatal depression. Fear may not only precipitate short term psychosocial morbidity, but could be implicated in the well-established phenomenon of "voluntary infertility" following cesarean surgery.^{9, 41-44} These findings lend urgency to calls for reducing the number of unnecessary cesareans^{9,10,21,43,45} and for improving postnatal review following complex birth.^{17, 35, 39, 47-50}

Study findings are also well-aligned with the literature in terms of mediating factors. The essential role provider support plays in women's childbirth experiences has been described in studies about cesarean birth,^{20, 21, 34, 55} complex birth,^{36-39, 50} birth in general^{47, 51} and birth in NS.^{2, 6, 52-54} Aston et al.⁵² found that the quality of NS women's relationship with their providers was "integral to maternity care responsiveness" while Bayes et al.⁴⁷ found that a lack of provider support creates a "diminishing climate" which erodes women's self-confidence and sense of control. As Olivia's frightening anesthetic experience suggests, unsupportive care could also be a risk factor for PTSD.⁵⁶⁻⁵⁸

Participants in the midwife group experienced fear but not as intensely as those in the physician group. Continuity of midwifery care may have been a factor. Qualitative studies have shown that continuity promotes reassurance and comfort⁵⁹, as well as familiarity and a sense of calm.⁶⁰ The value Canadian women place on this aspect of care is highlighted in numerous studies from NS^{2, 7, 52, 61} and in an Society of Obstetricians and Gynaecologists of Canada (SOGC) survey.⁶² It is, however, difficult to speak to the specific benefits of continuity in Canada since it is a national standard for midwifery care. In order to compare outcomes between continuous and discontinuous midwifery care models, we must look elsewhere. For example, when the level of continuity in the UK and Australia reaches Canadian regulatory standards,^{4,63} there's not only reduced obstetric intervention⁶⁴⁻⁷¹ and cesarean surgery rates^{65,67,70,72} but improved experiences.^{65,66,68,72-75} Women feel better

Midwifery care was associated with improved cesarean experiences in terms of reduced immediate fears, informed autonomy, continuity of support and extensive follow-up.

informed and more in control of their care.^{59, 8,74} Many of these benefits are amplified for vulnerable populations.⁷⁶⁻⁷⁹

The third mediating element of midwifery care, control, especially over the role of care providers⁸⁰ also has a strong evidence-base. Control improves satisfaction with birth experiences and care providers^{81,82} as well as overall perceptions of care quality,⁸³ while lack of control strongly predicts dissatisfaction⁸⁴ and negative birth experiences.⁵¹ Having a lack of control is often reported following cesarean birth^{13,}

^{20,21, 34, 35, 55} and extends to control over contact with the baby. National surveys in Canada¹⁸ and the USA⁸⁵ found delayed mother-infant contact to be disproportionately high following cesarean birth even after excluding babies admitted to NICU. The findings of the current study support Lobel et al.'s¹⁰ proposal for "reducing the aversiveness of cesareans" through "enhanced control" using measures echoing those suggested by study participants.

CONCLUSIONS

This phenomenological study found that intrapartum cesarean birth evokes a wide range of strong and long-lasting emotional reactions, most commonly fear, disappointment and self-doubt. The strongest positive mediating factor was provider support while the most negative was separation from the baby. Midwifery care was associated with improved cesarean experiences in terms of reduced immediate fears, informed autonomy, continuity of support and extensive follow-up. Since midwifery care did not mediate all of the negative psychosocial effects, reducing the rate of primary cesarean surgery is a first goal, however, one which is not inconsistent with attempts to create women and family-centered cesarean births. To this end, participants suggested practice changes with cross provider groups. These include routine prenatal cesarean contingency planning facilitated by a local hospital OR tour, a calm and family-oriented OR experience, two support persons, a larger role for partners,

uninterrupted contact with the baby, and finally, improved postnatal support involving routine medical review by the surgeon at six weeks with an option to return at four months, extended midwifery care and access to peer support. These changes need to be implemented within a mixed-methods research framework to ensure effectiveness and acceptability.

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