The Experience of Perinatal Care at a Birthing Center: A Qualitative Pilot Study

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ABSTRACT

The purpose of this qualitative descriptive pilot study was to describe women's experiences of care and satisfaction at a freestanding birth center. Data were collected through semistructured interviews with seven women who had given birth within 12 months of participant selection. Using qualitative content analysis, three themes emerged: (1) Empowerment, (2) Sense of Motherhood, and (3) Establishing and Strengthening Relationships. Data revealed that women value caring providers, that caring providers may affect positive outcomes, and that those outcomes may lead to a satisfactory experience.

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INTRODUCTION

As health-care providers strive to provide safe perinatal care, they must navigate the challenges of increasing litigation, which has resulted in reliance on defensive medicine (Studdert, Mello, & Brennan, 2004; Studdert et al., 2005; U.S. Congress, Office of Technology Assessment, 1994). Providers, fueled by fears of litigation, elect to use various interventions despite a lack of efficacy for those interventions in the scientific literature. Research findings suggest that more interventions fail to improve outcomes (Gabay & Wolfe, 1997; Goer, 1995; Kennedy & Shannon, 2004; Paine, Dower, & O'Neil, 1999). Gabay and Wolfe (1997) called this phenomenon "the perinatal paradox." Furthermore, Kennedy and Shannon (2004) noted that the Netherlands, the United Kingdom, Sweden, and Japan, not the United States, lead the world in healthy perinatal outcomes. Unlike the United States, these other

countries use midwives for primary maternity care, reserving obstetricians for high-risk pregnancies and births (Kennedy & Shannon, 2004).

Is it possible to reduce unnecessary interventions, improve outcomes, and possibly decrease lawsuits? The nurse-midwifery care model offers fewer interventions, improved patient satisfaction, and superior morbidity and mortality rates (Blanchette, 1995; Ernst, 1996; Gabay & Wolfe, 1997; Kennedy, Shannon, Chuahorm, & Kravetz, 2004; MacDorman & Singh, 1998; Oakley et al., 1996). Ulrich (2004) noted that providers following the midwifery model of care "used technology judiciously and focused on the psychosocial, spiritual, and cultural aspects of birth" (p. 390). Considering the connection between patient satisfaction and patients' decisions to file malpractice claims, it is reasonable to assume that incorporating the nurse-midwifery model could decrease litigation (Studdert et al., 2004).

BACKGROUND

Researchers have documented midwifery care outcomes through data collected using instruments that provided words and phrases with which participants agreed or disagreed. For this study, in contrast to supplying descriptive words, I sought to elicit each participant's perspective stated in her own words. In addition, this study focused on care provided at a freestanding birth center, whereas prior studies were not limited to birth centers. For this study, I chose a freestanding birth center accredited by the American Association of Birth Centers (2007), because care at these centers is guided by the midwifery philosophy.

Frame of Reference

The midwifery philosophy framed this investigation. Cragin (2004) evaluated theories of midwifery practice and concluded that proposed models share concepts of the midwifery paradigm: (1) The focus of midwifery is the recipient of care in her context; (2) mind, body, and spirit are interconnected; (3) the feminist perspective is a key element in the care process; and (4) midwives believe in and support the normalcy of pregnancy and birth. Cragin's (2004) findings are congruent with the philosophy of the American College of Nurse-Midwives (2004). In addition, Kennedy (1995) acknowledged the role of feminism in the midwifery philosophy. Focus on the woman's experience, knowledge, and perspective stems from feminist theory.

Morbidity and Mortality Studies

Numerous researchers have documented excellent morbidity and mortality outcomes of midwifery care (Blanchette, 1995; Cragin, 2002; Kennedy, 2000; Kennedy et al., 2004; MacDorman & Singh, 1998; Oakley et al., 1996; Raisler, 2000; Rooks et al., 1989). Blanchette (1995) compared birth outcomes of certified nurse-midwives with outcomes of obstetricians working in the same practice. Findings from the study demonstrated that the uninsured and underinsured women cared for by the midwives had outcomes comparable to those of the privately insured clients cared for by obstetricians. Blanchette concluded that nurse-midwives provide quality care and have acceptable outcomes even when managing a high-risk population.

MacDorman and Singh (1998) corroborated the findings of Blanchette (1995) to compare the outcomes of all low- and high-risk, physician- and nurse-midwife-attended singleton vaginal births

in the United States in 1991. After controlling for medical and sociodemographic risk factors, the data demonstrated decreased infant mortality (19%), decreased neonatal mortality (33%), and decreased occurrence of low infant birth weight (31%) for nurse-midwife-attended births.

Psychosocial Studies

Considering these positive outcomes, other investigators sought to determine the underlying reasons for such results. These studies suggest that the midwifery philosophy contributes to improved outcomes. Simkin (1996) noted that during the 1970s and 1980s, scientists began to realize that emotions influence the birth process and that care providers may improve outcomes by attending to the woman's emotional needs. Midwifery supporters believe that the midwifery process of care leads to high patient satisfaction, which contributes to improved outcomes. Studies indicate that the most important outcome of any birth for both the midwife and the family is a healthy mother and baby; yet, researchers have found that a satisfying birth experience also ranks high in importance (Hardin & Buckner, 2004; Proctor, 1998).

As researchers move toward connecting specific care processes with outcomes, they have made efforts to define satisfaction and the meaning of a positive birth experience. Many factors contributing to satisfaction with childbirth have been identified: feeling in control (Cragin, 2002; Green, Coupland, & Kitlinger, 1990; Hardin & Buckner, 2004; Kennedy et al., 2004; Melender, 2006; Proctor, 1998; Sauls, 2002; Simkin, 1991); personal expectations and involvement in decision making (Hodnett, 2002); and unhurried atmospheres, normality, security, and reasonable duration of labor (Melender, 2006). Throughout the literature, women have identified their relationships with and support from caregivers as the most important determinant of satisfaction (Hodnett, 2002; Matthews & Callister, 2004; Melender, 2006). In contrast, descriptive studies of the effect of medical interventions on satisfaction demonstrate that more interventions lead to less satisfaction (Hodnett, 2002). Some researchers, in addition to defining satisfaction, have

For information about freestanding birth centers, visit the Web site of the American Association of Birth Centers (www.birthcenters.org).

For information about the American College of Nurse-Midwives (ACNM) and midwifery care in the United States, visit the ACNM Web site (www.acnm.org).

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linked the midwifery model with factors contributing to positive psychological outcomes. For example, the midwifery model eases adjustment to the maternal role (Green et al., 1990; Proctor, 1998; Sauls, 2002). Investigators have also found that midwifery's philosophy of providing information to the woman and her family promotes emotional well-being and decreased feelings of postpartum depression (Green et al., 1990; Sauls, 2002). Furthermore, birth experiences may affect self-confidence and self-esteem by empowering women through a sense of accomplishment (Hardin & Buckner, 2004; Kennedy, 2000; Kennedy et al., 2004; Sauls, 2002; Simkin, 1991; Ulrich, 2004).

DESIGN AND METHODOLOGY

Qualitative description guided the present study, which sought to describe a complete and valid account of the participants' experiences and the meanings they attached to those experiences (Sandelowski, 2000). Data analysis occurred simultaneously with data collection.

Setting

All study participants received perinatal care and gave birth at a freestanding birth center located in a rural county in southeastern United States. The county has 42,070 residents, 94.9% of whom are Caucasian. The median household income is \$30,337 annually, and 66.7% of the population aged 25 years and older graduated from high school (U.S. Census Bureau, 2000). Certified nurse-midwives in consultation with family practice physicians provide care at the center. Obstetrician-gynecologists working at a nearby hospital perform cesarean births on birth center clients when needed. In 2005, 107 births occurred at the center, and the nurse-midwives attended 38 hospital deliveries. The combined cesarean rates for certified nurse-midwife-attended births at the center and at the hospital averages between 5% and 9% annually (B. Raahauge, personal communication, February 6, 2006).

Sample

Seven women, all Caucasian stay-at-home moms, comprised the final convenience sample. Qualitative experts recommend that studies aimed at analyzing experiences include six participants or a sufficient sample size to achieve data saturation (Sandelowski, 1995). Data saturation was reached after six interviews; one more interview was conducted to assure accuracy of the data.

Certified nurse-midwives at the birthing center identified clients meeting the inclusion criteria. English-speaking, insured women aged 18 years or older were selected to avoid a prolonged institutional review board evaluation related to vulnerable populations. An expedited institutional review board evaluation was sought due to time constraints. Primiparous women were chosen to avoid comparisons to previous birthing experiences that occurred at home or in hospitals and to obtain a homogenous sample. Finally, because the passage of time tends to change perceptions and memories of an event, only women who had given birth within 12 months of participant selection were included. Women who did not speak or read English, and those unable to speak about their birth experiences due to emotional or cognitive problems, were excluded.

Data Collection

Following approval by East Tennessee State University's Institutional Review Board, I conducted one-on-one interviews with each participant at the birthing center. Prior to beginning the interviews, each participant read and signed an informed consent document and an authorization release approved by the Health Insurance Portability and Accountability Act. Interviews took place 7.5 to 14 months after participants had given birth, ranged in length from 1 to 2 hours, and were audio-taped. I first collected demographic data and subsequently asked the following open-ended questions:

1. What influenced your decision to choose a birthing center?
2. Which components of midwifery care did you like? Dislike?
3. How has the care you received at the birthing center impacted your life?
4. Recall your birth experience. What was important to you? How did the experience compare to your expectations?

I permitted each woman as much time as she needed to answer and elaborate on the questions. When needed, further questions were asked to elicit more information about particular aspects of the experience. After completion of the interview, each participant received a \$10 gift card.

Data Analysis

I transcribed each audiotaped interview verbatim. Data analysis was guided by the Van Manen proce-

dures and managed using NVivo 2.0 software (QSR International, 2005; Van Manen, 1997). First, significant statements were extracted from each transcript. Next, I derived meanings from each statement and grouped statements with similar meaning. This step involved progressing from participants' statements to my interpretation of meaning. Selection of significant statements and derivation of meanings were repeated independently by an expert in qualitative analysis who was knowledgeable about birth and maternal health and had no connection to the birthing center. Finally, the expert and I formulated themes through reading and rereading the significant statements, intuiting, and conferring (Van Manen, 1997). I assigned pseudonyms to each participant to ensure confidentiality.

FINDINGS

Participant Profiles and Birth Decisions

Sara, a 31-year-old, married college graduate, experienced a vaginal birth with artificial rupture of membranes after a 10-hour labor. Although Sara had no complications, her daughter required phototherapy for 2 weeks due to jaundice. Sara chose the birthing center because her mother had recounted negative experiences with obstetricians and hospitals. Keeping her daughter by her side and choosing which medications her daughter would receive were important to Sara. She plans to have another baby at the birth center.

Elizabeth, a 28-year-old, married high-school graduate, had a vaginal birth after 30 hours of labor. She chose the birth center because she wanted an unmedicated birth, disliked the thought of bed confinement during labor, and felt anxious about hospitals due to many deaths in her family. Elizabeth valued the midwives' support of listening to one's body and delegating control to the laboring woman. She plans to have another baby at the birth center.

Kelly, a 30-year-old, married high-school graduate, experienced a vaginal birth after 9 hours of labor. She chose the birth center because she valued the focus on women and children and had had negative hospital experiences with friends' and family members' births. In addition, the idea of midwifery appealed to Kelly. She had first encountered midwives during her readings about medieval times and found their work fascinating. She desired a natural birth and appreciated the midwives' support of her decisions. She remembered feeling a great sense of support and security throughout labor, with her husband and two midwives at her side. Kelly plans to have another baby at the birth center.

Rebecca, a 28-year-old, engaged high-school dropout, had a vaginal birth with artificial rupture of membranes after 25 hours of labor. She experienced postpartum hemorrhage, requiring Pitocin. Initially, Rebecca chose the birth center due to financial issues. She did not decide to give birth at the center until her third trimester, and when her labor began, she continued to feel uncertain about choosing an unmedicated birth. The comments of women who had had negative hospital experiences and positive birthing center experiences influenced her final decision. Moreover, she appreciated allowing her body to decide the course of labor and birthing. Rebecca fought the urge to transfer to the hospital for an epidural, because, according to birthing center lore, no woman had been transferred for pain relief. She plans to have another baby at the birth center.

Jessica, a 26-year-old, married college graduate, experienced a postterm vaginal birth after 5 hours of regular contractions. Jessica chose the birth center because she desired a natural birth. She avoids putting chemicals into her body and believes that God designed women's bodies to give birth. Her mother had birthed Jessica and her siblings without medication, and Jessica had heard other women recount negative hospital experiences. She plans to have another baby at the birth center.

Marie, a 33-year-old, married college graduate, had a vaginal birth after 12 hours of labor. Finances and word of mouth influenced her decision to choose the birth center. Also, she wanted to avoid the hospital because of painful memories associated with sick family members, and she desired to keep her baby at her side rather than in the nursery. Marie's daughter developed severe jaundice and spent 3 days in a hospital intensive care unit. Marie plans to have another baby at the birth center.

Kathy, a 22-year-old, married high school graduate, experienced a vaginal birth after induction using a cervical gel. She labored for almost 24 hours while her entire church congregation of 20 remained at the center, eagerly awaiting her son's arrival. Kathy had always wanted to give birth at the birthing center. She learned of the center prior to becoming pregnant when she saw a billboard advertisement. Kathy had observed friends giving birth at the hospital and wanted to avoid bed confinement during labor. Furthermore, she desired a natural birth because she feared the potential side effects of an epidural. Kathy's son required oxygen immediately after birth but has had no further com-

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Themes

Three overarching themes emerged from the narrative data: (1) Empowerment, (2) Sense of Motherhood, and (3) Establishing and Strengthening Relationships. These themes portray positive effects that participants attributed to care received at the birthing center. All seven women described the overall experience as satisfying. No one expressed negative psychological outcomes, although some did experience physical complications.

Empowerment. The first theme encompasses concepts of achievement, accomplishment, self-confidence, self-esteem, strength, security, and inspiration. Every woman expressed a changed attitude regarding her capacity to assume new challenges. Prior to giving birth, they felt uncertain of their own ability to succeed, whereas afterward they felt empowered to face any task with confidence. Kelly illustrated this newfound courage:

I'm pretty much convinced if I could go through that, I can do anything. I grew wings; I'll go as high as I want now. I believe I can do anything now. And if it wasn't for the midwives, I would not believe that because they helped me believe that. They supported me on it, and they just, they're my backbone. . . . I feel more powerful.

Sara expressed a sense of accomplishment achieved through the experience of giving birth without pain medications:

And I just felt like, if I can do that, I can do anything. You know, I can, whatever, nothing can be that hard you know. Nothing else will ever be that hard. Yeah, it was, it was a huge accomplishment like more than I was expecting it to be.

"I'm pretty much convinced if I could go through [giving birth], I can do anything. I grew wings; I'll go as high as I want now."

Rebecca articulated new feelings of empowerment by emphasizing the strength she found within herself through accomplishing the task of birth. She noted that her newfound strength translated to a renewed self-confidence and self-esteem:

It just strengthened myself and made me very proud, you know, that I could do this. And I could, you know, I could do it, and I didn't have to have help. I had support, but I did it on my own. And, yeah, it does make me feel good; it makes me very proud.

Finally, Jessica experienced empowerment through a loss of the fear she had associated with giving birth:

But, I told my husband, now, you know for the next child, I'm excited. I guess there's no fear there. I'm sure you know the day I start going into labor, I'll be like, "Oh, I don't know if I want to do this." But, you know it's exciting to me because I had such a great experience. I don't have any fear in thinking about doing it again.

Sense of Motherhood. The second major theme addresses parents' anxiety about caring for their newborn. As new mothers, these women had concerns about childrearing. However, the care they received at the center gave them confidence in their ability as mothers. Elizabeth described the reassurance she received:

I wasn't as worried about the childbirth as I was worried about bein' able to take care of him when I got home. That scared me more than having the baby because I was scared half to death that I would not be able to do everything that he needed me to do. I wanted to make sure that I would be a good parent, I would be a good mother. And bein' encouraged so much and makin' it through the childbirth showed me that I can do that; I can be a good mother; and I can take care of him, and do the things that he wants me to do. . . it made it less scary when I took him home. So that I knew that I could do it. I wasn't as worried about it afterwards. So, yeah, it helped.

Kathy described this mother-baby connection and confidence in childrearing using the phrase "sense of motherhood," and she related this sense to understanding her child's experience of being

born. Experiencing birth without medications or interventions permitted her to truly experience the birth with her baby; she felt they had accomplished this together and that it would always connect them, as reflected in her comments:

But I think it also gave me a better sense of being a mom. I know exactly, exactly what he went through [in being born] and you know how special it is, you know, to be a mom. And it gave me a better sense of motherhood, I can say probably. . . a better sense of motherhood.

Establishing and Strengthening Relationships. The final theme describes the formation of new human connections and the growth of existing relationships that occurred throughout the perinatal experience. Marie, Kelly, and Sara illustrated the sense of friendship that extended beyond a traditional patient-provider relationship:

I formed some friendships through this as well. And so. . . just through the midwives and their husbands and their children and. . . I mean I, I just know that they're good people and have nice families. (Marie)

It's more of a friendship than a doctor visit. When you come in, they're just so excited to see you, and they're excited about the baby. (Kelly)

I felt like I was being taken care of by family. (Sara)

In addition to establishing relationships with the midwives, participants recounted the changed perceptions of their friends and family members following the experience. Elizabeth explained that others expressed a new positive perception of her, which contributed to her self-confidence:

My brother, the first thing my brother told me when he saw me after I had the baby, was that he was very proud of me, that he was so proud of me, that I did, you know, that I could do it. And I have people, I have a friend of mine who has had, just had her second baby, but she's had a c-section on both of hers. And she tells me that I am more of a woman than she'll ever be because she can't stand the pain.

Furthermore, participants explained that the experience strengthened their marital relationships by

improving their husband's perceptions of them. Kelly and Sara described their husband's responses to watching them give birth:

Ever since that night, he just thinks that I am like the greatest woman in the whole world and that I've accomplished more than anybody. (Kelly)

He's always thought that I didn't have much of a pain tolerance. And. . . yeah you know, he's always, I don't know there's kinda always been this you know, well, "[Sara] doesn't work all that hard, you know, she doesn't really do that much." But that changed afterwards. Yeah. (Sara)

Elizabeth explained family members' new regard for midwifery. She noted that the patient- and family-oriented care exhibited by the midwives inspired expressions of gratitude from family members:

It has changed a whole lot of my family's outlook on, on midwifery. And they're all, they all think positive about it. And all have, are so grateful to the midwives here at the maternity center. You know, my mother-in-law wanted to make a blanket for the, some of the babies that are coming in, to give back to the maternity center. My mother, we, we got a fruit basket to give back, you know because they're so thankful for the way that they treated my entire family, not just me but my entire family while we were here during my labor. And it was just wonderful.

DISCUSSION

The current study's Empowerment theme supports earlier findings that birthing experiences influence self-confidence and self-esteem by empowering women through a sense of accomplishment (Hardin & Buckner, 2004; Kennedy, 1995, 2000; Kennedy et al., 2004; Sauls, 2002; Simkin, 1991; Ulrich, 2004). Previous studies demonstrated connections between midwifery care and empowerment.

The Sense of Motherhood theme describes a mother-child bond and an increased confidence in childrearing abilities. This finding is congruent with previous study results linking the midwifery process of care to easing maternal role adjustment (Green et al., 1990; Proctor, 1998; Sauls, 2002). Additionally, data from the current study suggest one etiology for easing maternal role adjustment. An unmedicated birth results in a strong mother-child connection by permitting the mother to fully comprehend the in-

fant's experience of being born; mother and child experience the pain and challenge of birth together. Furthermore, the sense of accomplishment contributes to maternal confidence in childrearing abilities, which eases adjustment to the maternal role.

The Establishing and Strengthening Relationships theme supports the findings of Kennedy et al. (2004), who identified three themes: (1) The Midwife in Relationship with the Woman, (2) Orchestration of an Environment of Care, and (3) Life Journeys for the Woman and the Midwife. These themes reflect the friendship and mutuality foundational to the midwife-client relationship and are congruent with data revealed in the present study. Although *establishing* relationships supports previous findings, *strengthening* relationships represents findings not noted in the literature reviewed.

Findings from this study support the notion that care providers may improve outcomes by attending to the laboring woman's emotional needs (Simkin, 1996). In addition, participants indicated that they appreciated inclusion in decision-making. This supports previous findings that feeling in control leads to a positive birth experience (Cragin, 2002; Green et al., 1990; Hardin & Buckner, 2004; Kennedy et al., 2004; Proctor, 1998; Sauls, 2002; Simkin, 1991). The literature also stated that midwives provide information to the woman and her family, promoting emotional well-being and a decreased risk of postpartum depression (Green et al., 1990; Sauls, 2002). Data from the present study indicate that well-being is promoted, but none of the participants mentioned *emotional well-being* specifically.

LIMITATIONS

Some limitations of this pilot study must be noted. First, all participants expressed overall satisfaction with their experience and had uncomplicated births. The study did not reflect perspectives of unsatisfied women or those who experienced complications. Using a random sample rather than a convenience sample may have eliminated this limitation. Second, a more definitive connection could have been established between positive outcomes and nurse-midwives' care by asking participants to elaborate on specific actions and words that led them to feel more capable of mothering, happier with their relationships, and empowered.

CONCLUSION

Data revealed that women value caring providers, that caring providers support positive psychosocial

outcomes, and that those outcomes may equate to a satisfactory birth experience. Moreover, these results imply benefits of incorporating the midwifery care model into standards of practice for all perinatal health-care providers.

Implications for Research

The results suggest that positive outcomes are correlated to care provided by certified nurse-midwives. However, comparison studies of clients who received perinatal care from obstetricians, family physicians, and hospital-based nurse-midwives may support or contradict a correlation between provider/philosophy of care, place of birth, positive psychological outcomes, and satisfaction. Furthermore, future studies could explore additional variables affecting satisfaction with the birth experience.

The impetus for this study was the increasing problem of health-care litigation. I posed the question, "Is it possible to reduce unnecessary interventions, decrease lawsuits, and improve outcomes?" In response to this question, I noted that midwives practicing in freestanding birth centers use few technological interventions, focusing on psychosocial support, and that studies have documented superior outcomes and high satisfaction rates with midwifery care. Second, I considered that satisfied clients are less likely to file lawsuits. Thus, I sought to examine outcomes of midwifery care that result in satisfied clients. Although the results of this study indicate positive outcomes that may result in satisfied clients, I did not question participants about influences on decisions to pursue litigation. In order to establish a stronger connection among the midwifery philosophy of care, satisfied clients, and decreased litigation, future researchers could question participants who have filed lawsuits about the events that influenced their decisions.

Implications for Practice, Policy, and Education

Previous studies have documented long-term consequences of a positive or negative birthing experience (Matthews & Callister, 2004; Simkin, 1991, 1996). In addition, studies of women's experiences of childbirth consistently report a strong connection between satisfaction and caregiver support, behavior, and involvement (Hodnett, 2002; Melender, 2006). Results from the present study support these earlier findings and, consequently, reinforce the absolute necessity for caring, dedicated providers

throughout the perinatal period. Perinatal nurses, midwives, and physicians must acknowledge the effect of their behavior during this vulnerable and powerful time in a woman's life, while educators must teach and model excellent communication skills.

All study participants directly attributed their satisfactory experiences to close, caring relationships with the nurses and midwives who attended their births. This study's implications for practice and policy lie in the fact that an increase in interventions and defensive medicine has not decreased litigation. Rather, they have forged an increasingly wider gap between patients and providers. Participants in this study revealed that they value caring providers who demonstrate both a clinical and emotional depth of knowledge. Thus, those in practice and those writing policies should consider that one solution to decreasing litigation rates is to connect with patients through caring relationships, which results in satisfied clients and positive outcomes.

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