Birth Technology and Maternal Roles in Birth: Knowledge and Attitudes of Canadian Women Approaching Childbirth for the First Time

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ABSTRACT

Objective: To describe Canadian nulliparous women's attitudes to birth technology and their roles in childbirth.

Methods: A large convenience sample of low-risk women expecting their first birth was recruited by posters in laboratories, at the offices of obstetricians, family physicians, and midwives, at prenatal classes, and through web-based advertising and invited to complete a paper or web-based questionnaire.

Results: Of the 1318 women completing the questionnaire, 95% did so via the web-based method; 13.2% of respondents were in the first trimester, 39.8% were in the second trimester, and 47.0% in the third. Overall, 42.6% were under the care of an obstetrician, 29.3% a family physician, and 28.1% a registered midwife. The sample included mainly well-educated, middle-class women. The planned place of giving birth ranged from home to hospital, and from rural centres to large city hospitals. Eighteen percent planned to engage a doula. Women attending obstetricians reported attitudes more favourable to the use of birth technology and less supportive of women's roles in their own delivery, regardless of the trimester in which the survey was completed. Those women attending midwives reported attitudes less favourable to the use of technology at delivery and more supportive of women's roles. Family practice patients' opinions fell between the other two groups. For eight of the questions, "I don't know" (IDK) responses exceeded 15%. These IDK responses were most frequent for questions regarding risks and benefits of epidural analgesia, Caesarean section, and episiotomy. Women in the care of midwives consistently used IDK options less frequently than those cared for by physicians.

Conclusions: Regardless of the type of care provider they attended, many women reported uncertainty about the benefits and risks of common procedures used at childbirth. When grouped by the type of care provider, in all trimesters, women held different views across a range of childbirth issues, suggesting that the three groups of providers were caring for different populations with different attitudes and expectations.

Key Words: Labour, obstetric, natural childbirth, attitudes of health personnel, Caesarean section, evidence-based medicine, epidural, midwifery, home birth, episiotomy

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Résumé

Objectif : Décrire les attitudes des nullipares canadiennes envers la technologie liée à l'accouchement et leurs rôles pendant ce dernier.

Méthodes : La participation d'un important échantillon de commodité de femmes n'étant exposées qu'à de faibles risques et se préparant à leur premier accouchement a été sollicitée au moyen d'affiches apposées dans des laboratoires, dans les bureaux d'obstétriciens, de médecins de famille et de sages-femmes, et dans les locaux de cours prénataux, ainsi que par l'intermédiaire de publicités Web. Ces femmes ont par la suite été invitées à remplir un questionnaire en version papier ou électronique (Web).

Résultats : Parmi les 1 318 femmes qui ont rempli le questionnaire, 95 % l'ont fait sur le Web; 13,2 % des répondantes en étaient au premier trimestre, 39,8 % en étaient au deuxième trimestre et 47,0 % en étaient au troisième trimestre. De façon globale, 42,6 % des répondantes recevaient les soins d'un obstétricien; 29,3 %, ceux d'un médecin de famille; et 28,1 %, ceux d'une sage-femme autorisée. L'échantillon comptait principalement des femmes de classe moyenne et disposant d'un bon niveau de scolarité. Le lieu prévu pour l'accouchement allait du domicile à l'hôpital, ainsi que des centres ruraux aux hôpitaux de grande ville. Dix-huit pour cent des répondantes prévoyaient retenir les services d'une doula. Les femmes recevant les soins d'un obstétricien ont signalé des attitudes plus favorables envers le recours à la technologie liée à l'accouchement et moins favorables aux rôles des femmes dans leur propre accouchement, et ce, peu importe le trimestre au cours duquel elles se trouvaient au moment de remplir le questionnaire. Les femmes recevant les soins d'une sage-femme ont signalé des attitudes moins favorables au recours à la technologie au moment de l'accouchement et plus favorables aux rôles des femmes. Les opinions des femmes recevant les soins d'un médecin de famille se situaient entre celles des deux autres groupes. Pour huit des questions, la proportion des réponses « Je ne sais pas » (JSP) dépassait 15 %. Ces réponses JSP atteignaient leur fréquence maximale pour ce qui est des questions au sujet des risques et des avantages de l'analgésie péridurale, de la césarienne et de l'épisiotomie. Les femmes recevant les soins d'une sage-femme ont uniformément eu recours aux options JSP moins fréquemment que les femmes recevant les soins d'un médecin.

Conclusions : Peu importe le type de fournisseur de soins auquel elles avaient recours, bon nombre de femmes ont signalé une incertitude au sujet des avantages et des risques liés aux interventions couramment utilisées pendant l'accouchement. Lorsqu'elles étaient groupées par type de fournisseur de soins, tous trimestres confondus, les femmes avaient des opinions différentes pour ce qui est d'une gamme de questions liées à l'accouchement, ce qui laisse entendre que les trois groupes de fournisseurs de soins offraient leurs services à des populations différentes présentant des attitudes et des attentes différentes.

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INTRODUCTION

For a population of healthy women, the issue of choice in maternity care looms large. Expectant parents make choices about genetic counselling in pregnancy, management of labour pain, induction of labour, site for delivery (hospital, birth centre, or home), management of group B streptococcus colonization, and sometimes vaginal birth versus Caesarean section. Optimal choices are made within a context of informed choice or consent, in which the care provider gives women information prior to their making a decision, and women express their concerns, desires, and values to their provider. The information provided by the care providers should be based on the best available evidence. Our National Maternity Care Attitudes Survey[1] was undertaken to examine the attitudes and beliefs held by providers of maternity care and women approaching their first delivery. In the care provider portion of the survey,[1] we found that many obstetricians, family physicians, maternity nurses, and midwives differed in their attitudes about common interventions in labour. In the current study we set out to explore the attitudes and perceptions of Canadian women as they approached their first delivery.

The nature of women's attitudes and related knowledge prior to their first delivery is important. If they hold positive perceptions about the use of various technologies and procedures, they might be more often exposed to the benefits of elective Caesarean section (and not the risks) and to positive views of episiotomy and epidural analgesia. For example, elective Caesarean section, in the absence of indications, is known to be associated with more maternal and newborn morbidity than planned vaginal birth.[2–5] This view is supported by the recent Joint Policy Statement on Normal Childbirth of the Society of Obstetricians and Gynaecologists of Canada, which confirms the SOGC's prior position that, in the absence of specific indications, vaginal childbirth is the safest route for the mother, fetus, and newborn in the first and subsequent pregnancies.[6] Yet many care providers would still agree to a Caesarean section on maternal request, in the absence of indications.[1] As well, robust evidence supports abandoning the routine use of episiotomy[7,8] and has shown an association between routine epidural analgesia and an increase in instrumental deliveries and other adverse outcomes.[9] Yet many care providers are comfortable with these procedures being used routinely.[1]

Some of the evidence from The Canadian Maternal Experiences Survey[10,11] is related to our work, as were the findings of a parallel survey in the United States,[12,13] an earlier report of procedure use in Canadian hospitals,[14] and the follow-up to that report.[15] All of these sources indicated that large numbers of low-risk women were being exposed to numerous major interventions during labour and delivery.[16,17] For example, low-risk labouring women routinely had continuous electronic fetal monitoring, despite the absence of evidence supporting its routine use.[18] While epidural analgesia is offered in Canada in most urban and many rural obstetric settings[11,12] and is efficacious for pain relief in labour, if used routinely and before active labour is established, it increases the length of labour, rates of instrumental delivery, perineal trauma,[19–22] and possibly the Caesarean section rate.[23,24] Parallel qualitative data from a Montreal–Vancouver collaboration identified that, while most study participants were aware of the range of available providers and birth settings and felt generally well informed, they thought that information sharing, collaborative decision making, or both, were inadequate during labour and birth in the hospital setting.[25]