# The Attitudes of Canadian Maternity Care Practitioners Towards Labour and Birth: Many Differences but Important Similarities

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## Abstract

**Objective:** Collaborative, interdisciplinary care models have the potential to improve maternity care. Differing attitudes of maternity care providers may impede this process. We sought to examine the attitudes of Canadian maternity care practitioners towards labour and birth.

**Methods:** We performed a cross-sectional web- and paper-based survey of 549 obstetricians, 897 family physicians (400 antepartum only, 497 intrapartum), 545 nurses, 400 midwives, and 192 doulas.

**Results:** Participants responded to 43 Likert-type attitudinal questions. Nine themes were identified: electronic fetal monitoring, epidural analgesia, episiotomy, doula roles, Caesarean section benefits, factors decreasing Caesarean section rates, maternal choice, fear of vaginal birth, and safety of birth mode and place. Obstetrician scores reflected positive attitudes towards use of technology, in contrast to midwives' and doulas' scores. Family physicians providing only antenatal care had attitudinal scores similar to obstetricians; family physicians practising intrapartum care and nurses had intermediate scores on technology. Obstetricians' scores indicated that they had the least positive attitudes towards home birth, women's roles in their own births, and doula care, and they were the most concerned about the consequences of vaginal birth. Midwives' and doulas' scores reflected opposing views on these issues. Although 71% of obstetricians supported regulated midwifery, 88.9% were against home birth. Substantial numbers of each group held attitudes similar to dominant attitudes from other disciplines.

**Conclusion:** To develop effective team practice, efforts to reconcile differing attitudes towards labour and birth are needed. However, the overlap in attitudes between disciplines holds promise for a basis upon which to begin shared problem solving and collaboration.

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

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## Résumé

**Objectif :** Les modèles de soins interdisciplinaires concertés ont le potentiel d'améliorer les soins de maternité. Les diverses attitudes adoptées par les fournisseurs de soins de maternité peuvent nuire à ce processus. Nous avons cherché à examiner les attitudes des praticiens de soins de maternité canadiens envers le travail et l'accouchement.

**Méthodes :** Nous avons mené un sondage transversal (sur le Web et en format papier) auprès de 549 obstétriciens, de 897 médecins de famille (400 antepartum seulement, 497 intrapartum), de 545 infirmières, de 400 sages-femmes et de 192 doulas.

**Résultats :** Les participants ont répondu à 43 questions attitudinales de type Likert. Neuf thèmes ont été identifiés : monitorage fœtal électronique, analgésie péridurale, épisiotomie, rôles de la doula, avantages de la césarienne, facteurs entraînant la baisse des taux de césarienne, choix maternel, peur de l'accouchement vaginal et innocuité de l'endroit et du mode de l'accouchement. Les scores des obstétriciens indiquaient des attitudes positives envers le recours à la technologie, contrairement aux scores des sages-femmes et des doulas. Les médecins de famille n'offrant que des soins prénatals ont obtenu des scores attitudinaux semblables à ceux des obstétriciens; les médecins de famille offrant des soins intrapartum et les infirmières ont obtenu des scores intermédiaires en ce qui concerne la technologie. Les scores des obstétriciens indiquaient qu'ils présentaient les attitudes les moins positives envers l'accouchement à la maison, les rôles des femmes quant à leurs accouchements et les soins offerts par les doulas; leurs scores indiquaient également qu'ils étaient les professionnels les plus préoccupés par les conséquences de l'accouchement vaginal. Les scores des sages-femmes et des doulas indiquaient des opinions opposées quant à ces questions. Bien que 71 % des obstétriciens aient soutenu la pratique réglementée de la profession de sage-femme, 88,9 % d'entre eux s'opposaient à l'accouchement à la maison. Un nombre substantiel de membres issus de chacun des groupes présentaient des attitudes semblables aux attitudes dominantes adoptées par les autres disciplines.

**Conclusion :** Pour favoriser l'efficacité du travail d'équipe, des efforts visant à harmoniser les différentes attitudes envers le travail et l'accouchement s'avèrent requis. Cependant, le chevauchement des attitudes d'une discipline à l'autre s'avère prometteur à titre de fondement pour la mise en place d'un processus concerté de résolution des problèmes et d'une collaboration.


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## INTRODUCTION

Childbirth is undergoing dramatic change throughout the world. Rates of Caesarean section are continuing to increase in Canada and are reaching or exceeding 30% in some jurisdictions. While indicated Caesarean section can reduce morbidity and be life-saving for both mother and fetus, primary elective Caesarean section on maternal request is also becoming more accepted.[2] "Fear of vaginal childbirth" has affected many care providers but has been documented most extensively for obstetricians.[3–7] Professionals and women are confronted with conflicting opinions about potential negative consequences of vaginal birth on the pelvic floor (urinary incontinence, fecal incontinence, and sexual problems), compared with those following elective Caesarean section.[8–16] A rigorous study concluded that it is mainly pregnancy itself that increases the risk of urinary and fecal incontinence, and that Caesarean section decreases the risk only slightly compared with vaginal birth and mainly in the short term.[17]

There are multiple reports on the adverse effects of Caesarean section on maternal morbidity and mortality,[17–19] newborn morbidity,[20–25] and maternal complications in a subsequent pregnancy.[26–29] Well-designed Canadian studies have also demonstrated that elective Caesarean section is associated with more maternal[30,31] and newborn[32] morbidity than planned vaginal birth. A comprehensive systematic review concluded that, overall, vaginal birth is safer than Caesarean section for both mother and baby in the first and subsequent pregnancies.[33]

While it is rare to find published studies showing adverse maternal psychosocial outcomes associated with Caesarean section compared with vaginal birth in mainstream medical journals,[34–38] it is also rare to find published information on the benefits of vaginal birth. The conventional medical literature tends to focus on biophysical and anatomic problems,[9,12,14,39–43] to the exclusion of psychosocial issues. Much of this difference may be due to the fact that biophysical outcomes, such as urinary incontinence, are more amenable to capture by chart review and standard clinical assessments than are psychosocial outcomes, which are more complex and more difficult to measure.

While the Society of Obstetricians and Gynaecologists of Canada has taken a position that vaginal childbirth is the safest route for the fetus and newborn in the first and subsequent pregnancies,[44,45] and recently confirmed this in a SOGC Joint Policy Statement on Normal Childbirth,[46] professional groups and the public are likely to be influenced by the emerging literature on the presumed benefits of elective Caesarean section and by official statements from professional bodies in the United States and some North American opinion leaders.[47–52] The popular press and women's magazines regularly feature articles about celebrities glorifying the "virtues" of their elective Caesarean sections.[53–55] In spite of evidence to the contrary, we appear to be witnessing an emerging consensus among many obstetricians that mothers and babies have lower morbidity and mortality associated with Caesarean section compared with vaginal birth.[56–58]

Against this background, fewer family physicians are providing full-scope maternity care, and only specific forms of practice organization and attitudes seem to promote or encourage family physicians to continue providing maternity care.[59] In the short to medium term, the low output of the schools of midwifery in Canada cannot replace diminishing family physicians' involvement in maternity care. Moreover, retention of nurses in maternity care is