Patient and Provider Perceptions of Decision Making About Use of Epidural Analgesia During Childbirth: A Thematic Analysis

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ABSTRACT

This study examines the nature of differences in perceptions of decision making between patients and providers about use of epidural analgesia during labor. Thematic analysis was used to identify patterns in written survey responses from 14 patients, 13 labor nurses, and 7 obstetrician–gynecologists. Results revealed patients attempted to place themselves in an informed role in decision making and sought respect for their decisions. Some providers demonstrated paternalism and a tendency to steer patients in the direction of their own preferences. Nurses observed various pressures on decision making, reinforcing the importance of patients being supported to make an informed choice. Differences in perceptions suggest need for improvement in communication and shared decision-making practices related to epidural analgesia use in labor.

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Shared decision making in health care is the antithesis of medical paternalism and emphasizes the importance of active and informed involvement of patients in choices about their care. Shared decision making necessitates that patients and providers exchange much more than research-based evidence about risks and benefits of options. Personal values, preferences, and expectations about care and probable outcomes of choices are important components of all health-care decisions (Charles, Gafni, & Whelan, 1997; Elwyn, Edwards, & Kinnersley, 1999; Légaré et al., 2012). Childbirth in particular is associated with numerous value-laden choice scenarios. Imbalances in information between patients and pregnancy care providers can leave patients vulnerable to decisions that conflict with their personal values and preferences, ultimately leading to birth

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outcomes that do not meet individual needs and expectations.

Decisions made about "routine" interventions for labor and birth occur in the context of significant variations in clinical practice patterns, many of which are influenced by organizational culture, medicolegal pressures, and various nonmedical incentives rather than best evidence, patient knowledge, and patient values. The sustained and routine use of induction and augmentation of labor with the widespread use of epidural analgesia in the absence of evidence about health benefits for "low-risk" mothers requires closer examination. If imbalances exist between patient and provider perceptions of information sharing and understanding of these routine interventions, effective and carefully tailored strategies to address these imbalances will be needed to secure genuine shared decision making.

The objective of this study was to determine whether there were differences between patient and provider perceptions of decision making regarding epidural analgesia use during labor and if so, to identify the nature of these differences.

LITERATURE REVIEW

The implementation of shared decision-making practices within maternity care has recently gained attention as a strategy to improve perinatal health outcomes (Amnesty International, 2010; Gee & Corry, 2012; Sakala & Corry, 2008). Despite these efforts and the mounting research attesting to the positive health implications for mother and child associated with patient involvement in obstetrical decision making (Goodman, Mackey, & Tavakoli, 2004; Green & Baston, 2003; Green, Coupland, & Kitzinger, 1990; Harrison, Kushner, Benzies, Rempel, & Kimak, 2003; Jomeen & Martin, 2008), research suggests that patients in the United States continue to have limited access to shared decision making during childbirth (Declercq, Sakala, Corry, & Applebaum, 2006; Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013) and that the paternalistic model of care is still routine within today's health-care decision making.

Results from the national *Listening to Mothers III: Pregnancy and Birth* survey (Declercq et al., 2013) demonstrate how maternity care practices continue to undermine shared decision-making principles and patients' rights to voluntarily consent to or refuse medical treatment without pressure or coercion. The study's findings indicate that women's experiences of feeling pressured to accept an intervention have been on the rise since 2006 (Declercq et al., 2006; Declercq et al., 2013). Reports of pressure to undergo cesarean surgery rose from 9% to 13%, pressure to accept epidural analgesia for pain relief increased from 7% to 15%, and pressure for labor to be induced rose from 11% to 15%. Women who received these interventions were three times more likely to feel pressured than those who did not. In addition, mothers reported not having a choice regarding various procedures. Less than half (41%) of the women had a choice about receiving an episiotomy, only 17% of first-time cesarean surgery recipients reported being given a choice, and about half of the women who had a repeat cesarean indicated that their provider made the choice for them before they went into labor (Declercq et al., 2013).

These findings (Declercq et al., 2013) are concerning in light of patients' rights; however, these are only a representation of mothers' reports and do not include providers' perceptions of the decision-making process. Inclusion of those involved in the care experience (such as patients, labor and delivery nurses, and obstetrician–gynecologists [OB-GYNs]) is necessary to gain a broader picture of the current state of childbirth decision making.

Research conducted within various health-care specialties using diverse methodologies has yielded consistent results regarding the discrepancies between patient and provider decision-making preferences (Bruera, Sweeney, Calder, Palmer, & Benisch-Tolley, 2001; Declercq et al., 2006; Hammond, Bandak, & Williams, 1999; Jung, Wensing, & Grol, 1997; Levy, 1999; O'Cathain, Thomas, Walters, Nicholl, & Kirkham, 2002). Findings indicate that providers underestimate patients' desire to participate in health-care choices (Bruera et al., 2001; Hammond et al., 1999; Jung et al., 1997), and as a result, patients are afforded fewer opportunities to participate than they prefer (Declercq et al., 2006; Jung et al., 1997; Levy, 1999; O'Cathain et al., 2002; Rosen, Anell, & Hjortsberg, 2001). There is also evidence that patients receive less information about treatment options and alternatives than they desire (Declercq et al., 2006; Jung et al., 1997; Levy, 1999; O'Cathain et al., 2002; Rosen et al., 2001). However, because preferences are not necessarily an indicator of what occurs within health-care practice (Elwyn, Edwards, Gwyn, & Grol, 1999), examination of patient and provider reports of actual experiences of decision making is warranted.

The choice regarding pain relief and use of epidural analgesia is one that most pregnant women encounter and therefore was considered an ideal decision point to explore how patients and providers perceive the process of decision making.

Research Question

Is there a difference between patient and provider perceptions of decision making about epidural analgesia use during childbirth, and if so, what are the characteristics of these differences?

METHODS

Research Design

See JPE 23(2) for a companion article by these authors on "Differences Between Patient and Provider Perceptions of Informed Decision Making About Epidural Analgesia Use During Childbirth."

This research was part of a larger mixed method study examining perceptions of informed decision making about epidural analgesia use (Goldberg, 2011). The quantitative portion assessed the differences in intergroup perceptions (Goldberg & Shorten, 2013). Participants selected their degree of agreement or disagreement on a 5-point Likert scale to 27 statements. The qualitative section gathered information about the nature of the decision-making process. Three groups participated: patients, labor and delivery nurses, and OB-GYNs. Descriptive information about participants can be found elsewhere (Goldberg & Shorten, 2013). Data were collected within a defined time frame (October 2009–February 2010) and region to minimize geographic and historical event differences that could confound group perceptions. The study region was composed of medium-sized public hospitals that provide care for 2,400–2,800 births a year, with the exception of one small public hospital. The women who gave birth within these facilities during data collection were 32%–42% first-time mothers, 96%–98% singleton births, and 25%–32% cesarean surgery births (State of California Department of Public Health, 2009, 2010).

Ethics

Approval for this research was granted by the institutional review board from participating hospitals and the Santa Barbara Graduate Institute of the Chicago School of Professional Psychology. To ensure the protection of study participants, all patients and providers received and signed an informed consent form that included a description of the study, the requirements for participation, and the potential benefits and risks of participation. Confidentiality and anonymity was guaranteed.

Participants and Recruitment

Patients. Low-risk, first-time mothers ($n = 35$) who had experienced a vaginal hospital birth of a live singleton newborn after 37 weeks' gestation and faced the decision about use of epidural analgesia during labor completed a survey on decision making and use of epidural analgesia during labor. Patients were surveyed within 4 months of giving birth and were accessed via a free, county-wide home visitation program.

Providers. During the same time patients were surveyed, 28 nurses and 24 OB-GYNs who had hospital privileges completed an anonymous survey about decision making and epidural analgesia use. The surveys were distributed during a hospital staff meeting. A direct mailing was sent to those who were not present. Providers were instructed to respond based on the last patient they saw who was an English-literate, low-risk, first-time mother who birthed a live, singleton baby vaginally and faced the decision regarding epidural analgesia use for pain relief.

Data Collection

An open comment section was provided at the end of the survey to gain additional information about the decision-making process related to epidural analgesia use that was not captured within the survey questions. Half of a page was available for written responses; however, several participants used the back of the paper as well. Responses to the open-ended section constituted the qualitative data for analysis.

Analysis

Thematic analysis was used to identify patterns in patient- and provider-written responses about their decision making related to epidural analgesia use. Qualitative data were transcribed from the surveys, read, and reread to identify initial concepts. Major themes were recorded and coded. Because the themes were largely unique to group membership, patient and provider comments were analyzed separately. The themes from each group were organized into meaningful clusters. The research question was addressed through the identified themes. A secondary researcher performed the same analysis sequence to confirm findings and promote trustworthiness (Braun & Clarke, 2006; Lincoln & Guba, 1985).

Results

Thirty-five surveys were returned by eligible patients, and 14 of these provided qualitative responses for thematic analysis. Of the 28 nurses and 24 OB-GYNs who returned the survey, 13 nurses and 7 OB-GYNs provided qualitative responses for analysis. The characteristics of each group are published elsewhere (Goldberg & Shorten, 2013). The themes identified within the participants' comments are presented by group.

Patients

Most of the patients' comments were reflective of personal experiences regarding the duration of labor and sequence of childbirth events. In explaining how they made their choices about epidural analgesia use, it was clear that most made decisions prior to labor and as a direct result of information that was sought outside of their provider consultations. Patients commented specifically about the level of support they received from their providers, their decision whether to use epidural analgesia, and their feelings of satisfaction with their pain relief choices. The following is a description of the revealed themes within the patients' comments.

Decisions Made Before Labor. Most patients indicated that the decision regarding epidural analgesia use was made prior to labor. Some explained that their preferences regarding epidural analgesia use for pain management were explicitly written within a birth plan. One commented, "*I was aiming for a natural childbirth, and my birth plan said please do not offer drugs for pain. I am aware of the available options and will request them if desired.*"

Doing Their Homework. Patients took responsibility to seek out information regarding epidural analgesia use prior to labor. They learned about the risks, benefits, and alternatives through their own research and during childbirth education classes. One noted, "*Had it not been for the research I did on my own before I even chose a doctor, I may have had other opinions about epidurals.*" Some indicated that the information they gathered influenced their decision regarding who attended them during labor and birth. For example, some patients hired a doula to avoid the use of epidural analgesia, whereas others specifically requested care from a provider who, prior to pregnancy, supported their desire to have or not have epidural analgesia for pain relief.

> *I knew that I did not want an epidural because of the high risks of needing a c-section related to it. It was in my birth plan that I did not want pain medication and the hospital respected my wishes and never offered it. I also had two doulas and a very supportive husband who helped me through the process and were advocates for me. I also requested nurses who wanted to support a natural birth and all of them were great.*

Some patients had formed strong opinions about use of epidural analgesia prior to discussing pain relief options with their provider based on classes, their own research, and/or discussions with family and friends. Others did not discuss pain relief options with their providers at all.

> *I knew I wanted an epidural based on what I learned in childbirth class and talking to friends. My doctor never discussed pain management with me. I recall signing the consent form during labor, but I don't recall any conversation about the risks or benefits—perhaps because I stated upfront that I wanted an epidural.*

Seeking Respect for Decisions. Patients commented about the degree of support and respect communicated by their providers regarding the decision they made about epidural analgesia use. Most reported a supportive and informed experience.

> *I had a birth plan which advised that I may have an epidural, but I didn't want to be offered one—only I could bring it up during labor. The nurses and doctors respected the plan and until I asked [for an epidural], no one had mentioned it.*

Patients who commented on the fact that their choices were respected were happy that they were not offered epidural analgesia during labor. These patients seemed to want to control the conversation about pain relief and to be the only ones who could suggest epidural analgesia as an option. Patients were expecting to be pressured to use epidural analgesia during labor, perhaps against their expressed wishes, and therefore armed themselves with family members or a doula to help them

advocate for their preferred choice. They also discussed searching for the type of provider who was likely to respect their decisions or who had experienced normal birth themselves and would be more likely to support the choice of labor without epidural analgesia. A patient noted, "*I picked a doctor specifically for her stance on natural childbirth and because she was willing to allow me to birth naturally in the hospital.*"

Satisfaction With Decision. Patients reported satisfaction as a result of feeling their choice about epidural analgesia was respected and they had personal control over this decision. Regardless of whether patients decided to use epidural analgesia or not, the respect they experienced for their choice and the ability to control whether the topic of epidural analgesia use was even raised during labor was related to positive statements about their birth experience. Some noted being satisfied with the decision they made regarding pain management. They felt "*really happy*" and "*very pleased*" about their choice. Those who used epidural analgesia mentioned benefits such as being able to rest a little; experiencing pain relief and still being able to push; and feeling able to cope with a long, fast, and/or intense labor.

Nurses

Input from nurses included feedback regarding the various influences on patients' decision-making processes and views related to the importance of patient-based informed decision making. The following is a description of the themes that were identified within the nurse comments.

Decision-Making Pressure. Several nurses referred to various influences on patients' decision making regarding epidural analgesia use with sources of influences including media, family, and providers. They explained how manipulation from providers impacts the decision patients make regarding pain relief. One commented,

> *There are times when the physicians want the patient to have an epidural, but she does not and she can be pressured by the doctor. There are also times the anesthesiologists says get the epidural now or wait 'till I return which might be hours, so the patient feels pressured to get it now even if it is not needed now.*

Other nurses shared the opinion that mothers should use epidural analgesia for pain relief. "*I believe it is a very useful tool for managing pain for a mom having her first child.*"

Support for Informed Decision Making. Nurses made specific statements attesting to their views regarding the importance of patient access to information and informed decision-making opportunities during childbirth. The necessity of patients being free from outside influences and having the opportunity to change their minds was emphasized.

> *I strongly believe in advocating for women's birth choices and supporting them in their decision. That means information, education, advocacy, and support. I believe in labor support (physical and emotional) and that women deserve support regardless of their choice in pain management methods.*

Obstetrician–Gynecologists

OB-GYNs noted the various influences that impact patients' decision-making processes, expressed support regarding epidural analgesia use, and emphasized the importance of trusting medical expertise.

Pressures and Influences on Decision Making. It was evident that some patients had opinions about epidural analgesia use before discussing the option with their provider. OB-GYNs noted that family members and/or media commonly influenced patients' pain management decisions. An OB-GYN wrote, "*Patients are pressured from* family *to not get epidural (or get one less likely).*" Another commented,

> *Many have a preconceived notion of what their birth experience should be like, and have made decisions regarding every aspect of their birth that are based on limited exposure to lay publications and electronic media, and public fashion and marketing.*

Influences from outside the doctor–patient relationship can present a situation wherein the provider then needs to counteract information that is contrary to their personal medical beliefs about management of pain during labor. An OB-GYN noted an example of this kind of situation:

> *A great deal of our professional time is spent protecting patients from their own misconceptions, misinformation, and false beliefs . . . my patients*

are informed that if used properly, there is little risk from the procedure and the use of epidural is the single most important factor in patient satisfaction with respect to the birth experience itself.

Value of Epidural Analgesia Use. Several OB-GYNs expressed strong preferences and rationale for epidural analgesia use. Reasons included reference to their personal childbirth experiences, explanations that epidural analgesia will "*frequently help the patient avoid a cesarean delivery*," and statements about patient satisfaction: "*A good epidural can transform a very painful and excruciating event into a pleasant and happy time.*"

Views against "natural childbirth" were also expressed along with comments that underscored the doctor's role, desire for control over decision making, and preference regarding use of epidural analgesia during childbirth. "*By far the most pleasant events for all involved are those where the patients agree to an appropriately timed epidural, and then allow us to alert the patient when it's time to push.*"

Trusting Medical Expertise. OB-GYNs expressed high value of their medical expertise regarding pain management during childbirth and preferences for patients to follow their lead. The following exemplifies this perspective:

Even with patients having the highest degrees of education and greatest intelligence, it is not possible to convey 30 years of training and professional experience into a single discussion. Ultimately, the patient needs to trust the physician's opinions and recommendations.

This OB-GYN also noted much of his or her time is spent "*protecting patients from their own misconceptions, misinformation, and false beliefs*" regarding natural childbirth and noted, "*Sadly, few patients take advantage of the years of experience we carry and our opinions.*"

DISCUSSION AND CONCLUSIONS

The primary aim of this study was to generate insight into patient and provider perceptions of decision making regarding use of epidural analgesia during childbirth. Findings illuminate some of the differences between stakeholders' views regarding what is important in the decision-making process as well as the degree to which shared decision making is implemented.

Patients who participated in the study attempted to place themselves in an informed role in decision making. They sought out providers who aligned with their values and who would respect their choices about pain relief during labor. Most of the patients had researched their options prior to childbirth and gathered information separately from the consultations they had with their provider so they could make a clear choice about pain relief prior to labor. Birth plans were created as a tool to actualize their preferred decisions, and respect for these plans was valued by patients. Satisfaction was linked to respect for choice and control over options.

Providers expressed strong biases regarding the use of epidural analgesia, demonstrating a lack of neutrality in the decision-making process and a tendency to at times steer, sway, and coerce patients in the direction of their preferences— all contraindicative of shared decision making. Nurses noted the importance of patients being supported to make an informed choice. OB-GYNs were concerned about the challenges of informed choice when imbalance of medical knowledge and expertise, in addition to influence from outside sources such as the media, family, and friends, meant patients had formed opinions and did not always make the choices that were best for them in the eyes of the provider. Although nurses may have been supportive of patients' decision-making rights, their professional ability to enact support may be challenged because of the structures of power associated with provider roles and organizational culture.

Mounting research indicates that provider power highly influences the choices made during maternity care (Dixon-Woods et al., 2006; Heinze & Sleigh, 2003; Hindley & Thomson, 2005; O'Cathain et al., 2002; Shorten, Shorten, Keogh, West, & Morris, 2005). Strong provider biases for or against the use of epidural analgesia likely impacted patients' pain relief choices and the degree of support patients received regarding decision making. Similar to the power providers possess over the decision-making process, place of care has been deemed equally influential on health-care decision making (Declercq et al., 2013; Hindley & Thomson, 2005; Le Ray, Goffinet, Palot, Garel, & Blondel, 2008). The current

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climate of decision making within maternity care can be, in and of itself, a barrier to shared decision making.

Deficits in power in combination with the physical vulnerability that is inherent in the process of childbirth can constrain patients' abilities to partner with their providers in decision making. A recent study of informed consent regarding obstetric and gynecological surgery demonstrated that more than a third of the women consented to surgery, even though they were opposed to or ambivalent about it, because they did not want to disobey their providers' request for a consent signature (Dixon-Woods et al., 2006). Evidence of patient reports regarding provider swaying, coercion, and manipulation during childbirth decision making (Declercq et al., 2006; Declercq et al., 2013; Stapleton, 2004) in combination with this study's results suggests the paternalistic model of care still exists, and efforts are needed to institute shared decision making. These findings are concerning in light of research indicating that decisions made during childbirth can have short- and long-term effects on the physiological and psychological health and development of mother and child (Green & Baston, 2003; Green et al., 1990; Harrison et al., 2003; Jomeen & Martin, 2008).

Limitations

This study was only capable of collecting data from those who were aware that a decision needed to be made about pain relief options. The results are based on participants from a limited region and demographic group (Goldberg & Shorten, 2013). Findings would likely vary in different clinical settings, locations, and socioeconomic groups, thus restricting the transferability of these results. Because epidural analgesia is commonly used in the United States during childbirth (67%; Declercq et al., 2013), it is possible that patients and/or providers could have considered this choice a routine aspect of care rather than a legitimate decision. The mode of data collection could also be a limitation in this study. Reliance on participants to take the extra time to write down their thoughts about decision making in an open comments section may have been a hindrance to data collection, although it did allow the opportunity to share only that which was felt to be important. Risk of researcher influence on the data collection, which could be an issue in other qualitative methods, was not an obstacle in this study. However, interviews would have allowed a more in-depth exploration of the topic and possibly a more accurate understanding of the parties' perceptions and are therefore recommended for future research, along with studies of diverse participants in varied clinical settings and locations.

IMPLICATIONS FOR PRACTICE

The findings of patient and provider perceptions of decision making regarding use of epidural analgesia echo remnants of paternalism and have several implications for practice. The results highlight the importance of a partnership between patients and their providers. Attitudes, preferences, and decision-making styles can vary greatly among all involved parties. Shared decision-making principles can be difficult to implement when these key factors are mismatched. Therefore, patients are encouraged to interview providers and select those who align with their values, preferences, and decision-making styles. It is equally important for providers to assess the degree to which a patient matches their practice patterns and to make referrals when significant disharmony is identified.

Medical decision-making research has long recognized the prevalence of poor patient–provider communication within health care (Baker, Choi, Henshaw, & Tree, 2005; Gaston & Mitchell, 2005), making it important for those involved in childbirth choices to take extra time and effort to employ effective decision-making practices and to acknowledge the importance placed on respect for patients' choice and control in birth. Childbirth educators (CBEs) are ideally positioned to assist this process by offering patients evidence-based information as well as skills in decision making. Supporting patients to identify and understand their personal preferences and values associated with various childbirth choices prior to labor is an effective way to equip patients for conversations with their providers about their options and tactics to engage in shared decision making. Patients are encouraged to assume responsibility for asking questions and discussing issues of personal importance with their providers. In turn, it is suggested that providers invest more energy in implementing shared decision-making practices and employing extra sensitivity to their responsibilities related to a

patient's access to, awareness of, and understanding of the risks, benefits, and alternatives of care so that a decision can be made that reflects the patient's values, needs, and preferences. Providers can also encourage patients to participate in childbirth education classes as a way to supplement information gaps.

CONCLUSION

This study generated insight into the climate of decision making related to a common maternity care choice—use of epidural analgesia during labor. The nature of the identified differences in patient and provider perceptions suggests the need for greater investment in communication mechanisms prenatally and during the birthing process by all involved parties. Strides toward the implementation of shared decision-making practices so patients and providers can work together as a team within perinatal care are warranted.

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