Experience of Vaginal Birth After Cesarean: A Phenomenological Study

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ABSTRACT

The international literature concerning cesarean surgeries (CSs) make it clear that many of these procedures are unnecessary. Using a phenomenological methodology, we seek to understand the experiences and decisions of women who have undergone vaginal birth after cesarean (VBAC). Various factors contribute to the choice of VBAC. Making VBAC a more regular practice would contribute to a decrease in the total number of repeat CSs. The purpose of this study is threefold: (a) to understand the process that women use to select a VBAC rather than a repeat cesarean, (b) to understand the mothers' lived experience of that VBAC, and (c) to use the aforementioned data to inform the development of new educational programs for mothers considering VBAC.

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During the past three decades, the number of children born by cesarean surgery (CS) throughout the world has risen considerably (McGrath & Ray-Barruel, 2009). Italy has the highest number of CSs in the European Union and surpasses the United States and Canada (ISTAT, 2013). From 1980 to the present day, the percentage of CSs has more than tripled, from just over 11.2% in 1980 to about 36.3% in 2015 (ISTAT, 2015). The main reasons for this appear to be an increase in the average age of pregnancy and medical advances in relation to high-risk pregnancies (Terhaar, 2005).

Other factors have also affected this increase in CS procedures. Personal convictions, anthropological and cultural factors (Ridley, Davis, Bright, & Sinclair, 2002), the increasingly contested health culture (O'Boyle, Davis, & Calhoun, 2002), and/or medical recommendations were identified as influencing factors (Eden, Hashima, Osterweil, Nygren, & Guise, 2004; Shorten, Chamberlain, Shorten, & Kariminia, 2004; Weaver, Statham, & Richards, 2007). From a socio-cultural perspective, the erroneous conviction that CS can be a convenient alternative to vaginal delivery seems widespread (Arena,

2007). An important factor in the steady increase in CS is its repetition at the end of a second pregnancy (Cheng et al., 2011).

CSs are not, however, devoid of risks (Gilliam, 2006; Terhaar, 2005; Villar et al., 2007). Recently, the physical risks have been associated with adverse emotional consequences when compared to vaginal delivery (Barnes et al., 2007). Both the World Health Organization (WHO, 2015) and the Italian Government (Chamber of Deputies, 2015) have issued and are perfecting guidelines and suggestions for the appropriate use of CS. After a first CS, a second pregnancy should not automatically be concluded with a new CS, but with an attempt at vaginal delivery: vaginal birth after cesarean (VBAC). The method of VBAC has been shown to be generally safe (ACOG, 1999; Guise et al., 2010; Weaver, 2004), with proven physical and emotional benefits in the medium and long term for both mother and child (Fenwick, Gamble, & Hauck, 2007; Macones et al., 2005; Nilsson et al., 2015).

The success rate is high in women who have tried this method (Edozien, 2007; Landon et al., 2005). Despite this, the number of women with a past CS that conclude their second pregnancy with another CS is high in some European countries (EUROPERISTAT, 2013). These rates vary from approximately 30% in Ireland and Germany to 45%–50% in Finland, Sweden, and Holland (Euro-Peristat Project, 2004). In Italy, the rate of women who undergo VBAC is equal to 12% (ISTAT, 2013; The Ministry of Health, 2015).

International research initially focused on the clinical results of this method, offering little consideration to its psychosocial implications (McGrath & Ray-Barruel, 2009). Qualitative studies have investigated VBAC, focusing attention on the decision-making experiences of women who choose it (Goodall, McVittie, & Magill, 2009; McGrath, Phillips, & Vaughan, 2010a; Meddings, Phipps, Haith-Cooper, & Haigh, 2007; Moffat et al., 2007; Phillips, McGrath, & Vaughan, 2009; Ridley et al., 2002; Shorten, Shorten, & Kennedy, 2014). More specifically, the knowledge and expectations of women who chose VBAC have been investigated, as has the increasing influence of health providers on this choice (Goodall et al., 2009). Doctors, nurses, and midwives provide technical assistance, but also

have the delicate and important task of providing proper health education; informing patients about VBAC is part of this responsibility. The experiences of women for whom VBAC failed have been investigated as well (McGrath et al., 2010a).

Investigating the expectations, the knowledge, and the beliefs of women in relation to VBAC can assist professionals in planning and providing interventions to support a conscious choice. The Ottawa Decision Support Framework (ODSF) provides a structure, theory, and practice to develop interventions for supporting patients in their decision-making. It includes tools for the analysis of factors that contribute to conflicts in decision-making and aims to improve the quality of the decision-making process (O'Connor, Jacobsen & Stacey, 2002). To structure the tools to support decision-making and identify the decision-making needs surrounding VBAC, it is necessary to explore the lives of women who have experienced cesarean births before natural births.

Italy has not been among those countries that have investigated the lived experience of women undergoing VBAC. Understanding their experiences would allow them to become involved in the decision-making and care processes as required (Moffa et al., 2007). The knowledge they provide can also help to create health programs designed to reduce the rate of unnecessary cesareans. Therefore, the aim of this study is to understand the experience of women who gave birth with VBAC.

METHODS

A phenomenological methodology was chosen for the present study (Cohen, Kahn, & Steeves, 2000), combining aspects of descriptive phenomenology (Husserlian) and interpretative phenomenology (Gadamerian). This method promotes a deeper understanding of the phenomenon under study and the meaning that is attributed to it (McGrath et al., 2010b; Phillips et al., 2009). Suggested by Cohen:

Understanding patients' experiences may guide nurses to interact in ways that may differ from people who lack that understanding. The meanings that patients attribute to their experiences help create the needs they have and how these needs can best be met.
(p. 4)

Sampling

A purposeful sampling approach guided the selection of participants. This sampling was a logical

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consequence of the methodology used for conducting the study; because we wanted to understand the lived experience of women who have concluded a subsequent pregnancy VBAC, our sample included participants who had actually experienced VBAC.

The participants were women who satisfied the following criteria: aged over 18 years; Italian citizen; able to speak and understand the Italian language; unimpaired cognitive function; had experienced a CS; and had experienced a VBAC delivery which ended successfully and without complications (dehiscence of uterine scar, breakage of the uterus, cesarean emergency) within six weeks preceding the interview. Consent to participate in the study was acquired by guaranteeing anonymity and making clear that consent could be withdrawn at any time.

Data Collection and Analysis

Data collection was preceded by *bracketing*, a critical reflection that helps the researcher to be rigorous in analysis (Cohen et al., 2000). This technique allows the investigator to suspend his or her own ideas and prejudices concerning the phenomenon under study. All the researchers then wrote down their ideas and their own preconceptions concerning the rationale of the study before devoting themselves to it. In addition, the researchers who performed the interviews repeated this operation before each interview and then later. It was a difficult process for everyone, but it is used to avoid contamination during data analysis.

Each researcher also made use of a diary for field notes. All the interviews were carried out at the premises of each woman enrolled in the study after an appointment was made by telephone. All the women who agreed to participate chose their home as a place to conduct the interview. Each woman had given birth with the VBAC method without clinical complications within six weeks before our interview.

The main recruitment was made through purposeful sampling and occurred at an accredited hospital with the the Italian National Health Service (Servizio Sanitario Nazionale; SSN) that uses VBAC. Participating subjects willingly accepted participation. Only one refusal occurred without giving specific reasons. The researchers identified the possible participants within the structure. After acquiring an initial consent, the application for participation in the study was reformulated at the time of hospital discharge. Before the interview the participant was again asked if they desired to participate in the study.

In the context of each interview, the researcher maintained a friendly, reassuring attitude, without commenting on what the participants said. The interviews were conducted with a single open-ended question to allow the women full freedom of expression; the experiences of the participants thus became the focus of the research, and the possibility of the introduction of themes determined by the researchers was excluded (Polit & Beck, 2014).

Notes were made, both during and after each interview, relating to the setting, nonverbal communication, and personal reflections. The data reached saturation, that is the redundancy of the themes was extrapolated (Cohen et al., 2000), after 11 interviews. Each interview was audio-recorded and had an average duration of 15–20 minutes. The interviews were subsequently transcribed and integrated with field notes concerning such nonverbal elements as pauses, mimic expressions, smiles, and crying. All the interviews and their transcription and analysis were conducted in Italian. The interview was tested on two women whose data are not reported in this analysis to allow the investigators to become familiar with the methodology.

Analysis of the interviews was conducted by each researcher. In accordance with the methodology (Cohen et al., 2000), each researcher first reread the interviews and field notes to gain an overall view of the lived experience of the participants. This was followed by a close reading of the individual interviews to extract the meaning of the experience described. In this phase, passages deemed significant were highlighted and compared with those of the other interviews. The themes extrapolated from each interview were treated as objects for comparison among the various researchers. There was no disagreement about the themes extrapolated, confirmation was sought from the participants. All this analysis was conducted in Italian, the native language of the interviewed subjects and the researchers who conducted the interviews. To disseminate the results in the international field, however, all steps of the study

By accessing their living memory of this experience, the participants could describe in detail their feelings, externalizing the emotions experienced at the moment of the birth, the perception of the assistance they were provided, and the psychological support they received.

TABLE 1

Socio-Demographic and Clinical Characteristics of the Sample

Code	Initial	Age	Education	N° SON	N° CS HAD	Previous Years from Birth
01	AZ	26	High school	2	1	2
02	BV	32	Degree	2	1	2
03	CU	35	Middle school	3	1	5
04	DT	32	Degree	2	1	2
05	ES	37	High school	3	2	2
06	FR	34	Degree	2	1	3
07	GQ	30	High school	2	1	2
08	HP	30	Middle school	2	1	3
09	IO	33	Middle school	2	1	4
10	JN	35	Degree	2	1	1
11	KM	30	High school	2	1	1

have been translated into English with the help of professional editors.

Privacy Notice and Consent

The participants signed the consent form after having received all the information about the study, how it was to be conducted, and other finalities. Consent was granted for the duration of the study, with participants assured of complete anonymity and the opportunity to withdraw from the study at any time, in which case all related data would be destroyed. This study was performed in full compliance with the Declaration of Helsinki.

RESULTS

The average age of the participants was 32.18 years (range 26–37). Their level of education was medium-high. More specifically, four participants appeared to have earned a high school diploma, and four a post-secondary degree. Most participants had two children and had experienced a CS in the past. The time elapsed between the pregnancy that ended with VBAC and the previous pregnancy was on average 2 years and 8 months (range 1–5 years) (Table 1).

From the analysis of interviews and field notes, five main themes were identified: description of previous experience, desire for naturalness, poor information, vivid memories of VBAC, the perception of assistance, and psychological support received. Five sub-themes were identified as well: unexpected problems in postoperative care, autonomous research of

information, prejudices, experience of pain, and the moment of birth (Table 2).

Description of Previous Experience

Almost all the participants spontaneously described the experience of the CS that had preceded the VBAC. Every single interview began by describing the previous CS, a sign that this method leaves a strong mark in the minds of the subjects. Despite the passage of years, the experience was often described negatively, as reported by one participant (11KM): “I don’t have a beautiful memory of that day, though the birth of a child should be associated only with pleasant memories.” What was expressed most strongly by the women interviewed was regret and sadness at not being able to fully enjoy the birth of a child. Warmth and love were replaced by feelings of coldness that made that moment something “mechanical.” As one participant (09IO) reported:

Well! The first birth for a woman . . . you imagine that you’ll be doing what nature calls for and . . . just the fact of having to enter an operating room . . . it’s a cold sensation and . . . then you’re not really experiencing the birth of your son . . . Birth should be the most beautiful thing in the world!

Unexpected Problems in Postoperative Care. The normal sequelae of a surgical operation, that is CS, were often unexpected or underestimated by our sample. Women complained of problems they did not expect but that are common for this type of intervention; one participant (01AZ) recalled: “I was immobilized in the bed, with pain and discomfort and various . . . pains that continued even after . . . [touches her abdomen, probably at the point where the scar is, with one hand].” Another woman

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TABLE 2

Main Themes and Related Subthemes

Themes	Subthemes
1. Description of previous experience	1.1 Unexpected problems in postoperative care
2. Desire for naturalness	
3. Poor information	3.1 Autonomous research of information 3.2 Prejudices
4. Vivid memory of VBAC	4.1 Experience of pain 4.2 Moment of birth
5. The perception of assistance, and psychological support received	

Note. VBAC = vaginal birth after cesarean.

(02 BV) remembered: “I had pains, nausea . . . I was in bed and I could not move on my own . . . The recovery was hard and perhaps slower than what I’d thought.”

A lack of autonomy is one of the problems the women highlighted. It contributed to increased emotional distress that added to the difficulty of the recovery. According to one participant (06FR):

I couldn't do anything on my own, I was not autonomous, I had pain . . . for the medical people this seemed normal, but for me it wasn't. I could not go see my daughter in the nursery, and when she was in the room with me I needed someone to help . . . This saddened me a lot and perhaps even today . . . I feel as if I had not been immediately next to my son.

Desire for Naturalness

The desire for naturalness was crucial for the choice of VBAC. Wanting to feel like a mom “naturally” was for these women central to their choice of spontaneous birth over a further CS. One woman (10JN) said: “I feel like I did not have my son born . . . I mean, with cesarean technical birth . . . [gesticulates with hands] . . . is a little pain you test . . . is almost unnatural, you know? . . . I wanted to be a mother naturally.” Another woman (07GQ) said:

The memory of the smiles of mothers who had given birth naturally was vivid for me . . . Those images increased my sense of unease . . . I wasn't going to make the same mistake again . . . my son would have me near him just after birth, just as nature wants.

Poor Information

A common regret observed among the research participants was the lack of information they received about VBAC. The social conviction *cesareo ante, cesarean necesse est* seems to bewidespread and overbearing, including among health providers like nurses, doctors, and midwives. In fact, the regret expressed was also addressed to insiders, who were

often accused of giving information about the VBAC only on request and not always in an exhaustive way. One participant (11 KM) reflected on her request for information at the Local Health District (Azienda Sanitaria Locale; ASL): “When I asked about the VBAC they looked at me dazed . . . yet they must have been familiar with the VBAC method.” Another woman (06FR) recalled: “They took my second cesarean for granted . . . so it must be, I was told, and yet I was aware of friends who had had a vaginal delivery . . . but they seemed almost to discourage me.”

Autonomous Research of Information. After the news of a second pregnancy, our participants found there was a lack of information concerning VBAC. In response to this they independently sought out specific information and/or reference points. For almost all the participants, the Internet was the main source of information; as one participant (06FR) recalled: “So I had a look at a blog by women who talked about this experience, their difficulties, their emotions.” Another woman (09IO) remembered: “I contacted in private this online friend who recommended a professional pro-VBAC team; naturally, she specified that I had to rely on the professionals . . . Not all women can have a VBAC, but, still, it’s a possibility.”

Prejudices. In our study, the idea that a previous CS should necessarily be followed by another appeared to be a common one. This belief generates ingrained social prejudices that are difficult to combat; the women we interviewed found these convictions to be obstacles to free choice. One woman (09IO) recalled:

When I said that I wanted a natural birth at home, they thought I was crazy. My mother said that it wasn't possible, my husband feared for my health and that of the child [told with an ironic smile and wide-eyed, as if to emphasize the absurdity of the ideas of the members of his family].

Another woman (07GQ) said:

Initially they looked at me as if I was crazy, and if something had happened to me? . . . But I reminded them that even the cesarean is a surgical intervention—it is not without risks [With this, the woman's ironic smile fades, replaced by a serious expression as she touches her hands nervously] . . . Then they spoke with the team that would have followed me and they seemed to be reassured . . . but in my family some doubts still persisted.

Vivid Memories of VBAC

A vivid memory of the experience of VBAC is evident in all the interviews. Our participants described in detail the moments and emotions both before and after delivery. Important for these women was the sense of freedom and autonomy in immediately feeling physically ready to care for the child.

Despite the difficulties experienced by some interviewees, especially during the second stage of labor, it was important for the women to be able to feel active and share those moments with their partners, as evidenced by interviewee 10JN:

“As regards the experience of natural birth . . . it was a great experience . . . to be able to embrace her immediately, caress her, attach her to my breast, or at least to try [smiles] . . . take her in my arms by myself . . . so . . .”

The experiences of VBAC were described by the participants in great detail; these themes generated sub-themes such as the experience of pain and the moment of birth.

Experience of Pain. The sub-theme of pain was found to be common among the participants. Pain was labelled by some as an essential component of natural birth, as can be seen from the story of one participant (08HP): “The pain was . . . strong . . . However . . . we say . . . I do not say that I forget it but . . . I think it doesn't hurt.” She then added: “You know that it was strong, but the emotion of birth gives you power, so you would do it again.”

Women also spontaneously compared the pain experienced during VBAC with that experienced during the previous CS, as described by 10JN:

The pain of natural childbirth is very strong, but I don't know, nature is magical . . . I remember it now and it doesn't make me afraid . . . It is a pain of the moment that then almost disappears . . . while

the cesarean . . . well, if I think about that, sometimes I still feel pain in the wound [she touches her abdomen].

The Moment of Birth. All of the interviewed women described the moment of birth as the joy that rewards the fatigue and suffering of natural birth. The moment of birth is a vivid memory that seemed to allow the participants to forget the suffering necessary to complete the course of the birth. One woman (05ES) says: “It was really nice [a smile lights up her face] . . . suddenly I did not feel pain, discomfort . . . I had only joy . . . a sense of joy that repaid all the effort! . . . I wept, I was delighted.”

Another participant (11KM) told us: “Then . . . almost like in a fairy tale . . . from evil to good, from darkness to light . . . [closes her eyes and gesticulate with hands, excited to remember] . . . just a few instants and the pain disappeared . . . his weeping really made everything brighter.”

Perception of Assistance and Psychological Support Received

The perception of the assistance received during the experience of VBAC was generally positive. Health providers were seen as well-prepared and respectful of the choices made by the women.

The participants reported that professionals were present and always ready to offer psychological support. One woman (01AZ) told us: “They were always all there . . . they never made me feel alone . . . all ready with a word of comfort . . . encouragement.” The psychological support offered by staff who were confident in their actions was motivating. According to 05ER: “During labor I have to say I truly had no fear because I felt well-assisted . . . they were all there for me . . . ready . . . they were also smiling and witty . . . a little fun never hurts.”

DISCUSSION

The aim of the present work is to describe the lived experiences of women under going VBAC, by researching the motivations for their experiences. The themes described here emerged from a phenomenological analysis. They show how the participants experienced a previous CS and the unexpected problems in postoperative care that are common for this type of intervention.

The desire to discover the naturalness of childbirth was a decisive factor in the decision these women made to choose this mode of delivery.

The scarcity of information and social prejudices about the danger of VBAC did not discourage autonomous research for relevant information. By accessing their living memory of this experience, the participants could describe in detail their feelings, externalizing the emotions experienced at the moment of the birth, the perception of the assistance they were provided, and the psychological support they received.

In the literature, the spontaneous description of a past CS is very often associated with negative experiences. (Fenwick et al., 2007; Phillips et al., 2010). Although postoperative problems are common for this type of intervention, they are often unexpected or underestimated (RCOG, 2015; Shorten et al., 2014). In our study, as in the literature, the CS seems to violate women's expectations of motherhood (Fenwick et al., 2007); this is because women with a previous CS would like to avoid the recurrence of such an event (Weaver, 2004). In fact, this period is described in our study as hard, both physically and psychologically; all our interviewees complained about the lack of independence both in caring and breastfeeding the child and in the other areas of their lives, including caring for themselves.

From the literature, it emerges that the desire for naturalness is the primary reason for choosing VBAC (Meddings et al., 2007; Shorten et al., 2014). Giving birth naturally is a significant and important aspect of womanhood for many (Fenwick et al., 2007; Phillips et al., 2010). This naturalness is associated with improved attachment bonding and quick physical recovery, and it is also related to a lower rate of anesthetic drug use for both mother and newborn (Phillips et al., 2010). These findings also emerged in our sample.

That disinformation concerning VBAC is widespread, something our participants encountered, is also reported in the literature (Arena, 2007; Guarino et al., 2008; Phillips et al., 2010); so is the autonomous research of information (Mof-fat et al., 2007; Phillips et al., 2010; Shorten et al., 2014). However, the literature reports that the notions provided by health providers can influence the choice of VBAC (Goodall et al., 2009). The literature also revealed that there was a difficulty in understanding the information received, with much of it deemed to be statistical in nature (Lloyd, 2001), rather than the sort of practical information women sought out (Horey, Weaver, & Russell, 2004). In particular, the information about the possible risks of VBAC are well-known, yet they

do not represent a single element of evaluation for the women for this choice (Goodall et al., 2009). This could explain the autonomous research of information.

The Internet and its blogs have been the object of studies (Dahlen & Homer, 2013), and seem to be more than an alternative to the classic "groups of encounter and support." Women use blogs for debriefing on past experiences, to search for information to plan future births, and to get and give support to other women in similar situations (Goodall et al., 2009). The Internet and certain blogs are increasingly used as sources to meet the need for information. They are seen as places where one can gather information given freely and without taboos (Friedman & Calixte, 2009; Stadtman Tucker, 2009) while maintaining anonymity (Eastham, 2011).

The women in our sample complained that the people around them had negative preconceptions of VBAC. These ideas could be connected to social and cultural traditions and prejudices passed from one generation to the next. Information received from informal networks were found to have a greater impact on women waiting to decide upon VBAC (Fenwick, Hauck, & Downie, 2005). A family may push a woman to a repetition of the CS, believing that this is the best choice (Goodall et al., 2009). In recent years, excessive medicalization has produced in the collective imagination the need for continuous monitoring (Parry, 2008). Now pregnancy is seen not only as a physiological event, but also as a period of potential risk for the mother and the fetus (Mitchell, 2001; Woliver, 2002). The participants reported that they received the support of the family in the choice of VBAC only after overcoming the initial resistance linked to preconceptions rooted in their culture.

Vivid memories of VBAC are commonly reported in the literature (Meddings et al., 2007; Ridley et al., 2002). Our research participants gave particular focus to certain aspects of the experience, notably as pain and the moment of birth. The women interviewed about natural birth provided a precise description of pain and of the experience they lived at the moment of birth. These two aspects are those that are most emphasized by society as characteristics of spontaneous birth. The pain of childbirth is accepted as almost due (Rajan, 1993) precisely by virtue of its association with a normal physiological process (Walsh, 2012). Such pain is assessed differently than that presented in any pathology; here pain becomes an aspect of a tangible and fundamental

result: the birth of a child (Miller, 2007). The native culture influences the experience of labor of every woman (Backer, Choi, Henshaw, & Tree, 2005; Melzac, 1990).

The role played by health providers has also been assessed positively in previous studies (Moffat et al., 2007; Ridley et al., 2002). Yet in these studies, it is mainly the role of informants that is recognized. This study, however, suggests that health providers play an important role during childbirth; the relationship between women in labor and health providers positively influences the lived experience of those women (Hodnett, Gates, Hofmeyr, & Sakala, 2007; John, 2009).

The choice of VBAC is the result of the sum of many factors, including previous experiences, personal expectations, medical advice, and familial or social expectations (Gamble, Health, & Creedy, 2001; Hildingsson, Radestad, Rubertsson, & Waldenstrom, 2002; Shorten et al., 2004; Weaver et al., 2007). In such a significant moment, concern with the high rate of secondary CS is not considered essential; understanding the perspectives of women who want and choose a VBAC can encourage educational programs to support personal decision-making. An increased frequency of VBAC would decrease the total number of repeated CSs. Further studies relating to both the lived experience of women undergoing VBAC, investigating both the health providers and the families involved in this process, will certainly be useful for a better understanding of the subject. These studies could also contribute to the development of specific interventions that will enable women to make informed choices about their health that consider their values and individual preferences.

Limits

There are limitations to this study. Considering that a qualitative phenomenological study aims for the saturation of data rather than for a wide range of participants, the number of the sample is not a limitation, but the possibility that the sample does not adequately represent the population of interest is. There have been studies that consider how membership in an ethnic group can influence the attitude toward VBAC (Walker, Turnbull, & Wilkinson, 2004). The lack of variability (Moffat et al., 2007) in a sample group composed entirely of ethnically Italian women is one of the main limitations of this study. Secondly, it is known that women who use specific-pregnancy blogs to find information are generally well-educated

(Stadtman Tucker, 2009), limiting the generalizability of results. This is also characteristic of our sample, which has a middle-to-high level of education.

The data collected from the study offer an initial step in the development of instruments to support women in therapeutic decision-making. Narrative analysis can help women to consider the possible risks and also recognize their own values and preferences so that they become more involved in the decision-making process. Moreover, it improves communication between health providers and patients.

“What does this paper contribute to the wider global clinical community?”

Understanding the experience of vaginal delivery after cesarean will help:

- to create specific health programs designed to reduce the unnecessary cesarean rate;
- to provide proper holistic care;
- to allow health-care professionals to consciously and correctly address their role as educators;
- to guide the subjects in a proper decision-making process.

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DISCLOSURE

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