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Views of Women and Clinicians on Postpartum Preparation and Recovery

Anika Martin,
Department of Health Evidence and Policy, Icahn School of Medicine at Mount Sinai, One Gustave L. Levy Place, Box 1077, New York, NY 10029, USA

Carol Horowitz,
Department of Health Evidence and Policy, Icahn School of Medicine at Mount Sinai, One Gustave L. Levy Place, Box 1077, New York, NY 10029, USA. Department of Medicine, Icahn School of Medicine at Mount Sinai, New York, NY, USA

Amy Balbierz, and
Department of Health Evidence and Policy, Icahn School of Medicine at Mount Sinai, One Gustave L. Levy Place, Box 1077, New York, NY 10029, USA

Elizabeth A. Howell
Department of Health Evidence and Policy, Icahn School of Medicine at Mount Sinai, One Gustave L. Levy Place, Box 1077, New York, NY 10029, USA. Department of Obstetrics, Gynecology, and Reproductive Science, Icahn School of Medicine at Mount Sinai, New York, NY, USA. Department of Psychiatry, Icahn School of Medicine at Mount Sinai, New York, NY, USA

Amy Balbierz: amy.balbierz@mountsinai.org

Abstract

To explore important domains of women's postpartum experiences as perceived by postpartum mothers and obstetricians/midwives, and to investigate how postpartum care could enhance patient preparation for the postpartum period. Qualitative research study was conducted to explore women's and clinicians' perceptions of the postpartum experience. Four focus groups of postpartum women (n = 45) and two focus groups of obstetric clinicians (n = 13) were held at a large urban teaching hospital in New York City. All focus groups were audio recorded, transcribed, and analyzed using grounded theory. Four main themes were identified: lack of women's knowledge about postpartum health and lack of preparation for the postpartum experience, lack of continuity of care and absence of maternal care during the early postpartum period, disconnect between providers and postpartum mothers, and suggestions for improvement. Mothers did not expect many of the symptoms they experienced after childbirth and were disappointed with the lack of support by providers during this critical time in their recovery. Differences existed in the major postpartum concerns of mothers and clinicians. However, both mothers and clinicians agreed that preparation during the antepartum period could be beneficial for postpartum recovery. Results from this study indicate that many mothers do not feel prepared for the postpartum experience. Study findings raise the hypothesis that capturing patient-centered

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Correspondence to: Amy Balbierz, amy.balbierz@mountsinai.org.

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domains that define the postpartum experience and integrating these domains into patient care may enhance patient preparation for postpartum recovery and improve postpartum outcomes.

Keywords

Focus groups; Postpartum women; Obstetric clinicians; Preparation

Background

Childbirth has a major impact on women's lives. Yet, the healthcare system does not adequately prepare women for the immediate maternal consequences post-delivery [1, 2]. Women suffer from a number of adverse physical and emotional symptoms postpartum. For example, data suggests that nearly 80 % of early postpartum mothers report cesarean-section or episiotomy site pain and breast pain; and nearly one-third report urinary incontinence [3]. Lack of preparation for the postpartum period is associated with adverse maternal outcomes including postpartum depressive symptoms and lower satisfaction with clinicians [2, 3]. The literature has yet to explore, though, the circumstances that might cause women to feel inadequately prepared for the postpartum experience and opportunities to improve their preparation. To approach these questions, it is essential to first establish domains that accurately characterize the postpartum period.

Traditionally, objective clinical measures such as maternal morbidity and mortality have been used to assess maternal health during the postpartum period. However, these measures fail to offer a complete description of the patient's experience post-delivery. Recent data on urinary and sexual functioning postpartum has broadened the definition of maternal health status after childbirth, [4–7] but more attention needs to be placed on patient-centered domains in order to fully capture the multiple components of health that are significant to women during the postpartum period.

Although some postpartum education is provided by a number of allied health-related-professionals (e.g. nursing education [8], public health nurses conducting postpartum/newborn home visits through a women, infants, and children's (WIC) program [9], lactation consultants, [10], and doulaled programs [11], many of these educational activities focus on breastfeeding and infant care, rather than the physical, emotional, and social functioning of women postpartum. In this study, our objectives were to explore important domains of women's postpartum experiences with postpartum mothers and obstetricians/midwives, and to investigate how postpartum care could be improved to enhance postpartum preparation and maternal outcomes.

Methods

We conducted a qualitative study to explore patients' and clinicians' perspectives on the postpartum experience. The study was approved by our institution's Program for the Protection of Human Subjects (Institutional Review Board).

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The theoretical model that guided this work was adapted from the Common-Sense Model (CSM), a model that describes how patients identify when they are sick and what they can do to get better [12]. When a patient gets sick they attempt to match their symptoms to a known illness, a time-frame (how long it will last), cause (stress), potential for control (to get back to one's normal self) and consequences. Each person has a view of their normal self, based on a life-time of experience. The framework engages and/or motivates them to enact cognitive and behavioral strategies and tactics with the goal of returning to a prior self as functional and symptom free. This framework is also applicable to the postpartum experience where mother's view of her "normal self" is often based on her pre-pregnant state. If she is not adequately prepared, she may have unrealistic views of how she should look, feel, and may have incorrect time frame for recovery, etc. Many of these unrealistic views are modifiable and we explored this framework in the focus groups.

We developed moderator guides for the patient and clinician focus groups, containing open-ended questions with specific probes to facilitate discussion. Questions for the maternal focus groups sought to ascertain the specific problems mothers encountered following delivery and to identify ways new mothers thought their care could be altered to prevent those problems. Examples of questions include: Think back to the *first few days* after leaving the hospital. (a) Paint a picture of yourself and how you were feeling?—what sticks out? (b) What were the biggest problems you faced? (c) Did you know to expect these things after giving birth? How? (d) Did your doctor or midwife tell you what to expect those first few days after delivery of your child? (e) Were you prepared to deal with the problems you had when you left the hospital?

The moderator guide for the clinician focus groups examined providers' beliefs about the most common and problematic impacts of pregnancy and childbirth on women's functioning and well-being. A couple of examples of questions for the provider focus groups include: (a) What are the top three things a postpartum mother is concerned about? (b) What are the top three things you are concerned about? (c) How common are these things? (d) Do you think your patients knew about these problems before they occurred? (e) Do you think your patients should be prepared for these problems before they deliver?

The study population included obstetric clinicians and postpartum mothers from a large urban teaching hospital in New York City. Eligible obstetric clinicians were obstetricians and midwives caring for patients at an academic medical center, who we recruited at obstetrical grand rounds and in the obstetric clinic. For the maternal focus groups, potential participants, identified through a hospital internal database, were English speaking mothers, 2–12 months postpartum, whose infants weighed greater than 2,500 g and had a 5 min Apgar score greater than 6. We excluded participants who had a complicated childbirth, as measured by length of hospital stay, as we were attempting to ascertain the postpartum experience for women routinely classified as uncomplicated deliveries. For cesarean sections, we excluded women with a postpartum hospital stay greater than 5 days. For vaginal deliveries, we excluded mothers with a postpartum hospital stay greater than 3 days. The research team contacted eligible women over the phone and briefly discussed the content of the focus group discussions. Women were offered a $50 money order as compensation for their time. The maternal focus groups were stratified by insurance type

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(two groups of Medicaid and two of privately insured women) because prior research has suggested that type of insurance coverage significantly influences patients' experiences with medical care [13]. The groups were then divided by delivery type (vaginal and cesarean section).

A trained qualitative researcher facilitated all focus groups in 2000– 2001. Before the start of each focus group, participants gave written informed consent. Each patient focus group lasted approximately 90 minutes and each clinician focus group lasted approximately 70 minutes. Participants in each of the six focus groups were arranged in a circular pattern to encourage discussion [14]. At the end of the focus group participants were asked to answer a brief anonymous questionnaire to capture their demographics.

All focus group sessions were professionally audio-recorded and transcribed. We used grounded theory, which is a method of analyzing qualitative data grounded in the data without preconceived theories and is characterized by analyzing data, sentence by sentence, or phrase by phrase [15]. All focus group sessions were professionally audio-recorded and transcribed. Investigators then cleaned the data to ensure accuracy of transcription, removed all unique patient identifiers and developed a coding scheme comprising inductive and deductive codes. Two independent readers then coded the transcripts and a third reader reviewed the coded transcripts to evaluate inter-rater agreement. Disagreements were then discussed and resolved through consensus. The team then used iterative review of the transcripts, codes, field notes and comments generated during coding, to develop overarching themes.

Results

Thirteen obstetric clinicians (two midwives, eight attending obstetricians, and three resident obstetricians) participated in two clinician focus groups. Their mean age was 32 and 85 % of the clinicians were female. (Table 1) Most (62 %) practiced in a clinic setting. Forty-five mothers participated in one of four focus groups. Their mean age was 31 and mothers were on average 6 months postpartum. Thirty-nine percent of the women were Black/African American, 27 % were White/Caucasian, and 30 % were Hispanic/Latino. Half of the women were primiparous. (Table 1).

We identified four major themes from the focus group discussions describing women's postpartum experiences: (a) lack of women's knowledge about postpartum health and lack of preparation, (b) lack of continuity of care and absence of maternal care during the early postpartum period, (c) disconnect between providers and postpartum mothers, and (d) bridging the gap: suggestions for improvement. Each theme is discussed below.

Lack of Women's Knowledge About Postpartum Health and Lack of Preparation

Women across all maternal groups described how the postpartum period brought about significant physical and emotional changes and challenges, including exhaustion, stress, poor body image, and marital discord. Yet, most women did not feel prepared for these physical and emotional symptoms. Several mothers did not expect symptoms such as urinary incontinence, headaches, hair loss, and back pain. Even for those postpartum symptoms that

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women were more aware of, such as depression, sore breasts, and vaginal bleeding, they felt ill-equipped to manage these symptoms because they did not have a clear picture of how the symptoms would appear and develop over time, how long they should and could last, and the level of impact that they would have on their daily lives. One woman commented that she was bothered by the vaginal bleeding postpartum because it was different than what she was used to in her regular menstrual cycle:

> It was annoying…your vagina, it was so swollen…And then you see you keep bleeding, keep bleeding, they give you an ice pack. I don't want an ice pack, I want the swelling to go down and I want the period to be a regular period and I don't want all these big lumps of things falling out of me. [Medic-aid, vaginal delivery maternal group]

The obstetric provider groups also noted that their patients had inaccurate expectations regarding many of the things they experienced postpartum including the severity of pain following delivery, amount of bleeding, changes in sex drive, and not losing pregnancy weight right away.

Lack of Continuity of Care and Absence of Maternal Care During the Early Postpartum Period

Women and clinicians alike expressed frustration with the lack of continuity of postpartum care. This concern was most evident in the two Medicaid maternal groups. The inability to reconnect with providers impacted some mothers' ability to communicate their concerns and have those concerns addressed. Some mothers felt delivering doctors should follow up with their patients after discharge because they "know what you went through," and others were disappointed that due to changing providers, they "never got a chance to ask [the doctor] anything", found it difficult to establish a trusting relationship and to feel reassured in the care they received. One mother expressed her apprehension:

> One thing that I didn't like about my last pregnancy –when I used to go to the clinic I used to see my regular doctor from my health clinic. But when I go to have my baby I ended up with a different doctor… And it makes you uncomfortable

Clinicians also acknowledged that care continuity was important in patient-provider communication during the postpartum visit. One provider remarked:

> …if the patient knows you and feels comfortable with you, they're just gonna talk to you and say 'Hey this is bugging me' or whatever. But if the patient doesn't know you, she's just kinda… sitting there, waiting for you to ask… [MD provider]

Clinicians mentioned that maintaining the same provider in prenatal care through the postpartum period allowed providers to tailor postpartum care to the needs of the patients, rather than review a general checklist of items.

> When you see them and you've been seeing them, it's a continuation of a discussion you've been having for nine months. [MD provider]

Another concern identified by women and clinicians, was the significant gap in care in the time period before the first postpartum visit. After maintaining regular contact with their

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providers during pregnancy, mothers felt that support disappeared in the first 6 weeks postpartum. One woman commented:

> I thought my doctor was there more when I was pregnant and when I was getting ready to go into labor. I felt he was there more. And then it was like once I had the baby that was it. See you in six weeks. [Private, vaginal delivery maternal group]

Though all clinicians agreed that 6 weeks was the time frame in which physiologically women return back to "normal", one provider mentioned that at the first postpartum visit "you kinda miss that critical time… you're like the little reporter at the end of 6 weeks and say, so what did you manage to do in this past 6 weeks?"

Disconnect Between Providers and Postpartum Mothers

Focus group discussions revealed a disconnect in the main postpartum concerns of mothers and those of providers. Women were most concerned about how their symptoms affected their daily functioning, while providers were mainly concerned about potentially dangerous physical complications, such as infection and bleeding. One midwife commented:

> [The patients'] lists are a lot more practical. I mean, it's about things in their lives that are really tangible. They're not thinking about you know the fact that like I might have thrombophlebitis…or that I'm in an increased risk for it. They're thinking about money, they're thinking about time, they're thinking about their baby.

Clinicians also felt they did not have the time or the training to deal with the psychosocial issues. Women, on the other hand, looked to providers for support and thought it was part of their provider's role to link them with additional resources including lactation specialists, visiting nurse services, and social workers.

Providers believed that they discussed with their patients the major things that could be expected before, during, and after delivery, but could not cover all issues. On the contrary, women in our focus groups often made remarks such as "nobody told me it might happen" and "nobody discussed it" when referring to the challenges they experienced after childbirth. Some mothers felt that they had not received adequate instructions by their postpartum nurses and obstetric providers prior to going home from the hospital.

Mothers and providers also had different perspectives on what information should be conveyed to postpartum women by their providers. Some clinicians placed little emphasis on the normal consequences of childbirth that they thought would resolve on their own or that they felt could not be fixed through medical intervention.

> …if you investigate this problem [urinary incontinence] there's a limited utility to it. You're not going to do a lot of things to fix this problem at this point. So, you're just asking a question that's going to lead you to a place that you can't do any help for. [MD provider]

Women wished their providers had been more vocal about the things that might occur postpartum, irrespective of the normalcy of the symptom. One mother commented:

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> Like about I think the bleeding was fine. I knew what to expect. I knew it was normal. But just to hear someone say, 'Okay, yeah that is normal.' … It would've been great just to have somebody reassure me. [Private, vaginal delivery maternal group]

Bridging the Gap: Suggestions for Improvement

Mothers and clinicians offered their suggestions on how care could be improved to prevent or ameliorate the challenges women experience during the postpartum period. Women felt providers could better support mothers postpartum by contacting patients by phone, making referrals, or providing a list to mothers during late pregnancy on what to expect and how to prepare for the postpartum period. One woman wished she had received the same level of preparation for c-section recovery as she had for previous surgical procedures:

> I had knee surgery and I got a 'What to Expect' sheet from the doctor meaning that it said, 'Make sure you do this'…None of that came with that so trying to go home and cope with a c-section…you kind of have to feel your way through to see what kind of rhythm you need or something because none of that, none of it is really told to you. [Private, c-section delivery maternal group]

Some clinicians noted that preparation in the antepartum period might also lessen how much of a bother postpartum physical symptoms are to women.

> …I think the patients…the more you talk to them beforehand about all of these things. Or just prep them for what's going to happen, what could happen. They'll have a lot less questions, they're just more reassured, they know what to expect. [MD provider]

Providers felt information regarding postpartum recovery could be introduced to patients during the 3rd trimester when most of the major medical issues have been resolved and there is more "free time" in the visit. They also commented that the development of a "nice, simple, short" educational tool to supplement the information they give to their patients might help them better prepare women for the postpartum period.

Some providers mentioned that improvements in care practices, such as pain management, could potentially have a positive impact on mothers' daily functioning.

> I think pain control after a c-section could be better…If you haven't spent four days in excruciating pain, then you're in better mental condition to go home, basically, to do whatever you're doing…I mean it's very hard to get out of bed and feed the baby in the middle of the night after having a c-section. And if you're more comfortable – I mean it lends to your self-worth and your image. If taking a shower is a lot easier you feel better about yourself, you know? [MD provider]

Another suggestion mentioned by clinicians to improve care continuity and communication between providers was to have a tool, such as a summary sheet or checklist, to keep track of what is discussed in patient visits.

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Discussion

We conducted focus groups with postpartum mothers and clinicians to explore the problems mothers encounter following delivery and to identify ways that care could be altered to improve postpartum women's experiences. The results of our study indicate that women lack an understanding of and preparation for the physical and emotional symptoms they may encounter following childbirth—how common they are, their duration, their severity, and resources to cope with them. Postpartum mothers in our focus groups also felt they lacked the kind of support that they wanted from their healthcare providers, in preparing them and in helping them cope with symptoms that occur. This was particularly true for women with Medicaid, who faced lack of continuity with providers. There was a disconnect between what providers viewed as "normal" parts of postpartum recovery and what mothers classified as major problems that created difficulty in their postpartum experience. Yet, both new mothers and their clinicians suggested that there was time and receptivity during third trimester visits to share- through several different mediums, tips on what to expect and what to do.

Our results are consistent with other studies that have found that postpartum women feel inadequately prepared for the postpartum period [3, 16–18]. Women in our maternal focus groups also expressed dissatisfaction with the communication and preparation they had received for discharge. Lack of preparation after childbirth has been associated with report of more physical symptoms, functional limitations and depressive symptoms [2, 3]. These findings suggest that preparation and patient education for labor and delivery and the postpartum period are important for recovery after childbirth. However, our discussions also revealed that adequate preparation for the postpartum period requires that patients have a more comprehensive description of what they might encounter physically and emotionally during their postpartum experiences.

Mothers and clinicians also identified lack of continuity of care during pregnancy as a major concern. Studies have shown that care continuity is associated with trust in one's doctor, and a patient's desire for continuity is a significant predictor of trust [19, 20]. As noted by women in our focus groups, maintaining the same provider (or few providers) throughout pregnancy and the postpartum period was valued as an important aspect of obstetric care. Some mothers had multiple providers and had never seen the provider who delivered them until the day of their delivery. Results from two studies using a midwife-led model of care continuity also support this data, and found that continuity of care not only allowed women to build a relationship with their providers, but offered the reassurance to women that their providers would know their individual needs and provide the appropriate advice [21, 22].

Our focus group study revealed that the major postpartum concerns of obstetric clinicians might not adequately encompass the concerns of their patients. Clinicians emphasized objective markers of postpartum recovery, and these clinical outcomes did not fully capture all of the domains that were important to the mothers in our focus groups. Results also indicated that providers might not be aware of the extent to which normal physical and emotional consequences of childbirth impact the daily functioning of postpartum women. Other areas of medicine have found that clinician-generated outcome measures fail to

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account for key functional and quality of life domains in the patients' experiences of the disease [23, 24]. To address these gaps, several studies have investigated functional domains from the patient's perspective. These patient-centered outcomes assist in the understanding of the nature of the disease and recovery, and in understanding the implications on patient care [1, 23, 24].

There are some limitations to our findings. Qualitative research is exploratory in nature and therefore the results of this study may not be generalizable to the population of postpartum women as a whole. We asked mothers (2–12 months postpartum) to think back to their experience immediately following childbirth and their recollections are subject to recall bias. However, the average participant was only 6 months postpartum and studies suggest that postpartum women may actually underreport physical and emotional experiences postpartum [25]. Additional data suggest that maternal recall is reliable compared with the medical record for certain pregnancy-related events such as complications [26–28]. Since this data was collected, there has been an advancement of medical homes, which have expressed intent of improving coordination and continuity of care and the enactment of the Affordable Care Act. Although these factors may eventually decrease the lack of continuity of obstetrical care, currently many mothers with Medicaid continue to receive obstetric care from multiple different providers. Focus group participants described important domains of women's postpartum experiences and highlighted many areas that are relevant to current issues in postpartum care and can inform obstetrical care. The information gathered in these discussions has informed research in this area including a recent randomized trial that found that increased preparation and education for the postpartum experience reduces depressive symptoms among postpartum mothers [29].

Conclusion

Exploring aspects of postpartum recovery from women's perspectives is an important step to improve patient-centered obstetrical care. This information can be used to enhance providers' perspectives on the postpartum period and recovery after childbirth. In addition, providers might be better equipped to prepare their patients for the postpartum period, and ultimately improve maternal outcomes.

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Table 1

Participant characteristics

Mothers (n = 45) *	
Maternal age (years)**	
Mean (±SD)	30 (±8)
Months postpartum	
Mean (±SD)	6 (±2)
Parity	
Primiparous	22 (49)
Multiparous	23 (51)
Race/ethnicity—N (%)	
White/Caucasian	12 (27)
Black/African American	17 (39)
Hispanic/Latino	13 (30)
Asian	1 (2)
Other	1 (2)
Education—N (%)**	
Less than high school	6 (14)
High school graduate/GED	7 (16)
Some college/trade or technical school	15 (35)
College graduate/professional training	15 (35)
Insurance—N (%)	
Medicaid	27 (61)
Private health insurance/HMO	17 (39)
Currently employed—N (%)	19 (43)
Married	19 (43)
Clinicians (n = 13)	
Attending obstetrician—N (%)	8 (62)
Resident obstetrician—N (%)	3 (23)
Midwife—N (%)	2 (15)
Age (years)	
Mean (±SD)	32 (±3)
Gender—N (%)	
Female	11 (85)
Race/ethnicity—N (%)	
White/Caucasian	9 (69)
Asian	4 (31)
Practice setting—N (%)	
Private setting	1 (8)
Clinic setting	8 (61)
Combination	4 (31)

* 45 women participated in the focus groups, one missing demographic information

[**] Based on 43 responses (n = 43). Not all mothers answered every question on the demographic survey

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