Appendix C. Semistructured Interview Questions (Interview Guide)

The Oregon Evidence-based Practice Center (EPC) was commissioned by the Agency for Healthcare Research and Quality (AHRQ) to develop a national research agenda in the area of Vaginal Birth after Cesarean (VBAC). We are particularly interested in identifying topics stakeholders struggle with in clinical decisionmaking and health policy.

This project builds on the Oregon EPC's 2010 evidence report on Vaginal Birth after Cesarean, which provided the evidence base for the NIH consensus conference on VBAC. Although the 2010 report identified pertinent research gaps related to clinical outcomes for mother and infant, we know little about the contextual and health care delivery system factors that influence decisionmaking about VBAC and repeat cesarean (see attached document for further details). In phase 1 of the project, we will conduct a series of interviews with key stakeholders - including medical liability and insurance company representatives, hospital administrators, consumer advocates, clinicians, patients and others – in order to brainstorm the range of nonmedical factors that might be influencing policy and practice on VBAC.

In phase 2 of the project we will assemble a panel of 9-10 stakeholders to prioritize the range of identified future research needs – including both the health care delivery system research needs identified in phase 1 and the maternal and infant health outcome research needs identified in the 2010 evidence report.

The 2010 report concluded that relatively unexamined contextual and health care delivery systems factors such as medical liability, economics, hospital structure, and staffing may need to be addressed in order to more appropriately prioritize topics for future research. In particular, we are looking for gaps in our knowledge related in the following areas:

1. Rates and patterns of utilization of trial of labor after prior cesarean, vaginal birth after cesarean, and repeat cesarean delivery in the United States?
2. Nonmedical factors (e.g. provider type, hospital type) that influence the patterns and utilization of trial of labor after prior cesarean?

We are especially interested in investigating what information sources are instrumental in making decisions about VBAC, the key barriers to offering TOLAC and what additional evidence is needed to facilitate the decision making process. Our ultimate goal is to uncover future research needs in the area, especially with regard to the non-medical drivers of policy and practice surrounding TOLAC and VBAC.

QUESTIONS FOR DISCUSSION

Legal/liability/policy/consumer advocate:

1. We are aware that people wear a number of hats….what perspective are you coming from during this interview? Consumer advocate? Patient? Clinician?
2. Can you give us a sense of your/your organization's perspective on TOLAC/VBAC? (official/unofficial policy?)
3. In your mind, what are the barriers to routinely offering TOLAC? (probes: institutional policy, institutional culture, availability of appropriate staff, liability, previous experience, experience of colleagues, patient preferences, preferences of patients family, other)

Institutional/policy factors?

4. Did the NIH consensus conference and new ACOG statement impact policy and practice surrounding VBAC? If yes, can you give me some specific examples? If no, why do you think this is?
5. In your mind, is there anything that would make VBAC an acceptable/preferred option in any hospital? ("game-changing" evidence, consideration of risk in future pregnancies, framing of evidence, new evidence)

Individual-level factors

6. What information sources do you think are most important in shaping womens' views on VBAC? (media, medical literature, colleagues, friends/family)
7. Does consideration of risks in future pregnancies come into the decision-making process?
8. Is there any information you can think of that would make the decision-making process easier (i.e. that would make you say you would definitely have a VBAC….or alternatively that you would definitely not)?
9. Is there anything that, in your mind, would make VBAC an acceptable/preferred option for any woman (assuming she didn't have other risk factors that necessitated a cesarean delivery)?
10. Of the factors we touched on today, what do you think is the most important in influencing policy and practice related to TOLAC and VBAC?

Providers:

1. What is your role in the hospital? Do you wear more than one hat? How long have you been in practice?
2. Do you do VBAC? (official or unofficial policy on VBAC)
3. How do you usually address VBAC in your practice? Timing of Discussions?
4. Do you have a specific VBAC consent? What about repeat section? Does consent address risks of repeat section for future pregnancies
5. How do you counsel women regarding TOLAC? How do you explain the risks and benefits to her and the baby? Do you discuss risk in future pregnancies (i.e. of repeat cesarean)?
6. Patience preferences? Why do women want a c-section? Do you or other providers push back? After doing first c-section, do you tak about VBAC? What about your partners?
7. Can you give me some specific examples of the barriers to offering TOLAC? (probes: institutional policy, institutional culture, availability of appropriate staff, liability, previous experience, experience of colleagues, patient preferences, preferences of patients family, other).

8. Did the NIH consensus conference and new ACOG statement impact policy and practice surrounding VBAC? If yes, can you give me some specific examples? If no, why do you think this is?
    a. (if don't offer VBAC) In order to support/offer VBAC, what would you need to know?
9. Is there anything about VBAC that you would like to know but haven't been able to find the answer to? If you had better evidence on VBAC what would it be?
10. Is there anything that, in your mind, would make VBAC an acceptable/preferred option in any hospital (assuming no other risk factors that necessitated a cesarean delivery)?
11. Of the factors we touched on today, what do you think is the most important in influencing policy and practice related to TOLAC and VBAC?

Patients:

1. Have you had a VBAC? Can you walk me through your decision-making process?
2. What are your perceptions of VBAC? What is your understanding of the risks and benefits of VBAC for both the mother and baby? What about risks of repeat cesarean?
3. What information sources are most important in shaping your views about VBAC? (friends, family, media, medical literature, Healthcare staff?, etc.)
4. When thinking about your own decision to have/not have a VBAC, what pieces of information are/were most important to you?
5. When thinking about your own decision to have/not have a VBAC, whose opinion do you most value?
6. Is there anything about VBAC that you would like to know but haven't been able to find the answer to?
7. Is there any information you can think of that would make the decision-making process easier (i.e. that would make you say you would definitely have a VBAC….or alternatively that you would definitely not)?
8. Is there anything that, in your mind, would make VBAC an acceptable/preferred option for any woman (assuming she didn't have other risk factors that necessitated a cesarean delivery)?
9. Of the factors we touched on today, what do you think is the most important in shaping your views and decision-making regarding TOLAC and VBAC?

For reference:
ACOG 2010 Practice Bulletin

a. *Because of the risks associated with TOLAC and that uterine rupture and other complications may be unpredictable, the College recommends that TOLAC be* ***undertaken in facilities with staff immediately available*** *to provide emergency care.*
b. *Respect for patient autonomy supports that patients* ***should be allowed to accept increased levels of risk****, however, patients should be clearly informed of such potential increase in risk and management alternatives.*
c. *The decision to offer and pursue TOLAC in a setting in which the option of immediate cesarean delivery is more limited should be carefully considered by patients and their health care providers. In such situations the best alternative may be to* ***refer patients to a facility with available resources****.*