Midwifery 30 (2014) 817–824

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Professional attitudes towards normal childbirth in a shared care unit

María del Rosario Ruiz, RN, RM, MSc (Postmaster Researcher, Universitat Autònoma de Barcelona)[a], Joaquín T. Limonero, Psy, PhD (Professor of Health Education)[b,*]

[a] *Delivery Ward, Sabadell Hospital, Barcelona, Spain*
[b] *Stress and Health Research Group (GIES), Faculty of Psychology, Universitat Autònoma de Barcelona, Campus Universitari s/n, 08193 Bellaterra (Cerdanyola del Vallès), Barcelona, Spain*

ARTICLE INFO

Article history:
Received 22 March 2013
Received in revised form
11 June 2013
Accepted 1 July 2013

Keywords:
Normal childbirth
Midwifery
Professional attitudes
Shared care model

ABSTRACT

Objective: to identify and compare obstetricians', midwives' and, assistant personnel's attitudes towards Clinical Practice Guidelines (CPG) for normal birth of The National Health System.
Design: quantitative methodology using a self-completed questionnaire regarding the recommendations of the CPG for normal birth with two five-point Likert scales that measured the degree of agreement and the level of applicability.
Setting: a Labour Ward: Catalonia, Spain.
Participants: a total sample of 96 professionals (obstetricians=32, midwives=44 and assistant personnel=20) answered the questionnaire.
Findings: midwives and obstetricians often have significantly divergent levels of agreement on key recommendations. Assistant personnel have more similar opinions to midwives', even though they are a more diverse group. Midwives are more in line with the recommendations of CPG for normal birth than obstetricians and assistant personnel. Concerning the applicability, obstetricians showed greater degree of applicability, followed by the other two groups.
Conclusions: given that there is divergence in opinion on agreement and applicability between professional groups it is necessary to identify areas of accordance, disagreement or ambiguity of knowledge and practice among all care providers, so that midwives can facilitate normal childbirth in a shared-model unit.

© 2013 Elsevier Ltd. All rights reserved.

Introduction

Normalisation of childbirth

Childbirth can be an empowering and fulfilling experience for women, the results of which may have physical and psychological consequences for the rest of their lives (Montes-Muñoz, 2007). In the last few decades, the progress in obstetrics has implied an increase in the use of technology and therefore an excessive medicalisation of pregnancy and birth, in most developed countries (Davis-Floyd, 1994; Hodnett et al., 2011). Evidence based medicine demonstrates that the misuse of technology in childbirth, far from increasing safety, promotes bad practice and increases the caesarean and instrumental childbirth rates. It also interferes with the bonding process between the mother and the infant (Wagner, 2001).

There is strong evidence supporting the benefits of a non-interventional approach for normal childbirth. The World Health Organization (WHO, 1999) and the National Institute for Health and Clinical Excellence (NICE, 2008) guidelines are two of the many international associations which have supported and promoted non-interventional practices in childbirth.

In the last few years the process of normalising childbirth has been disseminated in Spain. The Ministry of Health (2008) stated '*Although delivery care in our National Health System (NHS) is developed with safety and quality standards similar to those of neighbouring countries, there is a general feeling of need for improvement in other aspects related to warmth, participation and involvement of women in their labour process*' (Ministry of Health, 2008, p. 12).

Therefore, following the international recommendations and listening to a small but growing group of women and couples, who were asking not only for a more physiological option of giving birth, but also to take part actively in their labour process, the Government of Spain and official associations had to update their protocols and guidelines: the Working group for the Clinical Practice Guidelines for normal birth - Grupo de trabajo de la

* Corresponding author.
E-mail address: joaquin.limonero@uab.cat (J.T. Limonero).

0266-6138/$ - see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.midw.2013.07.003

Guía de Práctica Clínica sobre atención al parto normal (2010) the Department of Health of Catalonia (2007), the Spanish Society of Gynaecology and Obstetric (Sociedad Española de Obstetricia y Ginecología) (2003), the Federación de Asociaciones Españolas de Matronas (Spanish Federation of Midwifery Association, 2007) among others.

The Clinical Practice Guidelines (CPG) for normal birth of the NHS provided a series of evidence based recommendations in order to offer more efficient and safe care to women in labour. They were based on the most updated and rigorous information for shared decision making between professionals and women. It was a key element to support for improvement of the initiatives and strategic plans that started taking place in Spain.

The CPG defined normal childbirth as '*spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition*' (Working group for the Clinical Practice Guidelines for normal birth, 2010, p.37).

Its recommendations were aimed at low risk pregnant women (who have not presented any disease or complication during pregnancy), but the application framework could also be extended to women who would have had problems during their pregnancy but whose childbirth would have a normal progress.

The CPG were based on the principles that birth is a natural process, woman-centred, and medical intervention needs to be reduced to a minimum and always with previous justification. The midwife has been appointed as the most appropriate caregiver for normal birth.

Birth in Spain

Seventy eight per cent of births are carried out in public hospitals. Statistics regarding level of interventions tend to be considerably better in the public hospitals than in the private clinics (22% caesareans, as opposed to 33.8% in the private sector). The changing attitude to childbirth is also more apparent in the public sector, where many midwives are pushing for a more respectful and less standardised approach. Twenty one per cent of births are carried out in private clinics. Home birth is not covered by the public health system in Spain (Ministerio de Sanidad y Política Social, 2009).

Birth in Catalonia

In 2011 there were a total of 79.820 births in Catalonia. The normal vaginal childbirth rate was 59.2%, c-section rate was 28.5% (23.9% public hospital versus 39.3% private clinic), ventous childbirth rate was 3.8%, forceps childbirth rate was 8.2% and breech childbirth rate was 0.3%. The c-section rate from 2005 and 2011 has been maintained between 28.9% and 28.5% (Generalitat de Catalunya, 2011).

The strategic plan for improving normal childbirth has been implemented progressively from two hospitals in 2006 up to 26 public hospitals in 2011. The total number of normal births was 600 in 2006 and 4752 in 2011 from the hospitals where the strategic plan had been implemented (Generalitat de Catalunya, 2011).

The percentage of births among women aged over 34 years continues to increase and stood at 31.8% in 2011. In the last decade, this percentage has increased by 50.7%. In Catalonia, nearly one in three women giving birth was more than 34 years old (Generalitat de Catalunya, 2011).

Shared care model

The WHO in 1999 stated that the midwife was the most appropriate caregiver for women in normal birth. The midwife is the professional whose philosophy is based on women-centred care. She has the knowledge that childbirth is a normal process of a woman's body, which requires expectant atmosphere and accompaniment to monitor progress and to encourage women. She is the expert of normality (ICM, 2008) and is also capable of identifying complications that occasionally could arise. Nearly 85–90% of women have the ability to give birth safely without outside help, without jeopardising the safety of the process (WHO, 1999). The Birthplace in England Collaborative Group (2011) with a sample of 64,538 women comparing intrapartum and early neonatal morbidities for births planned at home, in freestanding midwifery units, and in midwife led units on a hospital site with an obstetric unit with births planned in obstetric units, demonstrated that intervention during labour and birth is much less common for births in non-obstetric units and that adverse perinatal outcomes are uncommon in all settings.

However, there are big variations in the organisation of maternity services. In some countries doctors are the primary care providers whereas in other countries several combinations of midwife-led, medical-led and shared care models are available (Hatem et al., 2008). Previous studies comparing midwife-led models of care with other models of care (obstetrician-provided care, family doctor-provided care and shared models of care) for childbearing women and their infants demonstrated that midwife-led care confers benefits and therefore is recommended. The main benefits were a reduction of oxytocin use and episiotomy, reduction in the use of regional analgesia, more use of alternative positions for women to give birth, higher number of normal childbirths, best rate of breast feeding and greater maternal satisfaction, and all, without a detectable negative increase in perinatal outcomes (Bodner-Adler et al., 2004; Walton et al., 2005; Hatem et al., 2008; Overgaard et al., 2011). Reime et al. (2004) in their study conducted in a Canadian province, explored professionals' attitudes, beliefs and practices towards maternity care. They showed that obstetricians were the group the most attached to technology and intervention, whereas midwives the least.

According to previous studies, attempting to normalise birth in Spain may not be a smooth process, as midwives work under supervision or close collaboration with obstetricians. For example, Corchs et al. (2006), on a sample of 18 maternity hospitals in Barcelona, showed how the professional autonomy of the midwife depends directly on the complexity of the hospital where they work. The more technology an institution had, the less autonomy the midwife possessed, sharing it with obstetricians. Other studies based on countries where the autonomy of the midwife is limited by the workplace or by the system: e.g., Japan (Behruzi et al., 2010), Ireland (Keating and Fleming, 2009), China (Qian et al., 2006), Brazil (Misago et al., 2001; Santos and Siebert, 2001) Belgium (Van Kelst et al., 2013) or Norway (Blaaka and Schauer, 2008), showed that the unequal relationship between obstetricians and midwives was a source of obstacles to the process of humanisation of childbirth. Midwives do not have full autonomy and therefore, they do not practice as they wish. They find themselves between women and policies, between active and physiological management of labour and between the biomedical and natural ideologies. As shown by Hunter (2004), this conflict is a source of frustration, anxiety and anger. According to McCool et al. (2012), the strongest barrier for midwives in promoting evidence-based practice across nations was resistance to change on the part of their colleagues, particularly obstetricians.

On the other hand, the same studies point to another source of barrier: already from their training midwives are engaged in

Download English Version:

https://daneshyari.com/en/article/1084705

Download Persian Version:

https://daneshyari.com/article/1084705

Daneshyari.com