Addressing Lower Segment Cesarean Section Hesitancy: A Patient-centered, Pragmatic Communication Guide

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ABSTRACT

In women in whom a normal vaginal delivery is not possible or is not indicated, delayed acceptance of lower segment cesarean section (LSCS) or outright LSCS refusal, leads to complications that can easily be avoided. Hence, it makes sense for obstetricians and other health care professionals, to address LSCS hesitancy as an integral part of obstetric care. In this article, we discuss both the communication style and communication content, that is required to manage LSCS hesitancy in women in whom the intervention is indicated. We highlight the need to analyze the reasons for hesitancy, and address them in an appropriate and affable manner, using accurate information to buttress one's points. We also encourage seeking assistance from colleagues in the health care team, utilizing audio-visual and social media aids, and offering alternatives if the patient so desires.

Keywords: Communication, delivery, labor, maternal health, person-centered care, pregnancy

Modern obstetric care has succeeded in reducing maternal morbidity and mortality levels to levels lower than ever seen in the history of womankind. One of the reasons for this has been the judicious use of lower segment cesarean section (LSCS) as a mode of delivery.[1] Data from the National Family Health Survey (NFHS) shows that the incidence of LSCS has increased over the past few years.[2] Timely LSCS, in indicated situations, improves feto-maternal pregnancy outcomes, and contributes to long-term health in both mother and child. Delayed LSCS, on the other hand, associated with childbirth trauma, may contribute to fistulae, prolapse and incontinence.[3] Birth asphyxia, which occurs if delivery is delayed, can cause behavioral or cognitive dysfunction and developmental delay in offspring.

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There is however, poor awareness about various modes of delivery among antenatal patients.[4] In spite of the clear-cut advantages, many people continue to regard LSCS as an unnecessary or unsafe mode of delivery. The reasons for this have been explored in mixed methods studies.[5]

In a woman in whom vaginal delivery is not possible, and LSCS is clearly indicated, delayed LSCS acceptance or outright LSCS refusal, leads to complications that can easily be avoided. Hence, it makes sense for obstetricians and other health care professionals, to address LSCS hesitancy as an integral part of obstetric care. In this article, we discuss both the communication style and communication content, that is required to manage LSCS hesitancy. We highlight the need to **analyze** the reasons for hesitancy, and **address** them in an **appropriate** and **affable** manner, using **accurate** information to buttress one's points. We also encourage seeking **assistance** from colleagues in the health care team, utilizing audio-visual and social media **aids**, and offering **alternatives** if the patient so desires (Table 1).

COMMUNICATION DURING ANTENATAL CARE

- Build a good rapport with the patient, her husband and her family.
- Encourage them to ask questions and clarify doubts.

Table 1. The "10 A" Approach to LSCS Hesitancy

1.	Approach patient and her family in Affable manner
2.	Apprise them of current feto-maternal status, anticipated future trajectory of events and the indication for LSCS
3.	Articulate in BLACK (Benefits, Limitations, possible Adverse events, Cost and Knowledge required of/for LSCS) and WHITE (Warm empathy, Holistic understanding, Interests of mother and child, need for Team-based decision and Explanation of efforts made so far)
4.	Ascertain and Analyze reasons for LSCS hesitancy, if any: perceived lack of necessity, safety/tolerability or affordability
5.	Address these reasons in an empathic and firm manner
6.	Allude to the emergency/urgency/elective nature of LSCS during the discussion, and mention the time frame for decision-making
7.	Anticipate need for more information/time for decision-making, and share accurate sources of knowledge regarding the patient's diagnosis
8.	Ask for assistance from members of health care team, or use audio-visual/social media decision aids, if needed
9.	Arrive at shared and informed decision regarding the place timing and mode of delivery
10.	Accurately document the consent taking process, including LSCS hesitancy management in real time

LSCS = Lower segment cesarean section.

- Keep the patient informed about progress of pregnancy, and plans for place, time and mode of delivery, at each visit.
- Use 2D/3D models and aids to explain the female genital tract anatomy, as well as process of labor and delivery.
- Use salutogenic/positive language to encourage healthy behavior that can facilitate normal labor, (as long as there is no absolute indication for elective LSCS):
  - Exercise
  - Nutrition
  - Micronutrient supplementation
  - Yoga.
- Highlight consistently that the primary aim is a healthy mother and baby; the mode and timing of delivery is decided in such a way so as to ensure this aim.
- Clarify that the natal woman, obstetrician, family members and nursing/midwifery staff are a team, whose united objective is to ensure a healthy mother and child.
- Simultaneously, counsel women (and the family) that a normal vaginal delivery should not be viewed as a "badge of honor" or as a sign of "femininity".
- If you work in a busy, high-volume health care facility, identify and utilize alternative/complementary sources of accurate/appropriate information: colleagues, paramedical staff, visual aids, audio messages/video clips, websites.
- Ensure balanced communication regarding various modes of delivery.

COMMUNICATION IMMEDIATELY BEFORE/DURING LABOR

- Take a shared and informed decision regarding induction/augmentation and trial of labor, explaining all relevant aspects.
- Share clinical findings with patient and family during monitoring of labor.
- In case, LSCS is indicated, explain primary indication, and describe benefit to mother and child in positive language.
- Explore reason for LSCS hesitancy, if consent is not forthcoming.
- For pedagogic ease, we structure the main reasons for LSCS hesitancy as:
  - Perceived lack of necessity
  - Perceived lack of safety/tolerability
  - Perceived lack of affordability.
- History taking should be done in a hierarchal manner, to elicit the reasons mentioned in the order above.
- All communication should be documented, and may also be audio-recorded and/or video graphed as per standard of care.

PERCEIVED LACK OF NECESSITY FOR LSCS

- Explain primary indication for LSCS, inform about emergency/urgency of decision (Table 2) and list contributory factors.
- Use positive language, e.g., LSCS will ensure a healthy baby and a healthy maternal tract for future pregnancies.

Table 2. Indications for LSCS: Classification According to Urgency

Category	Feto-maternal health risk	Decision-to-delivery interval	Some indications
1: "crash" LSCS	Immediate threat to life of fetus and/or mother	As short as possible, maximum 30 minutes	Fetal bradycardia, cord prolapse, rupture uterus
2: emergency	Fetal and/or maternal distress, but no immediate threat to life	As short as possible, maximum 75 minutes	Meconium, abnormal cardiotocogram
3: emergency	No distress or threat to life, but early delivery is indicated	As short as resources allow	Poor progress of labor
4: elective	No compromise or threat to life	As per convenience of mother and health care system	Cephalopelvic disproportion, not in active labor

LSCS = Lower segment cesarean section.

- Clarify that you have best interest of mother and child at the center of your decision-making.
- Reiterate that you are part of a team, and that the captain of the team is the mother in labor (or decision maker in the family).
- Convey that it is neither the mother's fault, nor the obstetrician's fault, that normal vaginal delivery is not possible/feasible.
- Encourage the family to view LSCS as a life-saviour for the fetus/baby.
- If urgency, describe potential mishaps that may occur related to maternal and fetal outcome.
- If emergency, also explain secondary mishaps that may occur due to prolonged/obstructed/lack of progress of labor, e.g., maternal-childbirth trauma, stress urinary incontinence, prolapse, cervical incontinence and fetal - birth asphyxia sequelae.
- Reinforce the message through various members of health care team.
- Offer option of second opinion for place, mode and timing of delivery.

PERCEIVED LACK OF SAFETY/TOLERABILITY OF LSCS

- Explore specific myths and address them, e.g., inability to breastfeed/work/maintain conjugal relations/have normal vaginal delivery after LSCS.
- Use positive, non-judgmental language in patient and empathic manner, while reminding patient and family that time is of essence.
- Describe the postoperative rehabilitation process after LSCS.
- Allude to possibility of delayed rehabilitation after prolonged labor/childbirth trauma during vaginal delivery.
- Reassure the family regarding expertise and experience of operating team.
- Reinforce the message through various members of health care team.
- Offer option of second opinion for place, mode and timing of delivery.

PERCEIVED LACK OF AFFORDABILITY

- Inform differential in cost of normal vaginal delivery and LSCS, and explain the reasons for this (manpower, infrastructure and consumables).
- Encourage family to take a holistic view of cost of childbirth, including cost of neonatal and future child care, as well as future obstetric and gynecological care.
- Offer options for staggered or deferred payment, if feasible.
- Suggest economic alternatives for place of delivery if feasible.

SUMMARY

We reiterate that the decision-making regarding mode and timing of delivery is highly individualized, and must be based upon the unique combination of fetal and maternal factors at completion of pregnancy. LSCS hesitancy sometimes prevents the appropriate decision from being made in a timely manner. The points listed and tabled here provide an overview of the communication style, and communication content, which is required to manage LSCS hesitancy. We hope that this framework will encourage discussion as well as debate, which will strengthen not only our communication skills but obstetric care as well.

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Improved Diet could Reduce the Rate of Illness among Women

A new study published in *Nutritional Neuroscience* suggests that a healthy diet, especially one rich in foods containing a high amount of carotenoids, may help reduce the incidence of sickness among women. These bright-colored fruits and vegetables are particularly important in minimizing cognitive and visual decline.

According to the study, which examined and evaluated data from earlier studies stated that women accounted for about 80% of all autoimmune diseases collectively. Therefore, women require more preventive care because of their sensitivity, which is directly related to biology.

Women's vulnerability or sensitivity is caused by the way women's body retains vitamins and minerals. Women have more body fat than males, and this body fat acts as a large sink for many dietary vitamins and minerals, creating a helpful reservoir for women during pregnancy. However, because of this, the retina and the brain receive less nutrition, making women more prone to degenerative issues.

Experts stated that dietary carotenoids work as antioxidants, hence were very much essential. It has been demonstrated that lutein and zeaxanthin, two distinct carotenoids found in particular tissues of the eye and brain, directly ameliorate central nervous system degeneration. Additionally, the role of the microbiome and the bacteria in the gut, coupled with dietary elements produce the neurotransmitters and structural components of our brain.

Thus, the study stressed that women needed more vitamins and minerals and advised them to be aware of these facts. They further added that women should take proper measures to prevent these problems later in life.

(Sources: Hindustan Times, Jul 16, 2022; https://www.hindustantimes.com/lifestyle/health/women-can-lower-their-rate-of-illness-with-improved-diet-suggests-study-101657944857729.html)

Study Suggests Simple Tests to Identify Blood Clots Related to COVID-19

In a study published in the *American Journal of Pathology*, researchers revealed the use of a minimally invasive test to find blood clots in small blood vessels in the skin of patients who had severe COVID-19. These clots appeared normal and were not present in the skin of patients who had other types of severe infectious lung diseases or in people who only had mild or moderate COVID-19.

A skin biopsy, according to the researchers, can aid in determining the extent of COVID-19-related tissue damage as well as helping in separating this blood vessel disease from other severe respiratory infections. The study also included biopsy samples from 9 hospitalized patients who had severe or critical respiratory or kidney diseases and passed away prior to the COVID-19 era. Also, MxA an antiviral protein which can stop SARS-CoV-2 growth was detected in all the 6 mild to moderate COVID-19 patients.

Microthrombi or small blood clots were seen in 13 of the 15 patients with severe or critical COVID-19 while no microthrombi were found in the biopsies of patients with mild to moderate COVID-19 or the pre-COVID-19 era patients with severe respiratory sickness or kidney disorders. The scientists stated that these microvascular changes may be a unique characteristic of COVID-19 respiratory disorder compared to other acute respiratory diseases. (*Source: Hindustan Times, Jul 15, 2022*)