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Now is the chance: Patient–provider communication about unplanned pregnancy during the first prenatal visit

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ABSTRACT

Objective: Unplanned pregnancy is associated with psychosocial stress, post-partum depression, and future unplanned pregnancies. Our study describes how topics related to unplanned pregnancy were addressed with patients during the first prenatal visit.
Methods: We audio-recorded and transcribed initial prenatal visits between 48 patients and 16 providers from a clinic serving racially diverse, lower-socio-economic patients. We conducted a fine-grained thematic analysis of cases in which the patient's pregnancy was unplanned.
Results: Of the 48 patients, 35 (73%) had unplanned pregnancies. Twenty-nine visits for unplanned pregnancies (83%) included discussion of the patient's feelings about the pregnancy. Approximately half (51%) of the visits touched on partner or other types of social support. Six patients (17%) were offered referrals to counseling or social services. Only four visits (11%) touched on future birth control options.
Conclusion: Most initial prenatal visits for unplanned pregnancies included discussion of patient feelings about the pregnancy. However, opportunities to discuss future birth control and for more in-depth follow-up regarding social support and psychological risks associated with unplanned pregnancy were typically missed.
Practice implications: Obstetrics care providers should be cautious about making assumptions and should consider discussing pregnancy circumstances and psychosocial issues in more depth when treating patients facing unplanned pregnancy.

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1. Introduction

Nearly half of the pregnancies in the United States each year are unplanned, being either unwanted or mistimed [1,2]. Forty-four percent of unplanned pregnancies end in birth, 42% in abortion, and 14% in fetal loss [1].

Research indicates that unplanned pregnancy (UPP) is a risk factor for a range of psychosocial problems. Studies have found an association between UPP and depression and depressive symptoms both during and after pregnancy, including post-partum depression [3–9]. UPP is also associated with an increased risk of maternal anxiety during pregnancy and after birth [8]. Women with UPPs report more exposure to stressors and lower overall life satisfaction than women with planned pregnancies, and they tend to have less support from the father of the baby [3]. They are also at risk for difficulties with their contraception [10]. It is "difficult if not impossible" to demonstrate a causal link between UPP and negative maternal health outcomes [8], and not all women with a UPP will find themselves with psychosocial difficulties. Still, UPP brings women who may be particularly vulnerable to psychosocial problems into the care of a clinician.

The American College of Obstetricians and Gynecologists (ACOG) recommends conducting psychosocial evaluation for all women [11] and helping women manage psychosocial stressors "as part of comprehensive care for women" [12]. In its 2006 Committee Opinion "Psychosocial Risk Factors: Perinatal Screen-

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ing and Intervention," ACOG recommends in-depth psychosocial screening for all women seeking prenatal care [12]. Some elements of the recommendations include screening for depression, stress, psychosocial support, and pregnancy intention. This is in-line with research that suggests that the identification of health risks for post-partum depression during prenatal visits should consider pregnancy intention and how it relates to stressors, social support, and symptoms of depression [2]. The ACOG recommendations also include follow-up after the screening in order to identify areas of concern, give the patient information, and suggest possible changes if indicated [12]. Patients should also be counseled about the full range of pregnancy options, including adoption and abortion, if a pregnancy remains unwanted [12]. ACOG emphasizes that an effective referral system can help augment "the screening and brief intervention that can be carried out in an office setting" [12].

The first prenatal visit, which is the most in-depth, provides a key opportunity for communication between a woman and her provider. It gives providers an opportunity to learn about the context of the patient's pregnancy and about the patient's psychosocial environment, as well as to provide support and offer necessary referrals. Given the opportunity that arises for communication, we investigated the discussions that occur during this visit. While ACOG recommendations for psychosocial screening apply to all women seeking prenatal care, due to their increased vulnerability we focused our analysis on appointments with patients who indicated that the pregnancy was unplanned.

2. Methods

Drawing on data from a larger study of patient–provider communication during the first prenatal visit [13], we analyzed discussions about pregnancy options, birth control options, and psychosocial issues related to unplanned pregnancy at first prenatal visits. The University of Pittsburgh Institutional Review Board (IRB) approved this study. All patient and provider participants provided written informed consent for audio-recording, transcription, and qualitative analysis of their visits.

2.1. Setting and participants

We conducted this study at a hospital-based obstetrics and gynecology clinic at an urban academic medical center in Pittsburgh, Pennsylvania. The clinic primarily serves young, lower-income women, 55% of whom are African-American and over 90% of whom are on medical assistance. We recruited clinic health care providers and patients to participate in the study. Eligible provider participants were obstetrics and gynecology resident physicians, nurse practitioners, and nurse midwives who saw patients for initial prenatal visits at the clinic. Eligible patient participants were English-speaking pregnant adults presenting for a first prenatal visit with an obstetrics care provider who was enrolled in the study.

2.2. Data collection

We collected information about each provider participant's gender, race, and training level for resident physicians and years of practice for nurse practitioners and nurse midwives. From each patient participant, we collected information on age, parity, race/ethnicity, and marital status. Each patient's first prenatal visit was audio-recorded, de-identified, and transcribed verbatim. We conducted qualitative analysis of the transcripts and used ATLAS.ti 5.2 (Scientific Software, Berlin, Germany) to organize and manage our data.

Table 1
Number of cases touching on issues related to unplanned pregnancy ($N = 35$).

Issue	Number of cases	Percentage of cases
Patient feelings	29	83
Partner support	18	51
Decision	8	23
Other support	7	20
Referral	6	17
Future contraception	4	11

2.3. Qualitative approach

Using the "editing" approach to qualitative analysis developed by Crabtree and Miller [14], we analyzed discussions about pregnancy intention from patient visits. Consistent with the "editing" approach, we developed a code designed to identify cases of UPP. Two study investigators applied this code to each of the 48 transcripts, coding for presence or absence of a UPP. We considered a pregnancy unplanned if there was some discussion during the appointment about pregnancy intention, and the patient did not state without ambiguity that the pregnancy had been planned.

As the aim of our analysis was to describe communication in the context of an unplanned pregnancy and not to identify patient outcomes, we used a broad definition of UPP that incorporates mistimed pregnancies, unwanted pregnancies, and pregnancies with ambiguous intention, all of which are associated with elevated psychosocial risk [3,6].

After two investigators identified cases of UPP, a single investigator conducted a fine-grained thematic analysis of discussions in those visits about psychosocial issues related to UPP. The investigator used an iterative process arising from the "editing" approach [15,16] to develop a codebook of relevant topics. Each of the topics that emerged was given its own code, as listed in Table 1. The investigator used the codebook to analyze visits involving UPPs, applying a code to the verbatim transcript if the topic was touched on at least one time during the clinic visit. We conducted all coding using ATLAS.ti 5.2 qualitative data analysis software.

3. Results

3.1. Patient and provider participants

Fifty-one patients participated in this study with 16 different provider participants conducting the initial prenatal visits. If audio recording ended before a patient's physical exam was completed, due to technical malfunction or any other reason, we excluded that patient's data from this analysis as incomplete. We excluded three appointments as incomplete, leaving data from 48 patients seen by 16 providers. Thirty-five of 48 (73%) patients' pregnancies were unplanned. Patient and provider sociodemographic characteristics were similar for the 48 complete appointments and the 35 cases of UPP. They are presented in Table 2.

The 35 patients with a UPP ranged in age from 18 to 36 years old, with a mean age of 24 years. Twenty (57%) were African-American and all others (15; 43%) were white. Thirty-one (89%) were single, and 20 (57%) had given birth in the past. All 13 obstetric care providers who saw these patients were white and female. Eight (62%) were obstetrics and gynecology resident physicians, 3 (23%) were nurse midwives, and 2 (15%) were nurse practitioners. One nurse practitioner saw 20 patients with UPPs, while others saw 1–2 each.

3.2. Coding

While the discussions were limited, patient–provider communication about pregnancy intention pivoted on six main topics in