

Birth after emergency caesarean section: Women's perspectives on the factors influencing their decision making

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Abstract

The study explored the decisions women made in relation to mode of birth following a previous emergency lower segment caesarean section (emLSCS), particularly focusing on what different factors influenced women to choose a particular mode of birth and what they described as the rationale underpinning that decision.

Participants were recruited from a population of students and staff within the School of Human and Health Sciences at a university in the north of England. Sixteen individuals were selected using convenience sampling, who then completed open-ended questionnaires. The questions were non-leading and asked the women to identify and expand upon factors that influenced their decision on mode of birth. Data were analysed using a basic thematic framework analysis.

Many of the identified themes mirrored those well recognised in existing research: the woman's previous birth, her perception of risks, the influence of professionals and the influence of peers were all apparent. One factor not explored in existing literature, namely a sense of duty to existing children, appeared to be strongly influential in this data set. Interestingly, it was observed that each woman's philosophical framework and her relationship with the element of control substantially underpinned her consideration of key factors, leading her to an individual decision.

This article provides an interesting insight into the complexity of individual decision making in maternity care. The findings highlight the fact that professional guidelines may fail to meet the personal and individual needs of their subjects. This is a thought-provoking topic for policy and guideline authors, as well as for the professionals who counsel patients through decision-making processes in maternity care and wider fields of healthcare.

Key Words

Caesarean; VBAC; decision making; choice; woman-centred; ERCS; birth philosophy; risks; emLSCS.

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Introduction and background

In 2013–14 caesarean section (CS) births accounted for 26.2% of all UK births, significantly greater than the 10–15% deemed by the World Health Organization to be medically necessary in reducing mortality and morbidity (Health and Social Care Information Centre, 2015; World Health Organization, 2010). This high rate of primary CS results in increasing numbers of women becoming pregnant with a pre-existing uterine scar and therefore being faced with the choice between a vaginal birth after caesarean (VBAC) and an elective repeat caesarean section (ERCS) (NICE, 2011; RCOG, 2007). Approximately 48% choose ERCS, significantly contributing to the overall rate of CS (Knight et al., 2013). It could therefore be suggested that if the proportion of women choosing VBAC increased, the overall CS rate would fall closer to acceptable levels as a direct result.

CS is expensive when compared with vaginal birth; £28.3m per annum could be saved with a CS rate decrease of 4% (NHS Institute for Innovation and Improvement, 2012). Recovery from CS is typically more complex and can have implications for future pregnancies (Bonney & Myers, 2011; Gregory & Giddings, 2011; Jurkovic, 2014). Newly emerging evidence tentatively suggests that CS birth could be linked to health implications for the child in later life (Hyde, Mostyn, Modi, & Kemp, 2012; Polo-Kantola et al., 2014; Sinha, Bewley, & McIntosh, 2011). A reduction in medically unnecessary CS is warranted. It could be argued, however, that to achieve a reduction in the overall CS rate, it is primary emLSCS that should be the focus of reductions, as many of these are considered medically unnecessary (American Congress of Obstetricians and Gynecologists, 2014). However, with no definitive diagnostic tools to accurately indicate when emLSCS is required, those deemed unnecessary are often only identified in hindsight (Fogelston, 2010).

ERCS increases the risk of maternal mortality by 160%, yet the risk of mortality to the neonate is increased by 145% with a VBAC (RCOG, 2007). Many of the risks attributed to VBAC are associated with an unsuccessful VBAC that results in unplanned CS (Oboro et al., 2010). If a VBAC is successful it is very low risk, the same as a vaginal birth for the average nulliparous woman (Rozen, Ugoni, & Sheehan, 2011). The main risk cited in relation to VBAC is that of uterine rupture or scar dehiscence under the stress of uterine contractions. The risk of occurrence is low (0.2–0.7%), yet the consequences can be catastrophic (NICE, 2011; RCOG, 2007). Professionals are unable to categorically predict which VBACs will be successful, thereby adding further uncertainty to decision making (Kotaska, 2012).

The CS guidance produced by the National Institute for Health and Care Excellence (NICE, 2011) states that the risks of VBAC and ERCS are not easily comparable and it is unclear which is the safest option, and, therefore, women should be supported in the decision that is most acceptable to them personally. Both the NICE guidance and the Birth after Previous Caesarean Birth guideline produced by the Royal College of Obstetricians and Gynaecologists (RCOG, 2007) centre on weighing up physical risks. However, there is a substantial body of qualitative research that suggests that, aside from risks, numerous other factors are important to women when navigating the decision-making process (Baxter & Davies, 2010).

NICE and RCOG typically overlook qualitative findings, which provide an insightful dimension in relation to holistic health-related decision making. Existing qualitative

research identifies several factors that influence women when making the decision between VBAC and ERCS: risks, professional influences, previous experiences and peer influence have all been explored in some depth. Existing studies appear to have chosen particular factors for participants to consider rather than the factors being identified by the women themselves. Therefore, they may not represent the true complexity of influences. If professionals are to support women and reduce the number of 'unnecessary' ERCSs, understanding what influences women in the decisions they make is key.

Objectives

The study objectives were:

- to explore choices made by women regarding mode of birth;
- to understand the rationale behind the decision on mode of birth;
- to gain insight into the factors that influenced the decision-making process.

Method

Study design

The study aimed to explore personal experience; therefore, a qualitative approach was taken to extract rich, multifaceted information. With the strong focus on the individual participants, a qualitative approach appeals to the holistic and woman-centred core values of midwifery and the aims of the study (Holloway & Wheeler, 2013; Pearson, 2010; Taylor, 2014).

Sample

Convenience sampling was utilised as the initial step to recruit suitable participants from staff and students within the School of Human and Health Sciences at a university in the north of England (Goodman, 2008; Ritchie, 2014). A participant information sheet, consent form and questionnaire were distributed by a non-selective email including the following inclusion criteria. (1) Participants need to be females who have personally given birth. (2) Women should be members of staff or current students within the School of Human and Health Sciences at the northern university in order to meet the approval of the University Ethics Committee. (3) Women should have given birth by emergency caesarean and also had at least one subsequent live birth in the UK. (4) Participants must be English literate and able to give informed consent to participate in the study. If the inclusion criteria were met, recipients were asked to complete the questionnaire and return it by email or deposit it in a secure and confidential drop box by the deadline.

Questionnaire

Data collection took place through the use of a questionnaire constructed in line with qualitative principles (Guthrie, 2010; Merriam, 2014). Limitations to the application of questionnaires are well acknowledged, and include a lack of theme generation and subsequent data saturation arising from group interactions, misinterpreted questions and short, poor-quality responses (Midanik & Drescher-burke, 2010). In order to address some of the identified limitations, participants were encouraged to reflect upon their responses and consider them from multiple angles. In addition, it was envisaged that for the same personal reasons that respondents chose to participate, they would also be motivated to give insightful responses. The questionnaire contained open questions and provided extended writing space to encourage lengthy responses with supporting rationale (Chapman-Novakofski, 2011).

In order to address the aims of the study, participants were asked to rank the most influential factors and then encouraged to expand upon each one in more detail to provide depth of data. Finally, participants were asked what advice they would give to professionals who counselled women through the decision-making process. This was included to gain further insight into a factor well acknowledged in the current literature. The original draft was piloted on a selection of university students and some modifications to the wording were implemented as a result. The responses from the pilot were not included in the analysis.

Data analysis

A conventional thematic content analysis was implemented, using a basic framework model to provide a structured step-by-step approach to systematic analysis of the data; this increased the robustness and internal validity of the study (Smith & Firth, 2011; Ward, Furber, Tierney, & Swallow, 2013). Data analysis was undertaken individually and subsequently collectively by a multi-professional research group to reduce bias and increase triangulation. Themes were colour-coded and the transcripts highlighted to demonstrate the occurrence of each theme. The themes were then collected into common themes, as illustrated in Table 1 and Table 2.

Ethics

The basic ethical principles of beneficence, non-maleficence and autonomy were examined in relation to the proposed research to ensure the protection of participants, as per the Declaration of Helsinki (World Medical Association, 1964). Ethical approval was granted through the University Ethics Committee.

Findings

Thematic analysis of 16 completed questionnaires highlighted some commonality in the factors that influenced women's decisions regarding mode of birth. The data contained four main themes, each providing insight into the decision-making rationale: the previous birthing experience, the influence of the health professionals, the potential for risk or harm and the influence of other people. This closely mirrors the themes identified in the current literature. Table 1 depicts the framework analysis process. During data analysis it became clear that many of the women shared similar perspectives on the same factors, yet did not opt for the same mode of birth. On further analysis, other intrinsic influencing themes became apparent, which also closely mirror the suggestions of Dahlen and Homer (2014) and Konheim-Kalkstein, Barry, and Galotti (2014). The framework analysis of these influences is depicted in Table 2.

Key Themes	Clusters	Emerging Themes
Previous experience of birth	Positive views	The recovery was OK
	Negative views	Surgery and recovery last time Dissatisfied with previous birth experience
Risk perception	Understanding of the risks	Felt well informed or not
	Acceptance of risks	Appreciated the risks involved with decision
	Prioritisation of risks	Risks outweighed other factors Risks did not outweigh other factors
Professional influence	Information given	Felt well informed or not
	Professional steering	Aware of a professional's view/bias Were told what would be best
	Sense of support and understanding	Felt listened to and supported Felt unsupported
Peer influence	Partner's influence	Supportive
		Duty to partner
	Friends and family	Sharing experiences/horror stories
		Supportive or otherwise
	Duty to existing child	Guilt Need to be his/her mum Driving/cuddles/picking up/hospital stay

Table 1. Initial framework analysis of key influences affecting choice between VBAC and ERCS.

Key Themes	Clusters	Emerging Themes
Birth philosophy	Rite of passage	Vaginal birth is natural
		Links to femininity
	Result-focused	The baby was the important result
		Did not want a vaginal birth
Control	Self-belief	I knew I could do it
		Doubt of success
	Ownership	My decision/my experience/my birth/my choice/up to me
		Hands of the experts/followed advice
Out of control	Might all go wrong/fear at loss of control	
	Want control	

Table 2. Further framework analysis of more intrinsic 'underpinning themes' that influenced participants' perception of the key themes identified in Table 1.

Previous experience

Without exception, women discussed their previous birthing experience. This mirrors the findings of Rowlands and Redshaw (2012) and Ayers, Jessop, Pike, Parfitt, and Ford (2014), who investigated the effect of traumatic birth on future birth. Not all women explicitly ranked 'previous experience', but all discussed it, possibly indicating that it was more influential than they themselves realised. The majority of participants viewed their emLSCS birth negatively and hoped to avoid having a similar experience.

'...the thought of going through that again made me feel physically sick.' Q2

'Looking back I think I was to some extent traumatised by the first birth and my experience following this.' Q7

These are strong responses using emotive language, emphasising the negativity the women felt. Those choosing VBAC appeared to focus their negativity specifically on aspects relating to the surgery and recovery period itself.

'My recovery following the first c-section was slow as there were problems with my wound. I was reluctant to have this happen again.' Q10

'Just trying to sit up in bed after the c-section was extremely painful...' Q9

These women may have employed the rationale that VBAC presented the chance of avoiding surgery and post-operative recovery, which would be unavoidable with ERCS. The participants opting for ERCS appeared to blame the emergency nature of their birth for causing an overall negative experience, possibly leading them to rationalise that an ERCS would minimise the risk of another emergency procedure if an attempted VBAC failed.

'...if I could have guaranteed I wouldn't have to have another emergency section I would have opted for a vaginal birth.' Q6

The nature of an emLSCS is frightening for women: by definition, it is performed when either mother or baby is at high risk of harm. Somera, Feeley, and Ciofani (2010) found that the emergency situation can be more psychologically traumatic than the surgery itself; this was also evident in our data.

'...the whole experience was scary and, well obviously, an emergency. Even an elective section for my second baby would have reminded me too much of the first emergency experience.' Q12

Despite all the participants having undergone emLSCS, it was only the women choosing VBAC who expressed a strong sense of disappointment with their previous birth.

'I felt robbed of the experience to give birth to my baby myself.' Q1

'I feel like I cheated.' Q2

Choby, Séjourné, Callahan, and O'Reilly (2014) suggested strong links between emLSCS and feelings of disappointment and failure for many women. Birth is viewed by some women as a rite of passage, central to womanhood and motherhood; women who hold these views may want another chance to achieve this, and, thus, use it as a rationale to opt for VBAC (Clift-Matthews, 2010).

'The reason for my section is officially "failure to progress". I felt I needed to deliver my second baby vaginally to prove to myself I was not a failure.' Q16

Women's perceptions of their previous experience provide an emotive and influential context for their rationale in deciding a mode of birth in a subsequent pregnancy. However, with consideration of this factor alone it is not clear what caused each individual woman to view similar experiences from markedly different perspectives.

Risk perception

Participants all discussed risk to the baby and themselves, but some women concentrated purely on physical risks while others considered risk holistically. Participants appeared aware that every option had risks and they needed to prioritise which were most acceptable to them. Most of the women, regardless of their preferred mode of birth, prioritised the limitation of physical risks to their baby.

'Number one was health of baby...' Q5

'For me the most important issue was the safety of my baby...' Q8

The participants did not agree on which mode of birth was safer for the baby, with some choosing VBAC and some ERCS. Theoretically, it is accepted that VBAC poses higher risks to the fetus because of the chance of failed VBAC and subsequent emLSCS. This could indicate that the women who viewed VBAC as less risky to the neonate might have had greater belief that they would achieve a successful VBAC, which carries the lowest risks overall.

None of the women mentioned the physical risks to themselves posed by either VBAC or ERCS, such as haemorrhage or infection, although these are relatively common compared to the risk of morbidity to the fetus. In relation to themselves, women considered risk holistically, focusing on emotional and psychological morbidity, which are more difficult to numerically quantify.

'I also considered the risks to me psychologically of never giving birth properly.' Q1

'I think the psychological risk to myself of having to go through pregnancy knowing I was going to have to labour again would have been really horrendous.' Q3

This may indicate the inadequacy of current practice, whereby the physical risks to the woman form the core of discussions. Emotional and psychological morbidity is not addressed by current guidelines, despite clear recognition of the value of a holistic approach (NICE, 2011; RCOG, 2007). Participants possibly recognised what the guidelines do not, namely that the risk of psychological and emotional trauma is

considerably greater, and therefore more influential, than the comparatively small chance of physical harm.

Some participants discussed the risk of something going wrong, particularly relating to the uncertainty of achieving a successful VBAC.

'I thought there were too many things that could go wrong for a natural birth. For all the planned section stuff I read it seemed that pretty much everyone had the same experience and that there was much less deviation from the plan!' Q3

This fear is logical, given that unsuccessful VBAC is the riskiest birth for both woman and fetus. More holistically, however, Phillips, McGrath, and Vaughan (2009) identified 'fear of failure' as a driving factor for women making this decision. This possibly influences some who opt for ERCS, as it might provide the most predictable experience eradicating the risk of 'failing again', and this was also considered by some women who chose VBAC.

'I felt like if I tried for a vaginal birth and then failed again I would have really suffered psychologically and emotionally. There was a lot put at stake, I felt.'
Q1

All participants appeared to consider similar issues before opting for the choice they perceived to be less risky overall. Again, it was apparent that, even when participants identified the same issues and expressed similar opinions, they reached different conclusions on which option posed less risk overall, hinting at the complex intrinsic nature of personal decision making.

Professional influence

Most respondents discussed the influence of professionals; some ranked the professional explicitly while others alluded to their influence. Konheim-Kalkstein et al. (2014) argued that those choosing ERCS were more likely to be influenced by professionals than those choosing VBAC (45% versus 22%), and this disparity was also evident in our findings, with all those choosing ERCS discussing the influence of professionals compared to 63% of those choosing VBAC. Some of the women were aware of professional preference for either VBAC or ERCS; where this was perceived, the women readily accepted the advice.

'... I would have attempted a vaginal delivery but was advised against this by my gynaecologist.' Q8

'....she told me that a vaginal birth would be the best option for me. I was happy to go with what she thought was best.' Q2

The power dynamic between women and professionals is interesting. Despite the mantra of 'informed choice', one must question whether this is truly possible when the professional decides what information to share with the woman to inform her decision. These insightful statements may indicate that some professionals are not working strictly within guidelines, which state that women should not be influenced in their decision (NICE, 2011). It would have been useful to qualify these statements

further, as it is difficult to appreciate whether individual circumstances indicated a preferred option in the professionals' view. However, with amount of current supporting literature it is reasonable to believe these experiences are common.

The women identified what support they wanted from professionals: personalised information on risks, to feel listened to, and to have their decision respected. Interestingly, these themes closely mirror the recommendations in professional guidelines (NICE, 2011; RCOG, 2007). It is clear that the professional is highly influential in this decision-making process, but it remains unclear why some women are more influenced than others by professionals. It could be due to different professional practices or intrinsic differences between women that affect their awareness of, and susceptibility to, pressure and influence.

Peer influence

Almost all participants (14/16) discussed the influence of another person, particularly partners and existing children. The importance of existing children is not a factor addressed in the current literature, but was strongly influential for this group of participants. Women expressed a sense of responsibility to existing children and a duty to maintain their role as mother throughout the birth of a new baby.

'She had only just begun walking and was not old enough to understand why mummy could not pick her up. I did not want her to feel doubly rejected.' Q16

'I needed to be fit and able and on my feet as quickly as I could be, I needed to be able to pick him up and cuddle him to comfort him in a time which was already going to be unsettling for him...' Q1

This was seemingly an emotive influence on women to opt for the birth they felt would enable them to maintain most stability for their children; some felt that the faster recovery of a VBAC provided this and others viewed the planned nature of an ERCS as easier to manage with children. The open nature of the questionnaire is different to that of the majority of existing studies, which possibly contributes to the identification of a previously unrecognised factor.

Existing research has often found that partners influence decision making, but in this study only one woman talked about her partner, indicating that either the women were unaware of the influence, or that they viewed the decision as a joint one, with the partner central to the decision rather than an external influence, as hinted at below.

'... the appointments were always really aimed at me but we considered it to be a family decision and I felt my partner's opinions and fears weren't even considered.' Q2

As these factors are not well explored by current research, they may not be fully addressed by the professionals supporting women.

Philosophy

It was clear that participants discussed some influences in very similar terms, yet still reached different decisions. This indicates intrinsic differences in personal

philosophy surrounding birth, which then underpins individual rationale. Those choosing VBAC expressed the high value they placed on the normality of vaginal birth, fitting with Dahlen and Homer's 'motherbirth' theory (2014).

'I desperately wanted to experience actually giving birth (the way nature intended).' Q12

'I feel that as a woman I should experience giving birth to a baby normally and naturally. It's how it's supposed to happen, isn't it?' Q2

For some choosing VBAC, this view appeared to further influenced the rationale for their decision, as they felt a VBAC would remedy their previous 'unnatural' experience.

'Having a vaginal birth was a really important part of the healing process for me.' Q2

'I needed a vaginal birth as a form of catharsis.' Q16

The participants choosing ERCS did not demonstrate these opinions; not one participant mentioned the normality of vaginal birth, again hinting at the difference in philosophical perspective. Birth philosophy could be considered as a spectrum, from those who desperately want to experience birth, considering it central to motherhood, to those who view the baby as the ultimate goal and the birth experience as irrelevant in comparison. This philosophical viewpoint appears to be a factor that determines the outcome of women's consideration of the more extrinsic factors, hence their differing decisions.

Control

An undercurrent theme of control was evident in many of the participant responses. Those who chose VBAC demonstrated a strong internal locus of control when compared to those who chose ERCS, expressing a sense of ownership over their decisions and experiences, and a personal responsibility for their outcomes. This resonates with the findings of Konheim-Kalkstein et al. (2014).

'I wanted to ...actually say "yeah, I did that".' Q12

'... give birth to my baby myself.' Q1

Those opting for ERCS were more likely to relinquish control, preferring to give away the responsibility for decision making and birth, a potential catalyst for the disproportionate influence of professionals for those choosing ERCS versus VBAC.

'... whatever they advised I would have followed.' Q8

'... completely at the mercy of...other people.' Q3

Those who chose ERCS appeared to take a sense of control from the planned nature of an ERCS, which suggests that exerting a sense of control was still important to them in certain aspects.

'...I loved knowing exactly what would happen and when.' Q3

'I could plan around the birth for things like childcare for my other son as I had a definite date.' Q6

Women have differing associations with the element of control, which may affect the influence of the other factors during this decision-making process. This strongly reiterates the individuality and multi-level complexity of this decision, and indicates the subtle interplay between extrinsic factors and individual personality traits.

Limitations

The inexperience of researchers may have impacted upon the effectiveness and validity of the process (Flick, 2013). Participants formed a narrow, homogeneous field of well-educated individuals, who were motivated to volunteer their participation, thus limiting generalisability (Cleary, Horsfall, & Hayter, 2014; Uprichard, 2013). They included healthcare students with professional insight into service-user decision making, which potentially affected their responses. For some participants the decision was made many years previously, with recall ability and time lapse potentially limiting accuracy and relevance to the current professional practice and experiences of women in the UK (Foley, Crawley, Wilkie, & Ayers, 2014). Similarly, respondents were asked to discuss a decision for which they knew the outcome; hindsight is recognised as impacting upon recollection (Fessel, Epstude, & Roese, 2009). The well-recognised limitations of questionnaire use in research were also applicable to the study (Krueger & Casey, 2014). The limitations do impact on the internal and external validity of the study, but the results remain interesting, insightful and relevant in addressing the objectives that the study set out to achieve.

Conclusion and recommendations

The choice between VBAC and ERCS is complex and individualised. Several key themes were identified as influential. The majority of themes mirror those identified in the current body of literature. It cannot be assumed, however, that the emergent themes would be reflected in all cases, as the small sample of a homogeneous population limits the trustworthiness and generalisability of findings. The findings do provide insight into the intrinsic personality factors, thereby adding another level of complexity and individuality to the decision-making process. Furthermore, this study highlights the need for professionals to respect individuality and work within guidelines to provide women with personalised holistic support and credible evidence upon which to base their personal decision, regardless of whether or not that decreases the ERCS rate. What has prime importance is that women are supported to make the right decision for them personally.

Future research

This study has highlighted several interesting areas for further research:

- the impact of the existing child upon maternal decision making;
- the role of the professional in counselling women in decision making in relation to current evidence and professional guidelines;
- the effect of personality traits on decision making and birth choices.

References

American Congress of Obstetricians and Gynecologists. (2014). *Safe Prevention of Primary Cesarean Delivery*. Retrieved from <http://www.acog.org/Resources-And-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery>

Ayers, S., Jessop, D., Pike, A., Parfitt, Y., & Ford, E. (2014). The role of adult attachment style, birth intervention and support in posttraumatic stress after childbirth: A prospective study. *Journal of Affective Disorders*, 155(1), 295–298. <http://dx.doi.org/10.1016/j.jad.2013.10.022>

Baxter, L., & Davies, S. (2010). Balancing risk and choice in childbirth after caesarean section. *British Journal of Midwifery*, 18(10), 638–643. <http://dx.doi.org/10.12968/bjom.2010.18.10.78836>

Bonney, E. A., & Myers, J. E. (2011). Caesarean section: Techniques and complications. *Obstetrics, Gynaecology & Reproductive Medicine*, 21(4), 97–102. <http://dx.doi.org/10.1016/j.ogrm.2010.12.002>

Chapman-Novakofski, K. (2011). The open-ended question. *Journal of Nutrition Education and Behavior*, 43(3), 141 <http://dx.doi.org/10.1016/j.jneb.2011.03.135>

Choby, D., Séjourné, N., Callahan, S., & O'Reilly, A. (2014). Feelings of control, unconditional self-acceptance and maternal self-esteem in women who had delivered by caesarean. *Journal of Reproductive and Infant Psychology*, 32(4), 355–365. <http://dx.doi.org/10.1080/02646838.2014.930111>

Cleary, M., Horsfall, J., & Hayter, M. (2014). Data collection and sampling in qualitative research: Does size matter? *Journal of Advanced Nursing*, 70(3), 473–475. <http://dx.doi.org/10.1111/jan.121637>

Clift-Matthews, V. (2010). Vaginal birth as a rite of passage. *British Journal of Midwifery*, 18(3), 140. <http://dx.doi.org/10.12968/bjom.2010.18.3.46913>

Dahlen, H. G., & Homer, C. S. E. (2014). 'Motherbirth or childbirth'? A prospective analysis of vaginal birth after caesarean blogs. *Midwifery*, 29(2), 167–173. <http://dx.doi.org/10.1016/j.midw.2011.11.007>

Fessel, F., Epstude, K., & Roese, N. J. (2009). Hindsight bias redefined: It's about time. *Organizational Behavior and Human Decision Processes*, 110(1), 56–64. <http://dx.doi.org/10.1016/j.obhdp.2009.07.001>

Flick, U. (2013). *The SAGE Handbook of Qualitative Data Analysis*. London: SAGE Publications Ltd.

Fogelston, N. (2010). The Myth of the Unnecessary Cesarean. [Web log post]. Retrieved from <http://academicobgyn.com/2010/07/27/the-myth-of-the-unnecessary-cesarean/>

Foley, S., Crawley, R., Wilkie, S., & Ayers, S. (2014). The Birth Memories and Recall

Questionnaire (BirthMARQ): Development and evaluation. *BMC Pregnancy and Childbirth*, 14(1), 211–214. <http://dx.doi.org/10.1186/1471-2393-14-211>

Goodman, S. (2008). The generalizability of discursive research. *Qualitative Research in Psychology*, 5(4), 265-275. <http://dx.doi.org/10.1080/14780880802465890>

Gregory, I., & Giddings, D. (2011). Caesarean section: Patient preparation and initial care. *British Journal of Healthcare Assistants*, 5(1), 24–26. <http://dx.doi.org/10.12968/bjha.2011.5.1.24>

Guthrie, G. (2010). *Questionnaires*. New Delhi: SAGE Publications India.

Health and Social Care Information Centre (2015). *NHS Maternity Statistics – England, 2013-2014*. Retrieved from <http://www.hscic.gov.uk/catalogue/PUB16725/nhs-mate-eng-2013-14-summ-repo-rep.pdf>

Holloway, I., & Wheeler, S. (2013). *Qualitative research in nursing and healthcare*. Oxford: Wiley-Blackwell.

Hyde, M. J., Mostyn, A., Modi, N., & Kemp, P. R. (2012). The health implications of birth by caesarean section. *Biological Reviews*, 87(1), 229–243. <http://dx.doi.org/10.1111/j.1469-185X.2011.00195.x>

Jurkovic, D. (2014). Cesarean scar pregnancy and placenta accreta. *Ultrasound in Obstetrics & Gynecology*, 43(4), 361–362. <http://dx.doi.org/10.1002/uog.13346>

Knight, H., Gurol-Urganci, I., Meulen, J., Mahmood, T., Richmond, D., Dougall, A., & Cromwell, D. (2013). Vaginal birth after caesarean section: A cohort study investigating factors associated with its uptake and success. *BJOG: An International Journal of Obstetrics & Gynaecology*, 121(2), 183–192. <http://dx.doi.org/10.1111/1471-0528.12508>

Konheim-Kalkstein, Y. L., Barry, M. M., & Galotti, K. (2014). Examining influences on women's decision to try labour after previous caesarean section. *Journal of Reproductive and Infant Psychology*, 32(2), 137–147. <http://dx.doi.org/10.1080/02646838.2013.875133>

Kotaska, A. (2012). Quantifying VBAC risk: Muddying the waters. *Birth*, 39(4), 333–337. <http://dx.doi.org/10.1111/birt.12014>

Krueger, R. A., & Casey, M. A. (2014). *Focus Groups: A Practical Guide for Applied Research* (5th ed.). New Delhi: SAGE Publications.

Merriam, S. B. (2014). *Qualitative research: A guide to design and implementation* (3rd ed.). Oxford: Wiley-Blackwell.

Midanik, L. T., & Drescher-burke, K. (2010). Surveys and Questionnaire Design. In P. G. Miller, J. Strang & P. M. Miller (Eds.), *Addiction Research Methods*. (pp.92-106)

Oxford: Wiley-Blackwell.

NHS Institute for Innovation and Improvement. (2012). *Toolkit for Reducing Caesarean Section Rates*. Retrieved from [http://yhhiec.org.uk/wp-content/uploads/2012/01/1233 Toolkit for reducing Caesarean section rates1.pdf](http://yhhiec.org.uk/wp-content/uploads/2012/01/1233_Toolkit_for_reducing_Caesarean_section_rates1.pdf)

NICE. (2011). *Caesarean Section*. CG132. Retrieved from <http://www.nice.org.uk/guidance/cg132/chapter/guidance>

Oboro, V., Adewunmi, A., Ande, A., Olagbuji, B., Ezeanochie, M., & Oyeniran, A. (2010). Morbidity associated with failed vaginal birth after cesarean section. *Acta Obstetrica Et Gynecologica Scandinavica*, 89(9), 1229–1232. <http://dx.doi.org/10.3109/00016349.2010.499448>

Pearson, A. (2010). Evidence-based healthcare and qualitative research. *Journal of Research in Nursing*, 15(6), 489–493. <http://dx.doi.org/10.1177/1744987110380580>

Phillips, E., McGrath, P., & Vaughan, G. (2009). 'I wanted desperately to have a natural birth': Mothers' insights on vaginal birth after Caesarean (VBAC). *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 34(1), 77–84. <http://dx.doi.org/10.5172/conu.2009.34.1.077>

Polo-Kantola, P., Lampi, K. M., Hinkka-Yli-Salomäki, S., Gissler, M., Brown, A. S., & Sourander, A. (2014). Obstetric risk factors and autism spectrum disorders in Finland. *The Journal of Pediatrics*, 164(2), 358–365. <http://dx.doi.org/10.1016/j.jpeds.2013.09.044>

Ritchie, J. (2014). *Qualitative research practice: A guide for social science students and researchers*. Los Angeles: SAGE Publications.

Rowlands, I. J., & Redshaw, M. (2012). Mode of birth and women's psychological and physical wellbeing in the postnatal period. *BMC Pregnancy and Childbirth*, 12(1), 138. <http://dx.doi.org/10.1186/1471-2393-12-138>

Royal College of Obstetricians and Gynaecologists (RCOG) (2007) *Birth after Previous Caesarean Birth (Green-top Guideline No. 45)*. Retrieved from <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg45/>

Rozen, G., Ugoni, A. M., & Sheehan, P. M. (2011). A new perspective on VBAC: A retrospective cohort study. *Women and Birth*, 24(1), 3–9. <http://dx.doi.org/10.1016/j.wombi.2010.04.001>

Sinha, A., Bewley, S., & McIntosh, T. (2011). Myth: Babies would choose prelabour caesarean section. *Seminars in Fetal and Neonatal Medicine*, 16(5), 247–253. <http://dx.doi.org/10.1016/j.siny.2011.03.003>

Smith, J., & Firth, J. (2011). Qualitative data analysis: The framework approach. *Nurse Researcher*, 18(2), 52–62. <http://dx.doi.org/10.7748/nr2011.01.18.2.52.c8284>

Somera, M. J., Feeley, N., & Ciofani, L. (2010). Women's experience of an

emergency caesarean birth. *Journal of Clinical Nursing*, 19(19–20), 2824–2831.
<http://dx.doi.org/10.1111/j.1365-2702.2010.03230.x>

Taylor, R. (2014). *The essentials of nursing and healthcare research*. Los Angeles: SAGE.

Uprichard, E. (2013). Sampling: Bridging probability and non-probability designs. *International Journal of Social Research Methodology*, 16(1), 1–11.
<http://dx.doi.org/10.1080/13645579.2011.633391>

Ward, D. J., Furber, C., Tierney, S., & Swallow, V. (2013). Using framework analysis in nursing research: A worked example. *Journal of Advanced Nursing*, 69(11), 2423–2431. <http://dx.doi.org/10.1111/jan.12127>

World Health Organization. (2010). *The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage*. Retrieved from
<http://www.who.int/healthsystems/topics/financing/healthreport/30C-sectioncosts.pdf>

World Medical Association. (1964). *Ethical Principles for Medical Research Involving Human Subjects*. Retrieved from
<http://www.wma.net/en/30publications/10policies/b3/>

<http://dx.doi.org/10.5920/fields.2016.2117>

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