Family Centered Maternity Care

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SHARP MARY BIRCH AND GROSSMONT HOSPITALS

INTRODUCTION

- Care is influenced by…
  - *Mother
  - *YOU
- Social and psychological factors

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OBJECTIVES

- Outline historical trends affecting the development of perinatal care in the U.S.
- Discuss the major principles underlying the philosophy of family-centered care.
- Discuss the RN's role in establishing & maintaining family-centered care for our childbearing families.

HISTORICAL PERSPECTIVES

- Maternity care in America (**1700 - 1950**)
  - Midwifery
  - Obstetric Medicine
  - Hospital Care
- Consumerism in Perinatal Care
- Emergence of Perinatal Nursing
- Emergence of High-Risk Perinatal Care
- Regionalization in Perinatal Care

CURRENT ORGANIZATION OF PERINATAL CARE

- Influencing Factors:
  - *Socio-economic*
  - *Cost-containment*
  - *Technology*
  - *Ethics*
  - *Liability*
  - *Gender roles/Family structure*

PHILOSOPHY OF FAMILY-CENTERED CARE

- Birth options / alternatives
- Family participation in the birth
- Support people for labor & birth
- Participation of siblings
- Extended early parent-newborn contact

HOW HAVE HOSPITALS ADOPTED FCMC?

- Focus on care for the mother and her infant by the same nurse
- Increased parent access to infant
- Unrestricted partner visiting hours
- Classes for expectant parents and siblings on birth, breastfeeding, and infant care

FAMILY SYSTEM ASSESSMENT

- Cultural awareness
- Family members' knowledge and preparation for childbirth
- Degree to which preparation is individual or mutual

OBSTETRICAL MODELS OF CARE

- **Medical Model**
  - Eliminate sensation of labor pain
- **Midwifery Model**
  - Prevention of suffering

PAIN ≠ SUFFERING

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HOW WILL YOUR ACTIONS OR NON-ACTIONS BE PERCEIVED BY THE LABORING WOMAN?

WHAT CARE MODELS & PERSONAL VALUES INFLUENCE YOUR BEHAVIOR?

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PERSONAL TRAITS INFLUENCED PROVIDERS' PREFERENCES

(DE JONG ET AL 2008)

- How much they conformed to medical model
- Which positions they considered "normal"
- Their self-confidence in trying new positions
- Their own labor experience

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CULTURAL DIFFERENCES

VAN HOOVER 2000 (SECONDARY SOURCE)

- Expression of suffering
  - *Intended to elicit compassion from others*
  - "good pain" (Scandinavian); "tugging / pulling" (Danish)
  - "excruciating" (Chinese, Americans)
- Perception of suffering
  - Belief systems
  - Ethnic backgrounds

…influence nurse's perception of suffering of the woman…

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SUFFERING
LOWE 2002

- Perceived threat to body/psyche
- Helplessness
- Loss of control
- Distress
- Insufficient resources for coping
- Fear of death
  - Mother
  - Baby

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…similar to…

American Psychiatric Association
diagnostic criteria
for

TRAUMA

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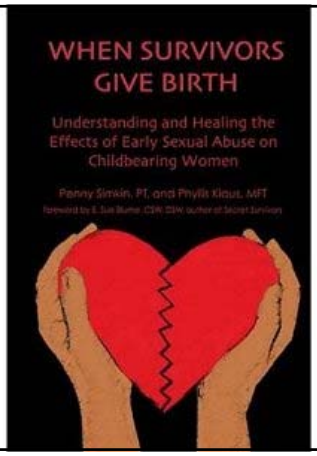
Simkin
&
Klaus
2004



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SIMKIN & BOLDING
2004

- Ironically….eliminating pain may…
  - Increase aspects of suffering
    - Helplessness
    - Insufficient resources to cope with distress
      - Lack of freedom of movement
      - ↓ self-confidence and sense of well-being

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SIMKIN & BOLDING
2004 (CONT'D)

- Pain perceived as…
  - Side effect of a normal process
  - Not a sign of damage, injury or abnormality
- Caregiver
  - Assist **coping**
  - Build self-confidence & mastery

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3 R'S OF COPING
SIMKIN 2008A

- Relaxation
  - Between and/or during Uterine Contractions (UC)
- Rhythm
  - Breathing, movement, moaning & mind
- Ritual
  - Same rhythmic activity each UC

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Pain Intensity Scale

RN perception

Pt perception

Pain Coping Scale

Wong & Whaley, 1986. Adapted by Simkin, 2010.

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MOTHER'S PERCEPTIONS

- Positive influences
  - Caretaker
  - Attitudes of others
- Negative Influences
- Disruptions
  - Separation
  - Conflicting expectations

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THE PAIN QUESTION

- Manage pain OR Assist coping?
- What is…
  - Our perspective
  - Our locus of control
    - The extent you feel in control of the events that influence your life.

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LOCUS OF CONTROL

- Low tech response
  - Mother is center
    - Informed choice
    - *Opt for…*
  - Change the environment
  - Social model
- High tech response
  - Obstetrical team "manages"
    - Informed consent
    - *Opt out…*
  - Change the woman
  - Physiological model

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WOMEN'S POSITIONS DURING THE SECOND STAGE OF LABOUR

- Control during birth
  - Associated with satisfaction
- Feeling in control of staff actions
  - Associated with type of relationship with provider

Journal of Advanced Nursing, Women's positions during the second stage of labour: views of primary care midwives. The Netherlands. de Jong et al 2008

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DO *YOU* TRUST BIRTH?

RECOGNIZE NOT ALL MOTHERS CAN OR DO.

AT THE VERY LEAST…RESPECT IT AND THEM!

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UNITES STATES CESAREAN BIRTH RATES 1989-2011

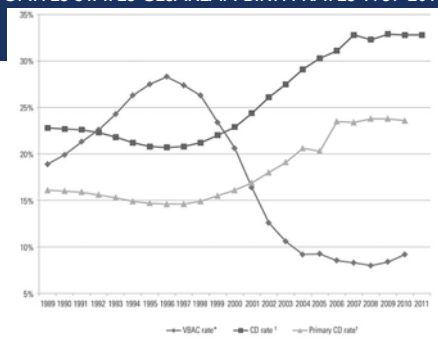

Fig. 1. U.S. delivery rates, 1989–2011. Data from National Vital Statistics. Abbreviations: CD, cesarean delivery; VBAC, vaginal birth after cesarean delivery. *Percent of women who have a vaginal birth after prior cesarean delivery. †Rate based on total number of deliveries. (Data from Martin JA, Hamilton BE, Ventura SJ, Osterman MJ, Mathews TJ. Births: final data for 2011. Natl Vital Stat Rep 2013;62(1:1–90.)

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CESAREAN DELIVERY ON MATERNAL REQUEST (CMDR)

Observed c-section preference and request rates pooled overall preference rate for c-sections was 15.6%

The proportions of women declaring that they would prefer to give birth by c-section ranged from 1.0% (a study in the United Kingdom [1]) to 62.2% (a study in Iran [2]).

The proportions of CDMR among all deliveries ranged from 0.2% (a study in Ireland [3]) to 24.7% (a study in China [4]). **ACOG states US rate is 2.5%.** [5]

1 Kingdon C, Neilson J, Singleton V, Gyte G, Hart A, Gabbay M, et al. Choice and birth method: mixed-method study of caesarean delivery for maternal request. BJOG Int J Obstet Gynaecol. 2009
2 Matinnia N, Faisal I, Juni MH, Herjar AR, Moeini B, Osman ZJ. Fears Related to Pregnancy and Childbirth Among Primigravidae Who Requested Caesarean Versus Vaginal Delivery in Iran. Matern Child Health J. 2015
3 Murphy DJ, Fahey T. A retrospective cohort study of mode of delivery among public and private patients in an integrated maternity hospital setting. BMJ Open. 2013
4 Liu X, Landon MB, Cheng W, Chen Y. Cesarean delivery on maternal request in China: what are the risks and benefits? Am J Obstet Gynecol. 2015
5 Cesarean delivery on maternal request. ACOG Committee Opinion No. 761. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019

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CDMR FACTORS

- Fear of giving birth (and particularly fear of labor pain) is the most common reason
- Perceived as a way to avoid the unpredictable dangers of childbirth
- Clinicians' attitudes towards c-sections have changed
- Greater exposure to biotechnology specifically ultrasound
- Reproductive assistance - IVF, IUI, Surrogacy

HOW IS WOMEN'S DEMAND FOR CAESAREAN SECTION MEASURED? A SYSTEMATIC LITERATURE REVIEW
CLÉMENCE SCHANTZ , MYRIAM DE LOENZIEN, SOPHIE GOYET, MARION RAVIT, AURÉLIEN DANCOISNE, ALEXANDRE DUMONT
PUBLISHED: MARCH 6, 2019 HTTPS://DOI.ORG/10.1371/JOURNAL.PONE.0213352

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INCREASED CESAREAN RATES

When Cesarean Section rates increase from 29% to 34%...

Risk	29%	34%
Maternal Death	14	32
Surgical Complications	5,000	24,000
Post Op Infection	4,000	6,000
Venous Thrombosis	200	300
Maternal Hospital Readmits		Increase by 2,200
NICU Admits		Increase by 33,000
Days in Hospital		Increase 930,000
Healthcare Costs	$750 Million	$1.7 Billion

USA NATIONAL INSTITUTE OF HEALTH

2006 CDMR Conclusions published in Contemporary OBGYN Vol 51 No12

- Insufficient evidence to recommend one mode of delivery over another
- No good data for "quality of life"
- More prospective research is needed

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CESAREAN DELIVERY ON MATERNAL REQUEST ACOG COMMITTEE OPINION #761 JANUARY 2019

ACOG Recommendation (paraphrased) assuming no medical indication for cesarean birth:

- If main motivation for CDMR is fear of pain in childbirth, providers should discuss and offer the patient analgesia for labor, as well as prenatal childbirth education and emotional support in labor.
- A plan for vaginal delivery is safe and appropriate and should be recommended.
- After exploring the reasons behind the patient's request and discussing the risks and benefits, if a patient decides to pursue cesarean delivery on maternal request, the following is recommended:
  - CDMR not before 39 weeks
  - Inform patients risks of placenta previa, placenta accreta spectrum, and gravid hysterectomy increase with each subsequent cesarean delivery.

MNNC - 2016 - SESSION NAME 30

WORLDWIDE PROFESSIONAL ORGANIZATIONS

FIGO & WHO

- **Absence of benefit**
- **Potential drain on resources**
- **Not ethically justified**

NICE & RCOG

- **Maternal request is not an indication for c/s**

SOGC

- **Vaginal birth remains preferred approach & safest option**
- **Carries less risk of complication**
  - **In pregnancy**
  - **In subsequent pregnancies**

FIGO - The International Federation of Gynecology and Obstetrics
WHO – World Health Organization
NICE – British National Institute for Health and Care Excellence
RCOG – British Royal College of Obstetricians and Gynaecologists

SOGC - Society of Obstetricians and Gynaecologists of Canada

REDUCING UNPLANNED CESAREAN RATES

- Manual Rotation Occiput Posterior
- Multiparity & Maternal age <35 years are associated with successful manual rotation
- Successful rotation, **drops the cesarean rate to 2%,** compared with 34% if the rotation failed
  - For every 100,000 successful rotations, cesareans drop from 34,000 to 4,000!

REDUCING PLANNED CESAREAN RATES

- One option for reducing planned cesareans – External Cephalic Version
- In 2016, 0.3% mothers had ECVs in the US

	Successful version	Failed version
Total	6,221 (55.8%)	4,937 (44.2%)
Vaginal-Spontaneous	4,229 (68.0%)	545 (11%)
Vaginal-Forceps	89 (1.4%)	10 (0.2%)
Vaginal-Vacuum	330 (5.3%)	25 (0.5%)
Cesarean	1,568 (25.2%)	4,356 (88.2%)
Unknown	5 (0.1%)	1 (0.0%)

Table made for www.evidencebasedbirth.com. Preliminary 2016 data from personal correspondence on September 13, 2017 with Anne Driscoll, Ph.D., at the Centers for Disease Control and Prevention.

WHY REDUCE CESAREANS?

- **Risks to Baby:**
  - Breathing problems
  - Surgical injury
- **Risks to Mom:**
  - Hemorrhage
  - Blood clots
  - Infection of the incision and/or the lining of the uterus (endometritis)
  - Surgical injury
- **Risk of complications in future pregnancies:**
  - Placenta previa & accreta
  - Uterine rupture
  - Complications from multiple abdominal surgeries

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RISK OF PLACENTA PREVIA & ACCRETA

According to Number of Previous Cesarean Deliveries

Number of Cesareans	Previa (%)	Accreta (%)	Accreta in patients with previa (%)
Two	1.33	0.31	11
Three	1.14	0.57	40 *
Four	2.27	2.13	61
Five	2.33	2.33	67
Six or more	3.37	6.74	67

UpToDate online www.utdol.com 2008

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FCMC – CESAREAN BIRTH

- Partner to remain with mother during preparation
- Use regional anesthesia where possible
- Partner present in OR
- Mother's hands free from safety device for contact with partner and baby
- Opportunity for both parents to interact with the baby in the OR and/or PACU

- If partner chooses *not* to be in the OR:
  - Allow another support person
  - have birth experience relayed to partner
  - given baby as soon as possible in the PACU

BIRTH PROVIDER AND LOCATION AS INFLUENCERS

Outcome Differences for Normal Birth

- Associated with provider only (OB vs Midwife)
  - MacDorman & Singh 1998
- Associated with birth site only (Hospital vs Birth Center)
  - Fullerton & Severino 1992
- Associated with birth site & provider
- Janssen et al 1994

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DIFFERENCES ASSOCIATED WITH PROVIDER

MACDORMAN & SINGH 1998 *(J EPIDEMIOL COMMUNITY HEALTH)*

- CNM vs MD attended births
  - All single vaginal births United States 1991
- After controlling for social & medical risk factors, CNMs…
  - Infant death 19% lower
  - Neonatal mortality 33% lower
  - Low infant birth weight 31% lower

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PROVIDER COCHRANE REVIEW 2016

- CNM attended births (excludes home birth)
- 15 studies involving 17,674 mothers and babies (search date 25 January 2016).
- "This review suggests that women who received midwife-led continuity models of care were less likely to experience intervention and more likely to be satisfied with their care with at least comparable adverse outcomes for women or their infants than women who received other models of care."

MNNC - 2016 - SESSION NAME

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PROVIDER POPULATION DIFFERENCES
MACDORMAN & SINGH 1998

- CNMs
  - *"greater"* proportion women at high risk for poor outcomes
    - *African Americans*
    - *American Indians*
    - *Teenagers*
    - *Single mothers*
    - *Less than high school*
- MDs
  - *"slightly"* higher proportion of births with medical complications

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BIRTH AT HOME STATISTICS
CDC NCHS DATA BRIEF NO. 144, MARCH, 2014

	Non-Hispanic White Women	Non-Hispanic Black Women
Actual OOH Birth Rate	2.05%	0.49%
Given the option would "Definitely" birth at home according to the *Listening to Mothers III* Survey	10%	25%

- In 2012, the risk profile of out-of-hospital births was lower than for hospital births, with fewer births to teen mothers, and fewer preterm, low birthweight, and multiple births.

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BIRTH SITE COCHRANE 2012

- Although no strong RCTs (Randomized Controlled Trial)…
  - "Quality of evidence in favor of home birth from observational studies…steadily increasing"
  - Seems increasingly clear…
    - Impatience & easy access to medical procedures increase interventions and increase unnecessary complications

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PLANNED HOME BIRTH

ACOG COMMITTEE OPINION # 697, APRIL 2017 (REAFFIRMED 2018)

- Give directive counseling against
- Do not participate
- Transport issue ~
  - "unlike Dutch healthcare…"
    - Not enough CNMs
    - Not as developed transfer system

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NATIONAL BIRTH CENTER STUDY II 2013

- 84% women who planned to birth in a birth center did so
- 93% had Normal Spontaneous Vaginal Delivery (NSVD)

- 4 million births yearly
  - If only 10% in BC….
    - $1 BILLION saved in facility fees

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WHY?

(MACDORMAN & SINGH 1998)

- More time with woman
  - During prenatal visits
- Greater emphasis on counseling & education
- Emotional support provided
  - Especially 1:1 care during labor & birth

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NATIONAL BIRTH CENTER STUDY II 2013

Birth centers are a high-value option for maternity care and complement the existing hospital-based system. Care that is provided by birth centers fully meets the "triple aim" vision of healthcare: improving the experience of care, improving the health of populations, and reducing per capita costs of health.

Translation……

CNMs and Birth Centers provide more

Family Centered Maternity Care

than MDs with better outcomes for low risk families at less cost.

LOSS OF BIRTH EXPECTATIONS

- Maternal response
  - Anxiety, fear, guilt
  - Disappointment, anger
- Family response
  - Crying, pacing, denial, guilt anger
  - Questions???, lots of questions????
- Nursing Interventions
  - Acknowledgement, information, empathy

…recall…

CULTURAL DIFFERENCES
VAN HOOVER 2000 (SECONDARY SOURCE)

- Expression of suffering
  - *Intended to elicit compassion from others*
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- Perception of suffering
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  - Ethnic backgrounds

…influence nurse's perception of suffering of the woman…

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…recall…

PERSONAL TRAITS INFLUENCED PROVIDERS' PREFERENCES
(DE JONG ET AL 2008)

- How much they conformed to medical model
- Which positions they considered "normal"
- Their self-confidence in trying new positions
- Their own labor experience

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ENKIN ET AL 2001

SIX FORMS OF CARE & EVIDENCE

- Beneficial
- Likely to be beneficial
- Trade off between beneficial & adverse effects
- Unknown effectiveness
- Unlikely to be beneficial
- Likely to be ineffective or harmful

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EXAMPLES

Beneficial:

- Women carrying their records
- Continuous support during labor & birth
- Unrestricted breastfeeding

Likely to be ineffective or harmful:

- Routine lithotomy for pushing

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FAMILY CENTERED MATERNITY CARE

Safe, Quality Care

Recognizing & Adapting

To

Physical & Psychosocial Needs of

Family & Newborn

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Dignity

&

Respect

…Power of Language…

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YOUR ROLES AS PERINATAL NURSES

- Achievements
- Challenges
- Implications for the future
- Perinatal research

SUMMARY

Photo credit Medical City Las Colinas, Irving, TX

The philosophy & practices of Family-Centered Maternity Care (Perinatal Nursing Care) *CAN* reflect nursing at it's best!

…KNOW YOUR
LOCOUS OF CONTROL

…influences…

YOUR MODEL of CARE

Is your model…
Evidence Based?
Family Centered?

What about your
Personal Values / Experiences?
Evaluate Unconscious Bias / Micro-Inequities

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