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Enhancing women's confidence for physiologic birth: Maternity care providers' perspectives

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ABSTRACT

Objective: The aim of this research study was to explore MCP's beliefs and attitudes about physiologic birth and to identify components of antenatal care that providers believe may impact a woman's confidence for physiologic labor and birth.

Methods: This qualitative descriptive study included maternity care providers (N=31) in the Midwestern United States. Providers participated in semi-structured interviews to describe their beliefs about physiologic birth, their role in providing information to women and specific care practices to promote women's confidence for physiologic birth.

Findings: Six themes emerged including: positive beliefs about physiologic birth, trusted relationship with provider, woman centered care, education and knowledge, barriers to confidence, and antenatal practices to enhance confidence. Variations in beliefs occurred amongst providers with different training (i.e., physicians and midwives).

Conclusion: Maternity care providers, including midwives, family physicians and obstetrician-gynecologists, overwhelmingly support a physiologic approach to labor and birth. These providers had a number of suggestions about how antenatal care could be enhanced in an effort to increase women's confidence during the antenatal period. Supporting physiologic birth is imperative for providers who wish to enhance outcomes for mothers and babies.

Introduction

Much has been written about the benefits of normal physiologic childbirth (Romano and Lothian, 2008; Sakala and Corry, 2008; Kennedy et al., 2010). However, medicalization of labor and birth in the United States (US) continues to persist. Despite spending more per capita on birth care than similar developed countries, the US ranks 61st globally in maternal health (Save the Children, 2015). There is evidence that normal or physiologic birth enhances maternal and neonatal outcomes (American College of Nurse-Midwives [ACNM], birthtools.org; ACNM et al., 2012; Buckley, 2015).

Normal physiologic childbirth includes the spontaneous onset and progression of labor, biological and psychological conditions that promote effective labor, vaginal birth of the infant and placenta, physiologic blood loss, and optimal newborn transition through skin to skin contact, early breast feeding, and keeping the mother-neonate dyad together (ACNM, birthtools.org; ACNM, 2012). Mothers benefit from decreased morbidity (Goer et al., 2012), decreased costs related to childbirth (Truven Health Analytics, 2013), and increased likelihood of breast feeding (Schwartz, 2013), which may impact overall long term health. Neonates experience fewer complications including respiratory distress (Gregory et al., 2012), an increase in breast feeding initiation (Schafer and Genna, 2015), and higher levels of maternal-infant attachment (Moore et al., 2016).

According to the Listening to Mothers-III survey (Declercq et al., 2013), the majority of women rely on their health care providers for health and wellness information related to pregnancy and birth. Moreover, 76% of first time mothers and 82% of experienced mothers get their pregnancy and birth information from their maternity care providers (MCPs) (Declercq et al., 2013). In contrast, only one in three women attend childbirth education classes. The fact that women most often cited their MCPs as a 'very valuable' source of information for optimal health practices during pregnancy and preparation for labor and birth underscores the importance of MCPs in enhancing a woman's confidence for labor and birth.

Given women's reliance on MCPs for education about pregnancy

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and childbirth, it is important to understand the beliefs and perceptions of providers towards physiologic birth. Reime et al. (2004) concluded that obstetricians were more 'attached' to technology and interventions than midwives and family medicine doctors. Ruiz Mdel and Limonero (2014) reported significantly different views and attitudes on normal birth between obstetricians and midwives in Spain with the former being more interventional. In addition, Klein et al. (2009) reported that obstetricians and other MCPs in Canada often do not provide evidenced-based maternity care (e.g. supporting doula care) to women and women are often uninformed about common procedures used during labor and birth resulting in lack of informed decision-making during the intrapartum period. In a follow up study, younger obstetricians (age less than 40) were more likely to view cesareans as 'just another way to have a baby' and believed that epidurals did not impact the labor process (Klein et al., 2011). Finally, Thompson et al. (2016) found that midwives in the Netherlands viewed the promotion of physiologic birth as key to their role but identified the hospital culture as a barrier to their practice. Similarly, midwives in Germany who worked in hospital settings were less likely to have favorable attitudes toward physiologic birth likely due to the culture of health care in hospital settings (Zinsser et al., 2016).

Previous research on perinatal self-efficacy and confidence has focused on the intrapartum period rather than examining how maternal confidence can be improved during the antenatal period. In addition, little attention has been given to confidence for physiologic birth, specifically. For this study, women's confidence was defined as the belief in one's own abilities and the ability to succeed (Perry, 2011). In one recent review, Tilden et al. (2016) found that interventions can impact childbirth self-efficacy and that greater childbirth self-efficacy was associated with improved outcomes such as decreasing pain and suffering in labor and improved parenting outcomes. Given the importance of promoting physiologic birth, the paucity of literature on the enhancement of confidence in the antenatal period, and the lack of evidence or information about the role that MCPs have in developing a woman's confidence prenatally, the aim of this research study was to explore MCP's beliefs and attitudes about physiologic birth and to identify components of prenatal care that providers believe may impact a woman's confidence for physiologic labor and birth.

Method

Study design

Because of the lack of data available on MCPs' perceptions of ways to increase a woman's confidence for physiologic birth during the antenatal period, a qualitative, descriptive design was used.

Sample and Setting

Maternity care providers who provided both antepartum and intrapartum care to women were eligible to participate in the study. Those still engaged in a formal training program (e.g., residency) were excluded. Participants were recruited from the state of Minnesota via email and word of mouth and included midwives, family doctors, and obstetrician-gynecologists (ob-gyn). Emails were sent to MCPs in multiple practice locations (e.g., urban, suburban, rural, academic) inviting them to participate in a 30–60 minute face-to-face, semi-structured interview. Additionally, some participants referred colleagues to the study.

Data collection

Informed consent was received from the participants prior to data collection. During the informed consent process, participants were provided information about the study and aim of the study. Participants were given a $75 gift card for participating in the interview. Data collection included completion of a demographic information form and an individual, semi-structured interview with one of the co-authors. All co-authors had previous experience collecting data via interviews and focus groups. Participants were asked to describe their beliefs about physiologic birth, their role in providing information to women, and specific care practices to promote women's confidence for physiologic birth. Examples of questions asked during the interview included 1) At what point in pregnancy do you believe it is optimal to begin discussions with women about labor and birth?; 2) Are there specific aspects or components of the antenatal care that you provide that you believe may hinder or decrease a woman's confidence for physiologic birth?; and 3) What is your role and responsibility in informing women about physiologic birth?

Interviews took place at the MCPs location of choice and included clinic offices, call rooms, provider homes, coffee shops/cafes and university offices. Interviews lasted between 15 minutes and an hour and were recorded and transcribed verbatim for analysis. The research team met monthly to discuss interview processes, data collection, and analysis. Recruitment ended when data saturation was reached (Lincoln and Guba, 1985).

Ethical consideration

Ethical approval was granted from the University of Minnesota IRB. Participants were informed verbally and in written form that the interview would be audio recorded and no names or identifying information would be included in the transcripts.

Data analysis

Using an inductive coding method like that of grounded theory, three levels of coding guided data analysis of the provider transcripts (Glaser, 1978). Open coding of the data (Level 1) involved line-by-line analysis of the 30 transcripts to identify beliefs and practices related to enhancing maternal confidence for physiologic labor and birth. These beliefs and practices or substantive codes were compared and assigned to categories (Level 2). The categories were then compared to other categories to ensure that they were mutually exclusive (Glaser, 1978). Reduction of the number of categories occurred to identify the primary themes from the provider interviews (Level 3; Glaser,1978).

Initially, all three members of the research team coded a transcript for Level 1 coding to ensure a similar approach was used. After verification of consistency between group members, analysis was primarily completed by two authors with regular meetings with the remaining author to determine Level 3 codes. Of note, one interview was not transcribed due to recording error; instead, interviewer notes from the encounter were included in the analysis.

Findings

Six themes emerged during data analysis. Themes included positive beliefs about physiologic birth, trusted relationship with provider, woman centered care, education and knowledge, barriers to confidence, and antenatal practices to enhance confidence.

Participants

The sample included 31 MCPs including 14 certified nurse-midwives, 9 obstetrician-gynecologists, and 8 family medicine doctors (See Table 1). Maternity care providers worked at various institutions including large urban hospitals, urban community hospitals, and two smaller cities (population < 90,000 and 111,000) that cared for women from local and rural areas. All participants reported that they encourage physiologic birth and more than 90% attended births in the hospital setting.