Family Centered Maternity Care

INTRODUCTION

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

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

WHAT CARE MODELS & PERSONAL VALUES INFLUENCE YOUR BEHAVIOR?

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

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...
SUFFERING
LOWE 2002

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

...similar to...

American Psychiatric Association diagnostic criteria for

TRAUMA

Simkin & Klaus 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

Pain perceived as:
- Side effect of a normal process
- Not a sign of damage, injury or abnormality

Caregiver
- Assist coping
  - Build self-confidence & mastery

3 R's of coping:
- Relaxation
  - Between and/or during Uterine Contractions (UC)
- Rhythm
  - Breathing, movement, moaning & mind
- Ritual
  - Same rhythmic activity each UC
MOTHER’S PERCEPTIONS

- Positive influences
  - Caretaker
  - Attitudes of others

- Negative Influences
  - Disruptions
  - Separation
  - Conflicting expectations

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.
LOCUS OF CONTROL

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

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

DO YOU TRUST BIRTH?

RECOGNIZE NOT ALL MOTHERS CAN OR DO.

AT THE VERY LEAST…RESPECT IT AND THEM!
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%.

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
**INCREASED CESAREAN RATES**

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

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

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**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.
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!

MNNC - 2016 - SESSION NAME 32

REDUCING PLANNED CESAREAN RATES

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

<table>
<thead>
<tr>
<th></th>
<th>Successful version</th>
<th>Failed version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>6,221 (55.81)</td>
<td>4,937 (44.21)</td>
</tr>
<tr>
<td>Vaginal</td>
<td>4,219 (48.01)</td>
<td>540 (111)</td>
</tr>
<tr>
<td>Vaginal Forceps</td>
<td>89 (0.41)</td>
<td>10 (0.21)</td>
</tr>
<tr>
<td>Vaginal Vacuum</td>
<td>330 (5.31)</td>
<td>25 (0.51)</td>
</tr>
<tr>
<td>Cesarean</td>
<td>1,568 (25.23)</td>
<td>4,356 (60.21)</td>
</tr>
<tr>
<td>Unknown</td>
<td>9 (0.11)</td>
<td>1 (0.09)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Number of Cesareans</th>
<th>Previa (%)</th>
<th>Accreta (%)</th>
<th>Accreta in patients with previa (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two</td>
<td>1.33</td>
<td>0.31</td>
<td>11</td>
</tr>
<tr>
<td>Three</td>
<td>1.14</td>
<td>0.57</td>
<td>40 *</td>
</tr>
<tr>
<td>Four</td>
<td>2.27</td>
<td>2.13</td>
<td>61</td>
</tr>
<tr>
<td>Five</td>
<td>2.33</td>
<td>2.33</td>
<td>67</td>
</tr>
<tr>
<td>Six or more</td>
<td>3.37</td>
<td>6.74</td>
<td>67</td>
</tr>
</tbody>
</table>

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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
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

DIFFERENCES ASSOCIATED WITH PROVIDER

MACDORMAN & SINGH 1998

- 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

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."
**PROVIDER POPULATION DIFFERENCES**
MACDORMAN & SINGH 1998

- CNMs
  - “greater” proportion of women at high risk for poor outcomes
    - African-Americans
    - American Indians
    - Teenagers
    - Single mothers
    - Less than high school education

- 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

<table>
<thead>
<tr>
<th></th>
<th>Non-Hispanic White Woman</th>
<th>Non-Hispanic Black Woman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual OOH Birth Rate</td>
<td>2.05%</td>
<td>0.49%</td>
</tr>
<tr>
<td>Given the option would “Definitely” birth at home according to the Listening to Mothers III Survey</td>
<td>10%</td>
<td>25%</td>
</tr>
</tbody>
</table>

- 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
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

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

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
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
**Cultural Differences**

**VAN HOOVER 2000 (SECONDARY SOURCE)**

- Expression of suffering
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...influence nurse’s perception of suffering of the woman...

**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

**Six Forms of Care & Evidence**

**ENKIN ET AL. 2001**

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

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

Likely to be ineffective or harmful:
- Routine lithotomy for pushing

FAMILY CENTERED MATERNITY CARE

Safe, Quality Care
Recognizing & Adapting
To
Physical & Psychosocial Needs of
Family & Newborn

Dignity & Respect

...Power of Language...
YOUR ROLES AS PERINATAL NURSES

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

SUMMARY

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

...KNOW YOUR LOCUS 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