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THE ROLE OF MATERNITY CARE PROVIDERS IN PROMOTING SHARED DECISION-MAKING REGARDING BIRTHING POSITIONS DURING SECOND STAGE LABOR

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Abstract

Introduction—Through the use of a variety of birthing positions during second stage labor, a woman can increase progress, improve outcomes, and have a positive birth experience. The role maternity care providers play in determining which position a woman uses during second stage has not been thoroughly explored. The purpose of this qualitative investigation was to explore how maternity care providers communicate with women during second stage labor regarding birthing position.

Methods—A literature informed framework was developed to conduct a process of deductive content analysis of communication patterns between nulliparous women and their maternity care providers during second stage. Literature regarding shared decision making, control, and predictors of positive birth experiences were reviewed to develop a coding framework. The framework included the following categories: listening to women, encouragement, information, offering choices and style of support. Forty-one audio tapes of women and their maternity care providers during second stage labor were transcribed verbatim and analyzed.

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Précis: Women become more involved with choices regarding birthing positions when providers move between open and informative approaches and more closed and directive approaches.

Results—Themes identified in the transcripts included all those in the analytic framework plus two added categories of communication: empathy and interaction. Maternity care providers in this study enabled women to select various birthing positions using a dynamic process that moved between open, informative approaches and more closed, directive approaches depending on the woman's needs and clinical condition. Women became more actively involved in shared decision making regarding birthing positions as providers found the right balance between being responsive to the woman's questions or directive as clinical conditions unfolded.

Discussion—Enabling shared decision making during birth is not a linear process using a single approach; it is dynamic process that requires a variety of approaches. Care providers can support a woman to use different birthing positions during second stage labor by employing a flexible style that incorporates clinical assessment and the woman's responses.

Keywords

physiologic birth; choice; shared decision making; birthing position; woman-centered care

INTRODUCTION

In second stage labor, how women and their maternity care providers approach decisions regarding birthing positions is important, since these decisions can influence clinical outcomes. Women's involvement in decision making has been shown to have a profound effect on their birth experiences and satisfaction with care.^{1,2,3} Yet research on the involvement of women in decision making in maternity care, including selection of position for birth, has primarily been framed as control during the birth experience, and the process of shared decision making has not been widely studied. Using women's birth stories, VandeVusse explored how sharing control contributed to the decision-making process and women's positive emotions regarding the birth experience.⁴ Her conceptualization of control was focused on women's active involvement in decision making. However, others have emphasized that the degree to which women want to participate in decision making regarding their care might vary.^{5,6} Women's involvement also seems to arise from feeling that they could challenge decisions made by others if the need arises instead of making decisions themselves.⁷ Women who felt supported enough by people present at the birth “to let go” rather than trying to assert control over events or over behaviour also reported positive birth experiences.⁸

Researchers highlighted the complexity of women's involvement in decision making during childbirth in a survey of 1573 American women who had given birth in the hospital at least once.⁹ Most women (73%) said they should make decisions after consulting their care providers, while 23% indicated that shared mother-caregiver decision making was a means to come to the final decision about an option or choice.⁹ How shared decision making during birth is or is not enacted regarding selection of birthing positions during second stage labor is an area that has yet to be explored.

Other researchers have indicated that the ability to change positions and a woman's ability to determine which positions are used affect their satisfaction with the birth experience and sense of control.¹⁰⁻¹² Currently there is no evidence that one specific position is

optimal¹³⁻¹⁵. When providers are attentive to the dynamic process of birth and open to changing positions during labor, this approach might be more beneficial than only using one position.¹⁶ This seems especially significant in longer second stages of labor or for women who receive epidural analgesia when a change of positions may contribute to the comfort of the woman, the alignment of the fetus with the pelvis, and progress towards birth.¹⁷ In observational studies of women giving birth in non-prescriptive environments where they were encouraged and supported to choose their own positions, women tended to use a variety of positions during second stage of labor as opposed to a single position.¹⁸⁻²⁰

All women do not have equal access to the use of different birthing positions or to involvement in decisions about the position to use.^{21,22} Aspects of shared decision making regarding birthing position include how much maternity care providers support and enable women to explore preferences in birthing positions and identifying comfortable and effective positions to support progress.^{16,20,23-25} In prior studies, researchers suggested that women value the support that care providers can offer, but they also want to have an influence on the decisions regarding birthing positions in conjunction with care providers.¹⁵

Insight into the interaction between women and maternity care providers regarding birthing positions during second stage labor can contribute to a better understanding of how to involve women in shared decision making regarding other aspects of care during birth. The aim of this qualitative study was to explore the communication between maternity care providers and women during second stage labor as choices and decisions regarding birthing position are made.

METHODS

Design, setting and data collection

An exploratory, qualitative investigation was conducted using audio-recordings of women during second stage labor that were part of a larger randomized clinical trial, the Promoting Effective Recovery from Labor (PERL) project. This project focused on prevention of incontinence associated with childbirth. Following institutional review board approval, women 18 years of age or older and planning a first vaginal birth enrolled in the parent project between 2000 and 2006 and gave birth at a teaching hospital in a Midwest university town. The study methods for the larger project are reported in detail elsewhere.²⁶ As an additional component of the parent project, a subset of the participants agreed to allow audio-recording of the conversations occurring during second stage labor. The audio-recordings were intended to serve as a validation of the pushing method used by women during second stage labor. The audio-recording was made using a regular cassette; it was started by the nurse once the woman entered second stage labor and continued through the birth of the newborn.

From the available 110 tapes, 50 were randomly selected and transcribed verbatim, including all aspects of communication. Of the transcribed tapes, 9 were subsequently excluded: 2 because of multiparous births, 5 because only a small fragment of second stage was recorded, and 2 because the quality of the recording was very poor. This left 41 tapes for analysis. The duration of the tapes ranged from just a few minutes to 5½ hours. In 8 of

the tapes there was no mention of the birthing positions used during second stage labor, all of which were of short duration. The tapes were transcribed verbatim by 2 individuals who had prior experience in transcribing individual and focus group data. Ten randomly selected tapes were listened to by two of the authors (MN and LKL) to confirm the accuracy of the transcription process and to allow the investigators to appreciate pauses, delays in communication, and/or periods of quiet when the only sounds heard were breathing or bearing down.

Analysis

The focus of the analysis was on the communication between women and care providers regarding birthing positions during second stage labor through birth. Partners and others present at birth were recognized as participants in this interaction but were not included in the scope of this study. The type of provider at the birth, midwife (CNM), physician (MD) or nurse (RN), was determined by how they were referred to on the tape as indicated in the transcript.

Data were analyzed using deductive content analysis, which is used when existing information on a topic or area exists, and the new analysis will add or extend that knowledge or result in theory development.²⁷ This process of analysis has also been described as extended case methodology, the goal of which is to increase knowledge rather than create an initial understanding of a phenomena.²⁸ Existing literature is available regarding shared decision making in other health care contexts and attributes women identify as contributing to a positive maternity care or birth experience. We developed a framework prior to the initiation of analysis based on studies about patients' active involvement in choices and shared decision making in general health care.²⁹⁻³¹ Behavioral elements from studies on sense of control and decision making during birth that contribute to positive birth experiences were also incorporated into the framework.³²⁻³⁴ Women's sense of control during birth has been shown to be an important factor contributing to positive assessment of the birth experience and subsequent well-being.^{1,2,3,13,35} Sense of control has been described as involvement in the birth process, influence over procedures, decisions or information, being offered choices, and participation in decision making.^{1,33,34} We included communication patterns previously described during second stage labor related to the types of pushing women may use and the provider role in encouraging that pushing approach.^{36,37}

The analytic framework generated from the literature included the categories listening to women, encouragement, information, offering choices, and style of support (Table 1). The transcripts were considered the primary data sources, and we analyzed them using this framework with a deductive process.²⁷ The first author read and reread the complete transcripts of each tape to identify any communication or interaction related to birthing positions. The central categories from the framework and key statements of the interaction on birthing positions were identified in each transcript. Beyond the central categories in the framework, the analysis process was open to identify any missing or new themes that would present themselves during the review of the transcripts, which were not included in the original literature based framework.

We also explored the development of the interaction between the woman and provider in relation to the dynamics of the birthing process. Using the definitions of provider styles from the analytic framework listed in Table 1, we listened to a number of tapes to determine whether our interpretation of the care provider's style of interaction from the transcript was supported by the tone of voice used in the communication. In 7 cases, care providers seemed especially attentive to supporting women in their choices for birthing positions. These tapes were analyzed further to explore the interaction and style of support providers offered. The second author conducted a dependability and confirmability audit to check the analysis against accepted standards and examine the analysis process and records for accuracy.³⁸ The qualitative findings are presented as descriptive summaries and interpretations of the key categories identified and are supported and illustrated by quotes from the raw data. NVivo 8 (QSR International, Victoria, Australia) was used for the qualitative analyses process, while socio-demographic data were analyzed with descriptive statistics using Statistical Package for the Social Sciences, version 19 (IBM SPSS, New York, USA).

RESULTS

The final sample included 41 participants; all were nulliparous and experienced uncomplicated term pregnancies. Demographic characteristics of the women are provided in Table 2.

Birthing positions

In a total of 33 tapes, birthing positions were mentioned at least once during second stage labor. The median for mentioning birthing positions was 9 times, ranging from 1 to 28 times. Change of birthing positions was mentioned more often when second stage lasted longer, and when midwives were the responsible care providers. Midwives were also noted to offer a greater variety of birthing positions.

The birthing positions most often offered to women by their care providers were squatting and hands-and-knees positions. Sitting, semi-recumbent, and side positions were offered less often. Standing positions and the use of the shower or bath were offered occasionally. The positions that were used most often were semi-recumbent, sitting, squatting and side positions. A few times the hands and knees positions or the shower or bath were used. Nearly all women changed to different positions several times during birth.

The most common reasons mentioned for change in position were comfort of the mother and to promote progress of labor. Fetal distress was only occasionally a reason for position change. Several times positions were changed to meet the woman's request. When women asked for a specific birthing position, it was primarily a vertical position, such as squatting or sitting. On a few occasions women asked to use a side position. Women never asked for a semi-recumbent position.

Provider involvement in decisions regarding birthing positions

From our analysis the role of care providers was significant in enabling women to consider choices regarding the use of various birthing positions and thus share in decision making. The following themes were evident in the data.

Listening to women—Care providers' responsiveness to signals given by the women enables active involvement of women in their care. Care providers in this study were responsive to women's requests about certain birthing positions:

Woman: I want to try the bar.

Provider (CNM): What do you think? Support you this way and grab on to it?

Okay, here's the bar (woman's name). Want me to put the head of the bed up so you're sitting up a little higher and then you can grab the bar? Okay? If you want I can lower the bar too.

Woman: Okay, let's do that.

However, in most cases the care provider assessed the woman's behavior and then recommended position changes instead of waiting for the woman initiate the change. In doing so, providers were trying to make women more comfortable. Occasionally, they asked how women felt in certain positions and explored how to further adjust positions for women's comfort: "Provider (CNM): If that's comfortable for you, if that helps. You can try it [squat bar] and if you don't like it we can take it right off."

Sometimes providers mentioned changes of position because they had the impression women were uncomfortable at that moment: "Provider (CNM): Is this position okay for you or did you want to use the pushing bar or anything like that?" They often combined their responses with assurance and encouragement, emphasizing that their primary task was to make everything as comfortable as possible for the woman.

Encouragement—Most of the verbal feedback given by care providers was aimed at encouraging women to go on pushing:

Provider (RN): I don't think standing is making it any worse. I think T told me that you like being up and about and that's what you should do. You should just do what's worked before in the past. Kind of change positions and just deal with each contraction as it comes and just do the best you can and get through it.

Information—Most of the information given on birthing positions was directed on how to use a certain position:

Provider (CNM): We'll put the back of the bed up and your feet down and you can, there are all kinds of ways to do it, but so you can kind of sit on the edge of where the bed splits here and sort of grab on to the bar. Like with a contraction, if you're able to kind of grab on to the bar and squat.

Woman: Okay, so I should get up.

Provider (CNM): Well, we'll put your bed up. We'll put your head up. Okay and we can adjust that if you need it lower.

Also the care provider gave information about why she wanted the woman to use a certain position at that moment, often explaining the mechanism of labor and the potential

relationship it should have in improving the woman's ability to bear down. Occasionally, information was given on restrictions against the use of certain positions (eg, with epidural analgesia).

Offer choices—Care providers used different approaches to offer changes in birthing positions and choices of positions to the women. The approaches moved from a very general, open approach to offering one specific position. Overall, most care providers expressed openness to using different positions and tended to use open, supportive approaches to introduce the topic of birthing positions in the beginning of second stage. They either asked an open-ended question about what birthing positions women would like to use, or they stated that women could use any position they felt comfortable with. This presented the possibility of a change of position as a natural part of second stage labor management and in some cases emphasized the importance of change: “Provider (CNM): There's not one way or one position that works for everybody. That's why you change around.” If care providers felt that women were uncomfortable or that the birth wasn't progressing optimally, they would become more directive and suggest only a limited number of options or direct the women towards one specific position.

Women participating in choices on birthing positions

A limited number of women actively communicated the desire to use a certain position, and a few were persistent in expressing their preferences, “Yeah, I think I should at least try it. I do a lot of squats at home.” Other women had a more hesitant approach and asked for direction, “Does this still seem like the best position? Am I being useful in this position? Somebody's gonna tell me if...” Most women were willing to try the positions that were offered to them and told providers whether the position was comfortable and worked or not.

Interaction between care providers and women

Maternity care providers used different styles to interact with women regarding birthing positions. We noted differences in styles between care providers and within the same provider. Often, two or all three styles (directive, supportive direction, and supportive) were used by the same provider. This depended on the provider's assessment of the clinical situation and the woman's needs. In their interactions with women, many care providers showed empathy and were concerned for the women's physical and mental well-being. They acknowledged women's emotions and the hard work they were performing. This seemed to add to a sphere of openness that allowed women to voice their wishes:

Provider (CNM): Good job! Did it feel okay to have your feet up on that squat bar?

Woman: Yeah, I mean both ways were fine. But it does feel like I have more leverage.

Provider (CNM): Yup, more leverage and more control, yeah. It's tiring isn't it?

Woman: Just when you feel like you're going to pass out. Ha-ha.

Some care providers provided extensive direction (directive style) and told women what to do and how to do it. This style was more prevalent when women were panicking, in pain, or

the condition of the fetus made adjustment necessary. Sometimes the woman explicitly asked the care provider to tell her what to do. However, when a directive style was initiated by the provider, it seemed to be the dominant approach used by that provider in general, and there was almost no verbal interaction with the woman related to birthing positions. Instead, the provider focused on giving directions on what to do and how to do it. This style was usually used in combination with direction to use a semi-recumbent position.

However, the majority of care providers started by openly exploring which positions women wanted to use (supportive style) by posing an open ended question and enabled women to use whatever positions they preferred. If the woman knew what she wanted, a dialogue evolved on how to establish that birthing position: the care provider gave different suggestions on how best to do it and the woman would comment on how it felt. If the woman was uncertain or couldn't find the right position, the care provider would move to a more directive approach (supportive direction) in an ongoing interaction. The care provider gave specific suggestions for certain positions and offered the woman detailed direction on how to actually use the position, including a process of confirming that the directions offered by the provider were understood or helpful:

Woman: I'm having a hard time keeping myself up.

Provider (RN): Would you like some support? We can put this in back and have your mamma sit on here.

Grandparent: Do what now?

Provider (RN): She wants to sit forward. Put your arms under her. Do you feel like you want to change positions?

Woman: I don't know what position I'd change to.

Provider (RN): You can try something different if you want. You can lean back and put your feet up on the bar.

A few women seemed more prepared for the use of certain positions, and in instances where women had specific ideas about the use of certain birthing positions, the care provider was triggered by these requests to become more active in their interactions. Once the care provider started working with the woman, the woman also actively worked with the care provider. For instance, when progress was slow, the woman would suggest a different position and the interaction became more shared between the provider and the woman to reach the best position to promote progress:

Woman: Let's try ... turning over seems like so much work. On hands and knees again seems like that would really help her get out.

Provider (CNM): It'll help but if you're too tired I'd go for the squat.

Woman: Let's try the squat then.

In our analysis of the transcripts, we identified all the categories from the initial framework: listening to women, encouragement, information, offering choices, and style of support (Table 1). In transcripts in which bedside care providers seemed especially sensitive and open to shared decision making and change in the use of birthing positions, all the behavioral elements of the framework appeared in some form or another. However, two additional categories were identified during analysis: empathy and interaction.

Empathy was representative of a broad dimension in the interaction between care providers and women that was crucial for enabling women's involvement in decision making.³⁹⁻⁴¹ Empathy was present when care providers were very responsive to switching their approach based on verbal and non-verbal signals given (when they could be inferred) by the women. Apart from women's verbal comments, it sounded as if the provider often assessed the woman's behavior and then interjected a recommendation for position changes instead of the woman actually requesting or saying anything specific about the need for a change:

Provider (RN): We can get a birthing bar that you can hang from, you can stand and push, you can do just any way you want.

Woman: This is most comfortable.

Provider (RN): If laying here is comfortable I wouldn't move. Do you want me to put you on your side for a bit?

Woman: Yeah.

Provider (RN): Whatever works. You're doing a great job.

Later during second stage, the same woman and provider had the following exchange:

Woman: [Crying]

Provider (RN): It's alright. Sometimes it helps if you want to put your leg up here. It kind of gives you a little bit of a leverage you know, where, what to do. It helps save your energy a little bit more too. Want to try that?

Empathy is indicated by the ongoing assessment whereby the provider made multiple intuitive and experientially driven assessments about how the woman was progressing in a specific position. This dialectic process combines the preferences of the woman with the ongoing assessment of the provider. The care provider then uses her expertise to adjust her approach to match the unique features of the clinical situation in concert with the woman's desires. This was present with both midwives and nurses at the bedside.

The other new theme that not previously included in the framework was interaction. Interaction was representative of the movement between preferences, needs, and knowledge of the provider and the woman. This process was a core element in reaching comfortable birthing positions and optimal progress to accomplishing birth:

Provider (CNM): You tell us when you're tired of this position okay? I know this is a hard one to stay in.

Woman: Yeah, I think I've got a couple more and that's it.

Provider (CNM): We also can push on your side, you can squat, you can do whatever you want.

Woman: Yeah, we can try squatting again.

Provider (CNM): That also takes a lot of energy so if you want to try an easy one in between.

The revised framework is provided in Table 3.

DISCUSSION

This study explored the communication between maternity care providers and women during second stage labor as choices and decisions regarding birthing position are made. Our findings demonstrate that when maternity care provider communication with women is a dynamic process it enables women's involvement in shared decisions regarding the use of birthing positions. Care providers in this investigation moved between an open, informative approach to a more closed, directive approach depending on the needs of the woman and clinical assessments. These needs were often identified by the care provider without the woman having to verbally express them. Similar to the results of Kennedy et al.,⁴² most care providers in this study attempted to create a care environment in which women's desires were met and normalcy was preserved.

Limited information was given to the woman and her partner about birthing positions overall, and in a number of cases, birthing positions were only discussed when the duration of second stage labor was longer or progress was limited. This finding was surprising, since women are provided with prenatal education about positions for second stage labor and can be reminded about the possibility to change positions at the beginning of second stage. In one study, women stated that the midwife's advice was by far the most important factor that influenced their decision regarding birthing position.²⁴ Women have also expressed a strong need to be informed about how to prepare physically and mentally for the birth, including the use of birthing positions, during pregnancy⁴³ so discussion of birthing position can occur well before labor. In this study, women who appeared to be more aware of possible birthing positions and who expressed their wishes for certain positions were able to use their preferences. Similarly, in a quantitative study among Dutch women, researchers demonstrated that women with strong preferences were more likely to use their preference.²¹

Not surprisingly, a longer duration of second stage as described by the providers or the woman was a reason to become more active in using different birthing positions, and other quantitative studies document this type of change.^{21,22} In these studies, quite often semi-recumbent positions were used and women changed to more upright positions to promote

progress. In our study, women were directed a number of times to lie flat on the back to promote the decent of the infant's head under the pubic bone. This may be a site specific approach employed uniquely in this hospital setting as there is limited evidence that this approach is valuable.

Strengths and Limitations

The use of audio-tapes provides a unique opportunity to directly explore the day-to-day practices regarding choice and use of birthing positions in second stage labor. The results of this investigation are generalizable to women who are giving birth in hospital settings where midwives, physicians, and nurses are part of the care team. Women in this study did not have doulas, which may result in different interactions between the woman and her care providers. Therefore, our results are not generalizable to this group. Although video-tapes provide evidence of non-verbal and verbal interaction and the actual use of birthing positions, video-recording may be perceived as more invasive to laboring women. The large number of audio-tapes from 2000-2006 could be considered dated but they reflect the realities of clinical practice and the use of evidence on the benefits of changing position and avoidance of supine positions. In the 27 trials included in the meta-analyses on birthing positions, all were dated before 2005, except for 3 trials.^{10,12} Care providers were aware of the recording, and that could have influenced their practice, but birthing positions were not a topic of interest in the initial parent study so it is unlikely they filtered their communication due to the ongoing investigation.

A strength of the study was the use of a literature informed framework developed for the analysis. All of the themes; listening to women, encouragement, information, offering choices and style of support were identified in the transcripts, Two new themes were also noted, empathy and interaction which were added to the final framework (Table 3). This framework can be used in future investigations of provider communication during the multidimensional process of labor and birth to evaluate the process of shared decision-making.

CONCLUSION

Women's involvement in shared decision making during birth is a complex phenomenon. Shared decision making in other aspects of health care require time, space for conversation, and opportunity to gain insights into the preferences and desires an individual may have for her health care outcomes.⁴⁴ In the context of second stage labor, the process of sharing information, communicating clinical findings, and reaching a decision may be more challenging for women than is usually described in the literature on shared decision making. Labor pain, the need for women to concentrate on coping with the pain, the urgency of certain decisions, and women's pre-existing assumptions and desires all influence the process of shared decision making. Therefore, enabling women's involvement in decision making during birth and selection of birthing positions is not a linear process with one correct approach. Instead, the process can be tailored to women's desires, comfort, and preferences while considering the clinical circumstances. Overall, outside of extenuating clinical situations, priority should be given to women's preferences and desires through a

process of shared decision making. This is enacted using varied behaviors and communication patterns, including being interactive, listening to women, offering encouragement, sharing information and choices, using a style of support, and employing empathy. The use of shared decision making between women and their maternity care providers can have a positive effect on their perception of their birth experience and may improve health outcomes related to second stage labor.

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REFERENCES

1. Waldenström U. Experience of labor and birth in 1111 women. *J Psychosom Res.* 1999; 47(5):471–82. [PubMed: 10624845]
2. Goodman P, Mackey MC, Tavakoli AS. Factors related to childbirth satisfaction. *J Adv Nurs.* 2004; 46(2):212–19. [PubMed: 15056335]
3. Waldenström U, Hildingsson I, Rubertsson C, Rådestad I. A negative birth experience: prevalence and risk factors in a national sample. *Birth.* 2004; 31:17–27. [PubMed: 15015989]
4. VandeVusse L. Decision making in analyses of women's birth stories. *Birth.* 1999; 26(1):43–50. [PubMed: 10352055]
5. Lavender T, Walkinshaw SA, Walton I. A prospective study of women's views of factors contributing to a positive birth experience. *Midwifery.* 1999; 15:40–6. [PubMed: 10373872]
6. Green JM. Commentary: what is this thing called “control”? *Birth.* 1999; 26:51–2. [PubMed: 10352056]
7. Green JM, Baston HA. Feeling in control during labor: concepts, correlates, and consequences. *Birth.* 2003; 30:235–47. [PubMed: 14992154]
8. Parratt J, Fahy K. Trusting enough, to be out of control: a pilot study of women's sense of self during childbirth. *Australian Journal of Midwifery.* 2003; 16:15–22. [PubMed: 12858479]
9. DeClercq, ER.; Sakala, C.; Corry, MP.; Applebaum, S. Listening to Mothers II. Report of the Second National U.S. Survey of Women's Childbearing Experiences. *Childbirth Connection*; New York: 2006.
10. Green JM, Coupland VA, Kitzinger JV. Expectations, experiences, and psychological outcomes of childbirth: a prospective study of 825 women. *Birth.* 1990; 17:15–24. [PubMed: 2346576]
11. American College of Nurse-Midwives; Midwives Alliance of North America; National Association of Certified Professional Midwives. Supporting healthy and normal physiologic childbirth: a consensus statement by the American College of Nurse-Midwives, Midwives Alliance of North America, and the National Association of Certified Professional Midwives. *J Midwifery Womens Health.* 2012; 57(5):529–32. [PubMed: 22954092]
12. Nieuwenhuijze M, de Jonge A, Korstjens I, Budé L, Lagro-Janssen A. Influence on birthing positions affects women's sense of control in second stage of labour. *Midwifery.* 2013; 29(11):e107–14. doi:10.1016/j.midw.2012.12.007. [PubMed: 23415350]
13. Gupta JK, Hofmeyr GJ, Shehmar M. Position in the second stage of labour for women without epidural anaesthesia. *Cochrane Database Syst Rev.* 2012; 5:CD002006. doi: 10.1002/14651858.CD002006.pub3. [PubMed: 22592681]
14. de Jonge A, van Diem MT, Scheepers PL, van der Pal-de Bruin KM, Lagro-Janssen AL. Increased blood loss in upright birthing positions originates from perineal damage. *BJOG.* 2007; 114(3): 349–55. [PubMed: 17217358]
15. Kemp E, Kingswood CJ, Kibuka M, Thornton JG. Position in the second stage of labour for women with epidural anaesthesia. *Cochrane Database Syst Rev.* 2013; 1:CD008070. doi: 10.1002/14651858.CD008070.pub2. [PubMed: 23440824]

16. Roberts J. The “push” for evidence: management of the second stage. *J Midwifery Womens Health*. 2002; 47(1):2–15. [PubMed: 11874088]
17. Wong CA, Scavone BM, Dugan S, et al. Incidence of postpartum lumbosacral spine and lower extremity nerve injuries. *Obstet Gynecol*. 2003; 101:279–88. [PubMed: 12576251]
18. Rossi MA, Lindell SG. Maternal positions and pushing techniques in a nonprescriptive environment. *J Obstet Gynecol Neonatal Nurs*. 1986; 15(3):203–8.
19. Hunt LM, Glantz NM, Halperin DC. Childbirth care-seeking behavior in Chiapas. *Health Care Women Int*. 2002; 23(1):98–118. [PubMed: 11822563]
20. Priddis H, Dahlen H, Schmeid V. Juggling instinct and fear: an ethnographic study of facilitators and inhibitors of physiological birth positioning in two different birth settings. *Int J Childbirth*. 2011; 1(4):227–41.
21. Nieuwenhuijze M, de Jonge A, Korstjens I, Lagro-Janssen A. Factors influencing the fulfilment of women's preferences for birthing positions during second stage of labour. *J Psychosom Obstet Gynecol*. 2012; 33(1):25–31.
22. De Jonge A, Rijnders MEB, van Diem MTh, Scheepers PLH, Lagro-Janssen ALM. Are there inequalities in choice of birthing position? Sociodemographic and labour factors associated with the supine position during the second stage of labour? *Midwifery*. 2009; 25:439–48. [PubMed: 18082298]
23. Hanson L. Second-stage positioning in nurse-midwifery practices. Part 2: factors affecting use. *J Nurse Midwifery*. 1998; 43:326–330. [PubMed: 9803710]
24. De Jonge A, Lagro-Janssen ALM. Birthing positions. A qualitative study into the views of women about various birthing positions. *J Psychosom Obstet Gynecol*. 2004; 25:47–55.
25. Walsh, D. Evidence-Based Care for Normal Labour and Birth: A Guide for Midwives. Routledge; London, UK: 2007.
26. Kane Low L, Miller JM, Gao Y, Ashton-Miller JA, DeLancey JOL, Sampselle CM. Spontaneous pushing to prevent postpartum urinary incontinence: a randomized, controlled trial. *Int Urogynecol J*. 2013; 24(3):453–60. [PubMed: 22829349]
27. Elo S, Kyngäs H. The qualitative content analysis process. *J Adv Nurs*. 2008; 62:107–15. [PubMed: 18352969]
28. Low LK, Martin K, Sampselle C, Guthrie B, Stewart A, Oakley D. Adolescents' Experiences of Childbirth: Contrasts with Adults. *J Midwifery Womens Health*. 2004; 2003; 4948:14–23. 192–198.
29. Wensing M, Wetzels R, Hermesen J, Baker R. Do elderly patients feel more enabled if they had been actively involved in primary care consultations? *Patient Educ Couns*. 2007; 68(3):265–9. [PubMed: 17686602]
30. Elwyn G, Hutchings H, Edwards A, et al. The OPTION scale: measuring the extent that clinicians involve patients in decision-making tasks. *Health Expect*. 2005; 8(1):34–42. [PubMed: 15713169]
31. Entwistle VA, Watt IS. Patient involvement in treatment decision-making: the case for a broader conceptual framework. *Patient Educ Couns*. 2006; 63:268–78. [PubMed: 16875797]
32. Bowers BB. Mothers' experiences of labor support: exploration of qualitative Research. *J Obstet Gynecol Neonatal Nurs*. 2002; 31:742–52.
33. Ford E, Ayers S, Wright DB. Measurement of maternal perceptions of support and control in birth (SCIB). *J Womens Health*. 2009; 18(2):245–52.
34. Larkin P, Begley CM, Devane D. Women's experiences of labour and birth: an evolutionary concept analysis. *Midwifery*. 2009; 25:e49–e59. [PubMed: 17996342]
35. Schytt E, Green JM, Baston HA, Waldenström U. A comparison of Swedish and English primiparae's experiences of birth. *J Reproduct Infant Psychol*. 2008; 26(4):277–94.
36. Bergstrom L, Richards L, Morse JM, Roberts J. How caregivers manage pain and distress in second-stage labor. *J Midwifery Womens Health*. 2010; 55:38–45. [PubMed: 20129228]
37. Sampselle CM, Miller JM, Luecha Y, Fischer K, Rosten L. Provider support of spontaneous pushing during the second stage of labor. *J Obstet Gynecol Neonatal Nurs*. 2005; 34:695–702.
38. Guba, EG.; Lincoln, YS. *Naturalistic Inquiry*. Sage; Newbury Park, CA: 1985.

39. Walsh D, Devane D. A metasynthesis of midwife-led care. *Qual Health Res.* 2012; 22(7):897–910. [PubMed: 22427456]
40. Bensing JM, Deveugele M, Moretti F, et al. How to make the medical consultation more successful from a patient's perspective? Tips for doctors and patients from lay people in the United Kingdom, Italy, Belgium and the Netherlands. *Patient Educ Couns.* 2011; 84(3):287–93. [PubMed: 21795007]
41. Neumann M, Bensing J, Mercer S, Ernstmann N, Ommen O, Pfaff H. Analyzing the “nature” and “specific effectiveness” of clinical empathy: a theoretical overview and contribution towards a theory-based research agenda. *Patient Educ Couns.* 2009; 74:339–46. [PubMed: 19124216]
42. Kennedy HP, Shannon MT, Chuahorm U, Kravetz MK. The landscape of caring for women: a narrative study of midwifery practice. *J Midwifery Womens Health.* 2004; 49:14–23. [PubMed: 14710136]
43. Seefat-van Teeffelen A, Nieuwenhuijze M, Korstjens I. Women want proactive psychosocial support from midwives during transition to motherhood: a qualitative study. *Midwifery.* 2011; 27:122–27.
44. Elwyn G, Frosch D, Thomson R, et al. Shared decision making: a model for clinical practice. *J Gen Intern Med.* 2012; 27(10):1361–7. doi: 10.1007/s11606-012-2077-6. [PubMed: 22618581]

Quick Points

- Maternity care providers offer a range of responses to support women in choosing birthing positions in second stage labor.
- The use of a flexible style in which providers move from being open and supportive to directive depending on the clinical circumstances appeared to be most associated with promoting the use of multiple birth positions.
- A framework that includes the following categories: listening to women, encouragement, information, offering choice, empathy, and style of support and interaction offers an approach to analysis of provider communication and shared decision making during the process of labor and birth.

Table 1

Framework for Analyzing Care Communication in Enabling Women's Involvement in Decision Making on Birthing Positions

Category/Concept	Care Provider Behaviors
Communication	
Listening to women	Is sensitive and responsive to verbal and non-verbal signs of the woman, asks for feedback from the woman on how she feels.
Encouragement	Encourages the woman to bring forward wishes and needs for positioning and reassures/affirms/stimulates the woman in her choices and use of positions.
Choices	Offers different options and choices, supports the woman in fulfilling her choices.
Information	Gives tailored information on change of birthing positions and on the different positions, gives advice.
Provider style	
Directive	Takes an authoritative approach, telling/instructing the woman what to do and how to do it; there is no give and take or conversation but primarily one way communication.
Supportive directive	Listens to the woman and responds to her questions and desires for direction but then returns to a supportive role when the question is answer or the need for some direction is met.
Supportive	Assumes a role of encouragement, acknowledging the woman, what she is doing but does not offer specific direction.

Table 2

Demographic Characteristics of Participants (N=41)

Characteristic	Value
Maternal age, mean (SD), y ^a	28.5 (5.5)
Education ^a , n (%)	
Up to some years of college	11 (28.2)
Finished college	11 (28.2)
Finished graduate school	17 (43.6)
Annual income ^a , n (%)	
< \$41,000	12 (30.8)
\$41,000	27 (69.2)
Ethnic origin ^a , n (%)	
Black	1 (2.6)
Asian	1 (2.6)
White, non-Hispanic	36 (87.8)
Other	1 (2.6)
Epidural ^b , n (%)	
Yes	27 (67.5)
No	13 (32.5)
Birth ^b , n (%)	
Vaginal	35 (87.5)
Cesarean	5 (12.5)
Responsible care provider at birth ^a , n (%)	
Nurse-midwife	12 (30.8)
Physician (obstetrician-gynecologist, family physician)	27 (69.2)

^a n=39 due to missing data^b n=40 due to missing data

Table 3

Adjusted Framework for Analyzing Care Providers' Behavior in Enabling Women's

Category/Concept	Care Provider Behaviors
Communication	
Listening to women	Is sensitive and responsive to verbal and non-verbal signs of the woman, asks for feedback from the woman on how she feels.
Empathy	Shows concern for the woman's physical and mental well-being, acknowledges women's emotions and the efforts she is making, acts accordingly.
Encouragement	Encourages the woman to bring forward wishes and needs, reassures/affirms/stimulates the woman in her choices and use of choices.
Choices	Offers different options and choices, supports the woman in fulfilling her choices
Information	Gives tailored information, gives advice based on the information
Interaction	Stimulates the interchange of preferences, values, knowledge and insights attuned to the woman's capacities and the birth context
Provider Style	
Directive	Takes an authoritative approach, telling/instructing the woman what to do and how to do it; there is no give and take or conversation but primarily one way communication.
Supportive directive	Listens to the woman and responds to her questions and desires for direction but then returns to a supportive role when the question is answered or the woman's need for some direction is met.
Supportive	Assumes a role of encouragement, acknowledging the woman, what she is doing but does not offer specific direction.

Involvement in Shared Decision Making During Birth