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What factors influence midwives' decision to perform or avoid episiotomies? A focus group study

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ABSTRACT

Objective: to explore midwives' reasons for performing or avoiding episiotomies and motivation to change episiotomy practice in a large tertiary maternity hospital.
Design: using purposive sampling, three focus groups were conducted to achieve theme saturation. Open-ended questions elicited personal reasons for performing or avoiding episiotomy, information sources, and opinions about past and future practice trends. Sessions were audiotaped, and transcripts independently examined by three researchers who coded for themes. An iterative process was used to achieve consensus. Grounded theory was used to interpret data and to derive a theoretical framework for understanding the reasoning that influences episiotomy practice.
Setting: a high volume delivery unit in Singapore.
Participants: 20 of 79 licensed midwives, aged 28–70, who performed independent deliveries at the delivery unit.
Findings: participants recognised maternal, fetal and other factors affecting their own decision to perform episiotomies. Patient request, better healing, midwife's reputation and job satisfaction were cited as main reasons to avoid episiotomy. Key sources informing practice were past training, delivery experience, anecdotal learning and lack of a protocol. There was no consensus on current trends in episiotomy practice. There was an absence of recognition of individual roles in reducing episiotomy rates. Clinicians were perceived as having both positive and negative influence.
Conclusions: midwives' reasons for performing episiotomies were attributed to midwifery training, fear of doing harm and perceived clinician expectation, and were not consistent with current international practice guidelines. Reasons for avoiding episiotomies were associated with patient-centeredness and job satisfaction. Midwives agreed on the need to reduce episiotomy rates.
Implications for practice: with reduction in episiotomy rates as a goal, a combination of guideline education, feedback, peer coaching and collaborative care with doctors may be needed to achieve desired outcomes. Views and experiences of midwives should also be incorporated into strategies to change episiotomy practice.

Introduction

Recent studies have shown that episiotomy does not serve its putative benefits of preventing pelvic floor damage and incontinence. Rather, the procedure increases the risk of severe perineal tear, need for suturing, wound complications and impaired sexual function (Hartmann et al., 2005; Viswanathan et al., 2005; Carroli and Mignini, 2009). Reported rates of episiotomy for both multiparous and primiparous women vary widely worldwide, from 9% to over 90% (Graham et al., 2005), despite increasingly compelling evidence and national practice guideline recommendations to minimise use of the procedure (World Health Organization, 1985; American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, 1997; National Institute for Health and Clinical

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Excellence, 2007; Munro and Jokinen, 2008). A reduction in use of episiotomy among primiparous and multiparous women is associated with benefits of improved healing, less pain and faster recovery post partum (National Institute for Health and Clinical Excellence, 2007; Munro and Jokinen, 2008), with secondary benefits of improved maternal–infant bonding and restoration of normal sexual function (Hartmann et al., 2005; Viswanathan et al., 2005; Carroli and Mignini, 2009). Despite recommendations to limit the use of episiotomies dating back to 1984 (Sleep et al., 1984), from both the midwifery and the obstetric literature (World Health Organization, 1985; American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, 1997; National Institute for Health and Clinical Excellence, 2007; Munro and Jokinen, 2008), use of this procedure continue to be high and variable (Graham et al., 2005). Some delivery practices, such as 'hands on', compared with 'hands poised' for perineal guarding have been shown to be associated with higher rates of episiotomy (McCandlish et al., 1998; Trochez et al., 2011); and provider experience, beliefs and training are other potential factors that may influence episiotomy rates (Hartmann et al., 2005). Thus a combination of clinical, experiential and personal factors may influence individual provider decision to perform episiotomies. An understanding of factors underlying this decision-making process will inform future strategies to change provider practice using motivational and other learning theories, hence aligning episiotomy practice in delivery units to current accepted practice guidelines.

Surveys of providers and audits of delivery unit records allow documentation of existing practice but fail to capture underlying reasons for this practice; thus they provide limited insights for designing effective educational programs to change practice behaviour. Anthropological approaches such as direct observation of practice, in this case, of deliveries, complemented by interviews of providers, may provide insight into motivations and reasoning underlying the decision to perform an episiotomy. However, such approaches are time-consuming and may be constrained by limited access of researchers to the delivery unit, providers and patients.

We therefore designed a focus group study to explore midwives' reasons for performing or avoiding episiotomies at a particular hospital in Singapore with a high documented midwife-performed episiotomy rate, especially in primiparous women (more than 90%) (Kok et al., 2004). The purpose of focus groups is to elicit group opinions on issues of common interest, using peer identity to encourage expression of common beliefs and to understand the degree of consensus or controversy around the issues or questions. The focus group approach, which has the advantage of engaging providers and allows construction of a framework (Kitzinger, 1995; Morgan, 1997), is useful for understanding the practice of episiotomy from the provider perspective. The goal of the current study was to elucidate reasons and motivations underlying decisions to perform episiotomies in order to design effective educational strategies and protocols for lowering the rates, and to potentially set a benchmark for appropriate episiotomy practice. Our research question was: what factors influence the decision to perform or avoid episiotomies among practicing midwives? We hypothesised that both midwifery training and peer influence would be among core factors influencing episiotomy practice.

Methods

Setting

Singapore is a developed island nation in Southeast Asia, with a population of 5.13 million (Department of Statistics Singapore, 2007). KK Women's and Children's Hospital (KKH) is a high volume delivery unit in Singapore with more than 12,000 deliveries per year. Twenty two per cent of deliveries are performed independently by midwives (for a total of approximately 3000 midwife deliveries per year) and 78% by doctors. In Singapore, women whose medical fees are subsidised by the government are delivered by midwives in the delivery suite, whereas women who are not subsidised are delivered by the obstetricians. Midwives perform independent deliveries and they only pass the decision-making for 'their' deliveries to the doctors in the event that the deliveries require instrumental-assistance or emergent caesarean section. Episiotomies are performed by midwives attending their deliveries but repairs are usually performed by attending obstetricians or residents. Over a period of one month in October 2011, the rate of episiotomy among midwives (236 deliveries performed by midwives in this period) was noted by chart review to be 88.7% for primiparous women and 26.1% for multiparous women, with an overall rate of 44.9% (Wu, 2011).

Study participants

Three focus groups ($n=6$, 6 and 8 respectively) were conducted over four weeks with 20–79 midwives from the delivery unit. Participants were trained, licensed English-speaking midwives employed full-time at the delivery unit who volunteered to take part in the focus group study between October and November 2011. They 'apply their professional knowledge and skills competently within their defined scope of practice, demonstrating professional conduct and practice according to the standards of nursing practice', as determined by the Singapore Nursing Board (Singapore Nursing Board, 2011a). Their primary duty is to ensure safe, competent and ethical care of women (Singapore Nursing Board, 2011b).

Focus group method

The number of participants and focus groups is defined by availability, group size and composition, and theme saturation. We used purposive sampling to reach a sample representative of the population of midwives, by age, ethnicity and years of experience, performing deliveries at the unit. The goal was to be inclusive of a wide range of views, cultural and training background and not to introduce bias due to self-selection and unforeseen factors such as work schedules. Participants were recruited through invitation from the unit's lead midwife and scheduled for focus groups according to convenience related to their work schedule. Recruitment was terminated when theme saturation was reached. Consistent with focus group methodology (Strauss, 1998; Brown, 1999), we (WLC, DL, RM) first constructed semi-structured, open-ended questions addressing the domains pertinent to the research question using a literature review. Through a process of discussion with key stakeholders (midwives and obstetricians) and piloting with lead midwives (JT, HSJ), the questions were refined, rephrased or re-ordered. The final question key comprised four main domains of inquiry asking about reasons for performing episiotomy, reasons for avoiding episiotomy, sources of information influencing episiotomy practice and views about trends in episiotomy practice (Table 1).

The focus groups were conducted in English using a prepared script with the question key, and were audiotaped with participants identified only by letters. One researcher (WLC) moderated all the focus groups. Focus group transcripts were typed, distributed electronically to two other researchers (DL and RM), and independently coded for dominant themes (by WLC, DL and RM). Each coder derived themes according to the four domains of inquiry. Each coder also produced a typed document listing the themes (and subthemes) identified for each domain. The group