Enabling Prenatal Clients to Overcome Barriers in Health Care Communication

A research project by the:

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Abstract

Introduction: Existing literature on health care communication has identified that barriers to communication and informed decision making are common among patients/clients and their caregivers. Childbearing women face unique barriers that may not exist in other patient populations. The Division of Health Care Communication at the University of British Columbia has developed communication skills training workshops for various client groups as part of the Informed Shared Decision Making Project. To date, workshops have been delivered to stroke survivors, seniors, cardiac and mental health clients.

Study objectives: This study is a needs assessment of prenatal clients to determine the need and opportunity for an adapted communication skills workshop for this particular client population. The main objectives were: to identify barriers to communication and informed decision making, to evaluate the coverage of communication skills in childbirth education classes, to identify any gaps in communication skills training, and to determine whether opportunities exist for adapting and implementing a communication skills workshop for use in existing childbirth education classes.

Methods: Seven participant groups were interviewed: childbirth educators (CBE), registered midwives (RM), family physicians (FP), doulas (D), obstetricians (OB), prenatal clients (PNC), and postpartum clients (PPC). Data was collected through semi structured interviews and one focus group with 32 respondents in Vancouver BC over the summer of 2004. Transcripts were analyzed using thematic analysis. Data was managed with ATLAS.ti software.

Findings: Some barriers are shared between prenatal clients and other patient/client groups, while others are unique to this population. The communication barriers that emerged were categorized into four areas: the health care system, the client-caregiver relationship, client factors, and childbearing experience. Firstly, the health care system itself is responsible for numerous barriers faced by prenatal clients, for example, lack of time in appointments, and intimidation. Specific barriers may be present in the individual relationship between the woman and her caregiver, particularly if they have different philosophies or values. The woman’s own background may involve factors that further inhibit good communication, such as level of education, language, and previous experience with health care providers. Finally, the childbearing experience contributes several unique factors that make communication difficult. Examples of these are: not knowing what to expect in labour and birth, pain, and fear.

Childbirth educators reported teaching skills to enhance communication between clients and their caregivers to varying degrees. Some educators utilized specific decision-making models to teach skills, while others reported that they encourage dialogue in the relationship but don’t teach specific techniques. Prenatal and postpartum clients that received this training in prenatal classes reported that it was effective in helping them communicate better with their caregivers, while those that had not received training felt that it would have been useful. Several gaps were identified in which clients are not receiving adequate communication skills training, or where further training would be of benefit. The main gaps are: no skills specifically addressing communication during labour, lack of any specific communication skills education in some classes (second hand reports indicate that this may be a gap particular to hospital-based prenatal classes), and little education on how to make prenatal decisions.

Conclusion: Out of the barriers to communication and gaps in existing skills training, a number of potential opportunities for the adaptation and implementation of a communication training skills workshop for prenatal clients were identified. Many of the barriers to communication such as lack of familiarity with asking questions, and lack of information sharing, may be alleviated by participating in a communication skills training workshop. Other barriers, such as lack of adequate time during appointments, may not be addressed by the existing workshop framework; however, there may adaptations or additions that could decrease these hurdles. Some CBEs expressed willingness to participate in the development of a workshop, or in piloting the adapted workshop in their classes.
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Introduction

Existing literature on health care communication has identified that barriers to communication and informed decision making are common among patients/clients and their caregivers. Despite enthusiasm for patient-centred care and ISDM, doctors have been slow to adopt the core values of the ISDM philosophy and to relinquish decision making power to patients. Communication is a two-way street; both caregiver and client must share the responsibility for ensuring good communication exists.

Most research on physician-patient communication has been directed at improving physician skills; however, we understand little about the patient’s potential to influence the quality of communication (Cegala, 2000). Barry (2000) has demonstrated that patients do not voice all of their objectives for the physician visit, leading to unwanted treatment and decreased compliance. She concludes that clinical practice and research should work towards supporting the patient in voicing their agenda, such as: “worries about possible diagnosis and what the future holds; patients ideas about what is wrong; side effects; not wanting a prescription; and information relating to a social context.”

Environmental, sociocultural, and psychological barriers to communication lead to poorer therapeutic outcomes and increased patient dissatisfaction with caregivers (Quill, 1989), which illustrates the importance of reducing these hurdles. Some might argue that the caregiver, being in a position of power over the client, should shoulder more of this responsibility. There is evidence to suggest that interventions targeted at the patient’s communication skills were more effective than those targeted at the provider, which showed only moderate effects (Anderson, 1991). Cegala (2000) tested the effectiveness of P.A.C.E., a four-part communication intervention for patients. Trained patients engaged in more effective information seeking, provided physicians with more information about their condition, verified information given by physicians, and expressed concerns more frequently. By learning specific skills, clients may also enhance the communication relationship with their caregiver.

Schott & Henley (1996) propose that communication is the single most important component of effective maternity care. Childbearing women face a unique set of communication barriers that are not common in other patient groups. Being pregnant and giving birth are often the most challenging experiences a woman goes through and mark the transition into a new social role. Despite the fact that the majority of pregnant women are in a state of health and the process of pregnancy and birth unfolds without complication, prenatal care has become increasingly risk oriented and routine interventions and tests abound. Thus, pregnant women and their families are faced with a large number of decisions. Giving birth, while treated in many respects as a private event, elicits abundant advice from friends and relatives, as well as considerable pressure from the media and society to make certain choices. Gregg (1993) believes that women internalize social pressures, “choosing” to use technologies in the absence of perceived alternatives.

Decision-making in the prenatal period is further complicated in that a triad of individuals are impacted by the decisions and their potential outcomes. For example, the interests of the pregnant woman can be seen as conflicting with the interests of the fetus, and vice versa. Furthermore, the interests of the father/partner/family must be considered in making decisions (Lavender, Walkinshaw, & Walton, 1999; Schott & Henley, 1996). Levy (1998) echoes this idea, proposing that women seek to maintain equilibrium in their decisions to protect and keep in balance the interests of themselves, their baby, partner, as well as caregivers.
The quality of communication is of particular importance to the first time mother as the experience of pregnancy is new, can be overwhelming, and women often don’t know what to expect or ask at each prenatal appointment. For multiparous women communication is equally important; evidence suggests that they experience more distress than first-time mothers if not included in decision making about their care (Harrison et al., 2003). Additionally, the communication relationship is unique for maternity clients in that the prenatal experience culminates in labour and birth. The current literature on women’s participation in communication tends to focus on the labour and delivery period, with less emphasis placed on the prenatal period (Brown & Lumley, 1994).

There is very little literature on communication barriers specific to the prenatal period, particularly from the client’s perspective. There is however a large body of literature on client satisfaction with maternity care, which offers insight into women’s perceptions on communication with caregivers. Pregnancy often provides women with increased motivation to seek out information (Framework for Women-Centered Health). According to Proctor (1998), women had three objectives in their desire for information: to help them prepare for parenthood, to enable them to make informed choices in their care, and as a source of reassurance. Caregivers overlooked the importance of reassurance as an outcome of receiving information. Pregnant women consistently reported the importance of being offered information. They did not want to take the initiative to ask questions themselves, or offer information about how they were feeling.

Pregnant women encounter a variety of caregivers during pregnancy, birth, and the postpartum period. Women often start out seeing one caregiver during pregnancy, but when it comes time to give birth, another practitioner is frequently on call. Furthermore, unfamiliar staff members in the hospital such as nurses and anaesthesiologists are frequently involved. If anything unusual presents, additional staff members enter the circle of caregivers the woman must communicate and negotiate with. This abundance of unfamiliar personnel, each with their own area of expertise and technical language, can make effective communication skills especially important.

Trust can be a double-edged sword in the relationship between client and caregiver. Some women, trusting in the knowledge and expertise of their caregiver, are willing, and indeed prefer, to hand over power and decision-making, thus devaluing their own knowledge (Bluff & Holloway, 1994). Trust is also essential in order for women to feel comfortable asking questions and expressing concerns about their care.

Technology has become an integral part of maternity care provision; never before has there been such a plethora of tests and interventions available to women. Prenatal care entails a series of pre-structured visits with the maternity caregiver. Each visit often encompasses a particular set of objectives. For example, a visit might include discussions of prenatal testing, ultrasound, or blood work, which are each discussed in turn at specific points in pregnancy. This has a tendency to render the tests and discussions routine with little opportunity for informed decision making as women are not offered options (Marteau & Dormandy 2001). Santalahti et al. (1998) report that many women make decisions that reflect a routine act, expressing the feeling that their choice was a given, rather than an active decision to participate. The demands of making several decisions in a limited time frame exacerbate this problem. Often new tests are presented to women as alternatives to the “old” test, an approach which negates the option of declining the test altogether (Pilnick 2004). In addition, technology often outpaces our ability to interpret the results, leading to confusion for caregivers and clients alike. It has also become increasing difficult for caregivers to keep up to date on the latest
information. Marteau and Dormandy (2001) found that women were often given poor quality information and little in the way of emotional and decisional support. Technologies often command the attention of the caregiver at the expense of the client. The caregiver relies on the “objective” knowledge generated by the technology rather than on the pregnant woman’s personal account of her own body (Gregg 1993). The language associated with technology can be intimidating and patronizing (Schott & Henley, 1996) which can exacerbate feelings of anxiety and fear, and affect the interpretation of information by the woman (Abramsky & Fletcher, 2002). Technology, with its associated interventions, clearly has an impact on the “choices” women are able to make in their care.

The meaning of good communication between pregnant women and their caregivers is complex. One benefit of good client-caregiver communication is that it allows the birthing woman to feel safe and relaxed. Despite not being able to control all aspects of birth, the outcome of good communication may be that the woman can feel good about the decisions made during her birth experience regardless of what transpired. Furthermore, feeling safe and relaxed in labour facilitates good progress. The benefits of strong communication skills do not end with a woman’s relationship to her primary caregiver, but may be of great benefit when she encounters other personnel during the course of her care, and furthermore, can be of value for parenting and all relationships in her life.

Rationale
The aim of this study is to conduct a needs assessment of prenatal clients to determine the need and opportunity for an adapted communication skills workshop. The main objectives are: to identify barriers to communication and informed shared decision making, to evaluate the coverage of communication skills in childbirth education classes, to identify any gaps in communication skills training, and to determine whether opportunities exist for adapting and implementing a communication skills workshop for use in existing childbirth education classes.

UBC’s Division of Health Care Communication (DHCC) is currently working on both sides of the communication relationship: workshops are being conducted with medical students at the University of British Columbia, as well as with patient groups in the Vancouver area. Previous research by the DHCC has identified communication difficulties specific to particular patient groups, which resulted in the development of workshops aimed at enabling mental health clients, seniors, stroke survivors, and cardiac patients to overcome some of the communication difficulties. Four major communication skills provide the framework for the workshop, which is centred on a trigger video simulating a patient-doctor encounter. The skills (represented by the acronym P.A.C.E.) are: Presenting information, Asking questions, Checking understanding of the information, and Expressing concerns. The workshop includes facilitated discussion based on the video scenario, as well as a booklet that highlights the importance of good communication and tips on how to implement these skills.

The literature review has identified some of the barriers to communication that pregnant women face, although no work was found that specifically focused on barriers to communication, rather the focus was on decision making processes and satisfaction with maternity care. This study is unique in that we set out to determine what the specific communication problems are according to a variety of groups: prenatal and postpartum clients, doulas, childbirth educators, family physicians, midwives, and obstetricians. In addition to satisfaction with the birth experience and potential improvement in health outcomes, good communication skills have the ability to improve communication relationships for the woman and her family in all aspects of life. We hope that the data
retrieved in this study will allow us to adapt the existing workshop to the unique communication needs of childbearing women.

**Methods**

This study was conducted as part of the Informed Shared Decision Making Project by the Division of Health Care Communication (DHCC) in the College of Health Disciplines at the University of British Columbia (UBC). Funding was awarded through a Health and Social Development grant from the Vancouver Foundation. Ethical approval was granted by UBC’s Behavioral Research Ethics Board.

A variety of methods were utilized to recruit participants. Potential targets were sent invitation letters via email or fax. Contacts at UBC were helpful in recruiting obstetricians and doctors, while email group lists were used to recruit doulas and midwives. Prenatal and post-partum clients were recruited through a variety of methods including invitation letters distributed via participant care providers, doulas and CBEs; posters, and announcements made by the research assistants at Childbirth education classes.

Separate interview questions were developed, piloted, and revised for each interview group. Prenatal clients were also given a questionnaire to acquire demographic information. Demographic information on other participant groups was acquired during the interviews themselves. See Appendix A for interview schedules and questionnaire. Semi-structured interviews were conducted by two summer research students; both first year university students, one in medicine, the other in midwifery. A standardized interview schedule was used to collect data from seven different participant groups between May and August, 2004. For a discussion on why each of the groups was interviewed see Appendix B. An attempt was made to ensure that both interviewers shared the different subject groups, to reduce interviewer bias. Interviews lasted between 45-90 minutes at locations of preference for the interviewee, often in their own homes. The numbers interviewed were: 6 Childbirth Educators, 5 Doulas, 5 Family Physicians, 3 Obstetricians, 5 Registered Midwives, 5 Postpartum Clients and 3 Prenatal Clients. One focus group consisting of 3 Prenatal clients (PNC) was also held. Throughout the data collection period as saturation was reached in some areas of inquiry, some interview questions were removed and others expanded upon as the particular angle of investigation shifted based on what was heard in the early interviews. All interviews and focus groups were tape recorded. Participants signed consent forms prior to the interviews, and during transcription of the audio data all identifying information was removed to maintain confidentiality. Selection bias is one limitation of this study; clients that volunteered to participate tended to be highly motivated and exhibited good communication skills. For this reason, we also relied on second hand accounts from CBEs who have contact with a wider variety of clients for a sense of what communication barriers are prevalent.

Thematic analysis was the main data analysis method. ATLAS.ti software was utilized to manage the raw data. Several themes emerged through a thematic analysis of interview transcripts and are outlined in Appendix C.

**Findings**

**Communication Barriers**

A variety of communication barriers between health care providers and prenatal clients were reported. For a list of items coded as barriers, as well as their definitions, see Appendix D. Most barriers were consistently reported between the participant groups. Following is a discussion of the main problems reported in the communication relationship.
Healthcare System
Many of the reported barriers to communication stem from the health care system. The system itself, for example, can contribute to feeling a loss of individuality. Terms used by respondents to capture this idea include, "conveyor belt," "medical track," and "patient treadmill." These terms imply an impersonal, expedient system in which communication can be difficult. The health care system is unfamiliar to many pregnant women, either because they are not regular users until becoming pregnant (UNIQUE?), or they come from somewhere with a different system. Not knowing how prenatal care is delivered can contribute to difficulties in knowing what to ask and expect. One client described,

"... we felt a little lost until we really got going in the system, not knowing what to do ... what about people that come here and don't know anything about the medical system." PNC

Of the other reported barriers related to the health care system, lack of sufficient time during prenatal appointments was the most frequently sited barrier to communication among all interview groups.

"Your time is limited and you have to squeeze everything in a short period of time so, that of course is, can be a problem with communication because you don't have the time." PNC

Lack of time leads to reduced information sharing. Many women reported that there is simply not enough time to ask questions and get answers in order to be well informed. In general, clients of FPs and OBs felt rushed during appointments and they identified this as an obstacle to informed decision-making. A CBE indicated a typical client complaint:

"... he's not even giving me the time of day, to talk about it or to ask a question, he's in here measuring my belly, listening to baby, and I don't even get a minute to talk ..." CBE

PNCs of midwives indicated that they value the added time that they have with a RM as it facilitates communication and decision making. There were many quotations from each subject group reporting that the opportunity for sharing of information between clients and HCPs did not always occur. This is a barrier particularly for ISDM.

"I'm being rushed ... sent for tests, I have no idea what they're for, I just go because I'm told to go." PNC

The variety and number of professionals birthing women encounter in the health care system can contribute to a lack of continuity. Women sometimes reported conflicting or confusing sources of information, which led to difficulties in decision-making.

"That was the only part of communicating with people that I felt really overwhelmed by because I was getting different advice from everybody and everyone was getting very stressed out about his weight loss and I think that that was very challenging [...] so we worked out a compromise because I so wanted to go home, you know. At that point I cried and felt, at every other point I felt very confident about my decisions but at that point I felt like oh my gosh, it's not just me anymore, I've got this little person. I really felt like I was starving him to death which makes you feel like a bit of a failure and there was such, um conflicting communication from the different people [...] and that was very unclear." PPC

Clients spoke about the value systems of different care providers. Midwifery seems to have a very clear and apparent philosophy of care that includes low intervention, personalized care, and a holistic approach. FPs and OBs tend to be associated with increased intervention and more routine care. The philosophy of care can create pressure to choose a certain way, or can equate to a lack of opportunity for involvement in decision making.

"... it's almost like the natural childbirth thing it's almost an institutional thing [...]"
like the literature that they have is all kind of, you know, hands-off, nothing invasive, try this option, which is one of the reasons you go to a midwife, right. But it, it you just feel this intense pressure, right. Whereas my friend went to the doctor and she had her triple screen and didn't even know it. She didn't even know she had a triple screen, right. It's kind of one extreme or the other.” PNC

Differences between physician care versus midwifery care can affect women in other ways as well. Labouring women perceived a status imbalance in the healthcare system in which midwives sometimes lose autonomy in the hospital setting. One midwifery client reported that her options were limited due to the position that her caregiver was in:

“My midwives were being very cautious because they had to deal with the hospital as well as me, I felt they had to kind of answer to both … So I felt like they had, that was kind of a political thing for them too is that they had to walk this very fine line between doing what they would do if they were sort of left to their own devices with their clients and knowing that they have to maybe change that to work within the current medical system and keep, and actually the one midwife who came in to the delivery with me actually even said, um, that this isn't what I would do normally but I have to work with this doctor.” PPC

Within the prenatal care setting the physical as well as psychological environments were reported as barriers to communication. Clients generally reported that hospitals and doctors offices were intimidating. During the focus group one PNC remarked that, "environment is a big deal!" and she would feel more comfortable if her doctor's office had a "couch and like an easy boy chair … and offer you a cup of coffee, well tea." Another PNC added the comment "like in my midwife's office."

"I think it's safety, a safe place where you can communicate that way. And I don't know how to get that in a medical environment." Doula

Another PNC reported that the doctor's office is an unfriendly environment that "... can put women into position, a very submissive position." PNCs report that being in a caring, accepting and supportive environment was important in making them feel like they were free to make their own decisions. If this support is lacking, ISDM is hindered.

"Um, I got a sense with the OBGYN we had to deal with that he was kind of either annoyed or amused by my questions and by my vehemence of avoiding a C-section and I got the impression he thought I was very silly by wanting to avoid an episiotomy and it was hilarious because he told me if I wouldn't, didn't have an episiotomy I would tear down to my anus. Well he ended up cutting me down to there anyways so I was like what's the difference?" PPC

"... when I went in to confirm my pregnancy with him he asked me about my care and I said we're going to have midwives and I want to have a home delivery and he got quite upset with me and said that basically insinuated I was going to kill my baby if I had my baby at home … So we agreed to disagree and then never talked about it again … as much as I like him as a person I just want to be supported in those decisions and I don't want to have to argue with someone ever time I go in …" PPC

Intimidation and power were mentioned numerous times as some of the biggest barriers. Many respondents reported that women don't feel they can talk to their doctor.

"One of my friends said to me, I always feel like I'm high maintenance when I ask my doctor questions." PPC

Medicalization and terminology can further contribute to intimidation.

"The intimidation is often, especially in hospital situations during birth, it's not deliberate intimidation but everybody is so
professional, and so medical, and the terminology is ... it may be foreign and often I think people don't know what they have the right to, or what they can do and what they can't do. It's somebody else's territory." CBE

The territorial idea expressed in the above quote is also represented in the language that CBEs report the prenatal clients use such as, "that's the way my doctor does it" and "my doctor says ..." The perception of authority or hierarchy was a pervasive factor that inhibits communication for many clients. One CBE refers to a "... God complex, and so [clients] are just oh yes, yes, yes".

"... when they're seeing the caregiver who's in the know and all powerful and well paid and an authority figure, given those already restrictions, it's gonna be difficult for them to know what the hell to ask." CBE

When faced with a decision, women were often inhibited in their participation:

"I think it was just more like a power struggle between her and me and it was more like that she wants to be in charge. I think she was a bit bossy and she wanted to make - you know whatever she says or whatever she decides it is kind of in her interest and not really in my interest ... But it is my baby and it is my body. It was kind of disappointing." PNC

Sometimes the client would choose which decisions were 'worth fighting for' and went along with their caregiver on decisions that they felt were more minor.

"I came out here to this doctor and it's like well this isn't good enough, you have to have this done, you have to have this blood done, you have to have this test done, she insisted on that one. She insisted on a lot of things that my doctor who obviously knew me a lot better didn't insist on ... She was like, 'this just doesn't cut it in B.C.' was her words. So I'm like alright, alright." PNC

The paternalism inherent in the medical system was identified by each of the participant groups as a barrier. Often HCPs minimize the concerns of the prenatal client. The perpetuation of the authority of medical professionals and myths about childbirth contribute to a lack of empowerment and understanding among childbearing women, hence making it more difficult to ask questions.

"They have no idea that they could suggest or ask to have the baby placed on their chest ... it's not something they are familiar with. A lot of people still think, 'Oh, this is the way it is,' ... that's still I think the general perception out there about what childbirth looks like." CBE/Doula

Caregiver routine, hospital protocol, and lack of information often prevent clients from realizing that they have a choice regarding their care. Frequently it was reported that clients may not be offered procedures as a choice:

"I was just given a piece of paper and told to go, there was no discussion of, you know, how may false positives there are, um, do I need to take this test, why?" CBE

Clients also expressed uncertainty about whether tests were mandatory or optional.

"... we knew the timing for ultrasound so I guess it just came up in previous appointments - Again it was more like it was just part of the care. It wasn't really, it wasn't presented as an option." (PNC)

Having an additional person (partner, nurse, doula, interpreter) present during prenatal visits and labour is usually helpful to the communication between client and HCP, however, occasionally their presence can hinder communication. When the additional person is a resident or student, clients may feel unable to truly express themselves. This is expressed by one FP who indicated that clients are sometimes inhibited by the presence of a resident,
"... they finally get you alone; they'll start to open up and say all these things that they hadn't been saying because there was a resident...” FP

Client-Caregiver Relationship
Choice of caregiver was identified as an important determinant of successful communication. Thus, barriers to communication may result when the personal match is not suitable between the client and HCP.

"I mean you work it out with the patient but, uh, if they're not able to communicate with you, there's some issues, then transfer them. And help them with the transfer ... don't just abandon them." FP

All respondent groups emphasized that clients should seek a caregiver they feel comfortable with in order for communication to succeed.

"If they feel inhibited or they feel insecure or they don't feel met they're not gonna be comfortable ... they're gonna have anxiety and with that more tension, with that more pain, with that more anxiety and the whole things just can spiral. And so it's really beholden on the caregivers who, um, provide them with a sense of security and comfort and confidence and ease and respect so that they can be as relaxed and confident with themselves ...” CBE

Not having the ability to access a suitable caregiver is a particularly challenging barrier to overcome, as often few options exist when seeking a caregiver. For example, some respondents expressed that they wanted a midwife for their primary caregiver but were unable to find a practice in their area that was taking new clients.

Matching personal characteristics such as philosophy, personality, attitude, and communication style between the client and HCP is important to ensure the client can have her specific needs and desires met throughout pregnancy and childbirth.

"I think in my case there was nothing to build. Probably even if I had attended workshops or done something, I don't think it would have worked, because our personality is different. We didn't get along really well." PNC

Clients and CBEs emphasized the importance of client and HCP working together to meet the needs of the client, including communication needs.

"I like a doctor who wants to spend time with me and get to know me and, like you said make you feel like a part of a team because I know I don't, she doesn't. I don't feel like a part of a team. She's just gonna show up, she might, she's on holidays so she might not even show up for the birth, who knows." PNC

Client Factors
It was pointed out by a CBE that communicating with HCPs is out of the realm of what some women are able to do. Another barrier reported by a CBE is that some women are overly idealistic and stuck with being right, hence making the communication relationship difficult. Many women may be unfamiliar with the health care system or face additional barriers to communication due to language and cultural factors.

Some stories were shared about women's loyalty to their family doctors. Sometimes clients may feel that they don't want to "betray" their HCP by questioning their actions, refusing intervention, or seeking another HCP during the prenatal period.

“She has such loyalty to her family doctor that she's had since she was like 10 that she, while it's her heart's desire to have a midwife and a home birth, she couldn't possibly do that to her doctor ... wouldn't he be devastated ... he'd never want to see me again. She's making her decisions on how her doctor would feel about it” Doula
Factors relating to the knowledge level of clients, such as familiarity, education, and information can affect communication. They often expressed a lack of familiarity with asking questions, and what questions are good to ask.

"I think it just goes back to what we've said over and over again that you just, that you need to ask questions, you need to educate yourself as much as possible, you need to take advantage whether it be a class, or, um, a clinic or just take advantage of everything that you can, basically, you know, and know that you have the right to ask questions ..." PNC

"I think that women believe that they don't have choices in their childbirth experience, I think most of them come in thinking that their doctor has ... 'I'll do it the way my doctor does,' or 'That's the way my doctor does it,' and they don't recognize the value and benefit of making an informed choice, that's where teaching about informed choice, encouraging them to talk to their caregivers ..." CBE

"... you're just like okay man, you're the one who went to school for seven years [...] so I'm just gonna put some faith in you that you're gonna make the decision that's the best for me and my baby." PNC

Taking charge of certain aspects of care can lead to a greater feeling of responsibility for the decision-making process.

"With the midwifery care [...] I do my own urine test, I do my own weighing and ... I feel I'm in charge of myself, you know. That kind of helps [feeling ownership of decisions]." PNC

Occasionally women reported the lack of desire to be active in decision making. Sometimes clients felt that the responsibility for decision-making should fall on the care provider.

"... and with the ignorance comes the fear. And when they're afraid, that inhibits their communication..." CBE

"She would go through the entire time feeling uncomfortable with some, you know, maybe unrealistic fears or fears that could be alleviated if they were talked about." CBE

"You know, how well are you gonna be able to advocate for yourself if you are, you know, completely embedded in fear?" Doula

CBEs felt that most women don't know their options and rights, and lack a "consumer driven" attitude about health care. For example, women don't know that it is acceptable to change caregivers or get another opinion if they are feeling uncomfortable. Unfamiliarity with the hospital setting and medical terminology can further increase intimidation. Furthermore, information about specific HCPs procedures, call systems, and how to contact HCPs is often not conveyed to women early enough in pregnancy. Lack of empowerment was reported as being a fundamental barrier to enabling the prenatal client to communicate.

"You're gonna be so, you know, if you're overwhelmed it's very difficult I think to express your needs clearly and you're probably gonna get stomped, they're just gonna get stomped out, you know, just say it once and, you know, if people don't listen then you might just give up on it. And that's not right. I mean I think that women really need to be empowered prenatally to, um, take responsibility for their own care, you know." Doula

Childbearing Experience

Factors relating to the childbearing experience are unique to prenatal health care users and can often have great impacts on communication. Fear is one contributing factor, and is perpetuated by telling of negative birth stories that lead the woman to doubt the labour process, and by the ignorance toward birth in our society.

"... and with the ignorance comes the fear. And when they're afraid, that inhibits their communication..." CBE

"She would go through the entire time feeling uncomfortable with some, you know, maybe unrealistic fears or fears that could be alleviated if they were talked about." CBE

"You know, how well are you gonna be able to advocate for yourself if you are, you know, completely embedded in fear?" Doula
First time mothers in particular may not know what to expect in labour, sometimes causing them to feel meek and less assertive. In second pregnancies they felt less passive and more demanding.

"... unfortunately you get people telling you different things and that just makes it more miserable. It must be a whole lot easier with your second kid." PPC

Labour and birth are unpredictable, hence negotiating plans with caregivers can be difficult.

"There's so much unknown around it, unpredictability around it but to try and make plans, that's difficult." CBE

Sometimes, although good communication may have occurred, the timing was not ideal. CBEs reported clients were often disappointed late in pregnancy when they are told their HCP may not be there to attend the delivery. It is also necessary for women to receive information/options in advance, so that they are prepared to make a decision if it arises.

"... explaining each and every procedure prior to it happening ... oftentimes women just need a little reminder during labour." Doula

Furthermore, during labour women experience considerable pain and often enter into an altered state. This can make communication more difficult.

"Some women say, 'I wish I would've remembered to tell him to do this, I couldn't get out of my body to tell him I really needed that back pressure, it felt so good when he did it but I didn't have the ... I couldn't come out of my space to say, 'keep doing that I need you to do that there ...'" CBE/Doula

The wrong kind of communication during labour was identified as a barrier that may impact health outcomes.

"As doulas, we're wanting them to get into their bodies, be in labourland, and the caregiver comes and wants to bring them out of that and into their head to talk about options or something ... it interferes with the labour process, it slows things down." CBE/Doula

Prenatal clients themselves indicated that they often forget to ask specific questions during the appointment because they become excited, for example by listening to the baby's heartbeat.

"... being a woman who's been through labour, you lose everything, you're so focused on yourself and so focused on the pain and the baby and, you know, the touch and the sense and things like that that you, your information source isn't there so it needs to repeat it several times." CBE

Pregnancy and the transition into motherhood can also change the way women make choices, as the outcomes of health care decisions affect not only themselves, but their child.

"... while I was very outspoken about my care when I was pregnant I was very unsure of myself after the baby came which I'm sure a lot of first time mothers experience. And you just want your baby to be healthy. So I didn't really speak up as much as I wish I had now. I wish I had just said to people no, I'm going home to go to bed to nurse my baby. You know if he's still losing weight in a week then talk to me. What I ended up doing was compromising with knowing that I wasn't gonna be allowed to leave unless I agreed to supplement, compromising with syringe feeding rather than a bottle, sending my husband out to rent the pump and, um, three days later I had a little nervous breakdown." PPC

One prenatal client offered a different perspective, indicating that if the situation was about her alone she may not speak up,

"... but because it's my baby ... and if something does go wrong then I will
The fact that decisions in pregnancy affect the baby makes women's partners more involved than in other health care decisions. Most clients seemed to involve their partners in decision-making but generally responsibility for decision-making falls on the pregnant woman.

"He supports my decision because it's ultimately, it's me carrying the baby, I know what's happening. I am more versed in the facts than he is and I'll be the one giving birth to the baby." PNC

Women sometimes felt like their male partners needed to feel more control in the decision-making process because everything else was so out of their control. The father of the baby may influence the choices of a pregnant woman, or pressure her to choose something that she would decide differently on.

Women encounter a number of health providers during pregnancy, labour, birth, and postpartum. When they do manage to develop a relationship with their primary caregiver, that person may not be the one attending the delivery. Furthermore, aside from the primary caregiver, there will most likely be a number of staff members involved at a hospital birth. The required negotiating and communicating can be overwhelming in labour, especially when those involved are unfamiliar faces.

"So I said that we, I would consent to forceps delivery and I'd then, had, was trying to negotiate no episiotomy with him but he was like no no no no, we're gonna have to have an episiotomy and so he and I bickered back and forth and he suggested that he leave the room and let me discuss it with my midwife and, you know, my husband and my doula and he was very good about that so we did. And so I had to sort of negotiate with this new person I'd never met before which was interesting. And again I'm told I was very polite and professional with him." PPC

Prenatal Class Coverage of Communication Skills

Most CBEs interviewed reported that they do cover some communication skills in their classes. For a list of tools CBEs use to teach communication skills, see Appendix E.

In general, instructors expressed that the way they help women communicate is by providing them with information, encouraging them to explore further and emphasizing that they have options. Frequently, CBEs reported that they encourage women to ask questions of their caregiver. Some CBEs use specific tools to help clients ask questions; others encourage general questioning and attempt to convey to women the importance of being informed consumers. Sometimes role-plays are used in which the instructor plays a caregiver and the participants practice asking questions.

"They're just supposed to ask the six questions and that might lead to all sorts of information that wouldn't have come out otherwise which will lead to them asking questions about the new information." CBE

One instructor hands out a question card to keep in a wallet that can be pulled out to remind clients what questions to ask when a decision needs to be made (ie: Is this an emergency or do we have time to talk?) Furthermore, most instructors inform the participants about the option of writing a birth plan to encourage dialogue with their caregiver. For a discussion on the benefits and disadvantages of birth plans, please see Appendix F.

One important limitation of this study is that only instructors that are independent of the hospitals were interviewed, so it is not known whether instructors that teach out of the hospitals include communication skills in their classes. One independent instructor who is also a labour and delivery nurse and had
attended a CBE series led by the hospital was asked if the instructor covered communication skills:

“They really can't ... The hospital classes get almost all of their referrals from doctors. They cannot talk about changing caregivers or challenging their caregiver. They're very restricted that way. They cannot talk about home birth, it's not an option. They can't talk about anything that isn't done in the hospital ... or is against hospital protocol so if it's routine policy in the hospital whether to get EFM for 20 minutes upon admission they can't talk about that being optional. So it's quite different [from independent classes].” CBE/Labour & delivery nurse

Other CBEs expressed a similar sentiment that hospital classes teach things as protocol rather than a choice.

"When I watch a hospital prenatal class, um, some of the wording is 'this is what will be done, this is what you can expect.' Whereas my wording is this is what they would like to do and these are your choices and if you speak up you have a say." CBE

Many of the clients interviewed had not taken prenatal classes, but stated they would recommend taking them to others. Those who had participated in classes reported that some classes covered communication specifically, and others didn't, but encouraged questioning and helped indirectly by exploring options. Many clients felt that learning the skills was useful and helped them prepare for visits with their doctor or midwife. One PNC recalled learning how to make her wishes known, and that she didn't have to go along with everything the HCP or nurses suggest.

"... 'cause it's your birth and if something is important to you, you can make it known. We probably wouldn't have thought of that at the time ... The one phrase we learned that I didn't realize is that 'it's your pregnancy your way,' which is the one thing that sticks in my head. So ... for that for me, it's all I need to remember, it's your pregnancy your way." PNC

Based on women's reports, communication techniques taught by CBEs were often specifically to use when something unexpected happened, such as how to ask questions during a crisis. Several acronyms for decision-making models were taught, which are aimed for use when a decision needs to be made during labour. There were few reports of skills being taught to use during the prenatal period.

**Gaps in prenatal class communication skills training**

- Some CBEs teach communication skills only insofar as they inform women of their options and encourage question-asking; they do not provide clients with specific techniques.
- Skills that are taught are mostly decision-making models for interventions/unexpected situations in labour, not the prenatal period (when many decisions come up).
- It is not known whether hospital classes teach communication skills. What was heard from CBEs and what clients report hearing from their friends is that hospital classes do not adequately cover communication skills. Furthermore, interviewees speculated that women attending hospital classes may be less assertive and ask fewer questions. It is thought that women that self-select to alternative classes may have enhanced communication ability.
- Communication during labour requires specific skills that may not be adequately taught.

"I mean there's the whole prenatal time but then in labour, it's such a specifically vulnerable time when it is really really difficult to bring oneself to ask questions. It might be just room for a really specialized kind of instruction on that ... even [for] people who are really good at it [communicating] prior to labour ... it's almost impossible to remember what your
six questions were in the middle of a contraction.” CBE

Opportunities for implementing communication skills training for prenatal clients

Respondents were asked if they felt there was an opportunity for an adapted communication skills workshop for prenatal clients.

“I think that’s a fantastic idea. I would suggest there’s even more need with prenatal clients almost with any other group since it’s the only completely normal healthy, technically non-medical thing that is mostly looked after by hospitals doctors. So yeah, huge. And because there are so many common procedures associated with pregnancy and birth again starting with the basis that the person isn’t actually sick.” CBE

“Yes. I think because even tonight I … realizing … I have more options than I ever thought I did and … if I’d known to say, ask this question or whatever, I may have done that. But I haven’t so far, so I think it’s valuable that way.” (PNC, focus group participant)

CBEs and clients generally expressed enthusiasm for communication skills training and believe there is a need for clients to improve communication skills. Particular communication challenges come up in labour and specific skills could be very useful to this client group. Other frameworks might be more beneficial to teach for use during labour, as it is difficult to remember certain questions and communicate them while in labour. Furthermore, many of the skills taught are specific to decision making around interventions or testing. A workshop that addressed general communication skills training for common prenatal situations and specific skills to use during labour would help enable women to make the most of communicating with their caregivers.

Many helpful suggestions for teaching communication skills and on workshop adaptation were shared. Collaboration on development is a possibility for some instructors. See Appendix G, Table 2, for an outline of the advantages and disadvantages of potential community partners that may be interested in assisting in the development of a communication training workshop for prenatal clients.

A significant proportion of BC pregnant women don’t participate in CBE classes, so a large group would not be accessed this way. Additionally, general feedback was that the training should be delivered as early in pregnancy as possible for maximum benefit. As pregnant women and their partners don’t generally attend CBE classes until the third trimester, many prenatal healthcare decisions have already been made. Women and other respondents were asked to identify common prenatal decisions that were often challenging. One of these decisions could be utilized in a standardized patient video scenario for inclusion in a training workshop. Table 3 in Appendix H lists common difficult decisions with some suggestions on which may be most suitable for use as a video scenario.

Some ideas were put forth as to how we could deliver training to women earlier in pregnancy (See Appendix G). However, respondents agreed that while earlier would be better; improvement in communication skills would be beneficial at any time. See Appendix H for more detailed feedback and suggestions for training development. Table 1, below, summarizes the communication barriers identified by respondents and suggests which barriers might be improved through additional communication skills training.
Table 1: *Communication barriers and skills that could be taught to help overcome them*

<table>
<thead>
<tr>
<th>Communication Barrier</th>
<th>Improved with Comm. Skills?</th>
<th>Skills to teach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTHCARE SYSTEM</strong></td>
<td></td>
<td></td>
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<tr>
<td>Routine / not offered choices</td>
<td>Yes</td>
<td>Teach that almost everything is a choice, information seeking, questioning</td>
</tr>
<tr>
<td>Low level of information sharing</td>
<td>Yes</td>
<td>Questioning skills, information seeking</td>
</tr>
<tr>
<td>Intimidated by presence of 3rd person (eg, resident)</td>
<td>Yes</td>
<td>Teach it’s OK to say no</td>
</tr>
<tr>
<td>Lack of adequate time</td>
<td>Yes</td>
<td>Organize questions, advocate for answers, information seeking</td>
</tr>
<tr>
<td>Intimidation</td>
<td></td>
<td>Build confidence, practice skills</td>
</tr>
<tr>
<td>Power / hierarchy / authority</td>
<td></td>
<td>Build confidence, practice skills</td>
</tr>
<tr>
<td>Value system of HCP = pressure</td>
<td></td>
<td>Teach ‘patients rights,’ consumerism</td>
</tr>
<tr>
<td>Paternalism</td>
<td></td>
<td>Build confidence, practice skills</td>
</tr>
<tr>
<td>Medicalization/terminology</td>
<td></td>
<td>Question asking</td>
</tr>
<tr>
<td>Lack of continuity of care / unfamiliar caregivers</td>
<td></td>
<td>Encourage women to find out model of practice, try to meet potential caregivers</td>
</tr>
<tr>
<td>Conflicting information sources</td>
<td></td>
<td>Teach critical thinking, information seeking</td>
</tr>
<tr>
<td>Unfamiliar/intimidating environment</td>
<td></td>
<td></td>
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<tr>
<td>Status imbalance (midwives-loss of autonomy in hospital)</td>
<td>No</td>
<td></td>
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<tr>
<td>Impersonal (care not personalized)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Lack of choice of HCP</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>CLIENT-CAREGIVER RELATIONSHIP</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor client-caregiver match</td>
<td></td>
<td>Teach importance of careful caregiver selection, and how to select a HCP</td>
</tr>
<tr>
<td>Not working as a team</td>
<td></td>
<td>How to express needs and have them met</td>
</tr>
<tr>
<td>Lack of support for decisions</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>Low comfort level</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td><strong>CLIENT FACTORS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client level of information / education</td>
<td>Yes</td>
<td>Information seeking skills, questioning</td>
</tr>
<tr>
<td>Don’t know rights</td>
<td>Yes</td>
<td>Teach rights</td>
</tr>
<tr>
<td>Don’t know how to ask questions / what to ask</td>
<td>Yes</td>
<td>Questioning</td>
</tr>
</tbody>
</table>
Conclusion
The findings from this study suggest that good communication is of key importance in the relationship between childbearing women and their caregivers. The barriers identified reaffirm what existing literature on health care communication describes. The women interviewed related examples of times in which informed shared decision making did not occur in relation to health care decisions in pregnancy. A workshop intervention aimed at helping clients enhance communication with their caregiver has the potential to empower women to take a more active role in their care.

Acknowledgements
We would like to thank all of the participants who took part in this study: family physicians, midwives, doulas, childbirth educators, obstetricians, and most of all, the women who shared their stories of pregnancy and birth. In addition, thank you to the Vancouver Foundation, to the Faculty of Medicine Summer Studentship Awards Program and The University of British Columbia Workstudy Student Program for providing the funding to undertake this project.
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APPENDICES
Appendix A: Interview schedules and prenatal client demographic questionnaire

The questions were developed based on the study objectives, ideas about what information each group could provide, and from examples of other interviews conducted by the DHCC investigating issues of Patient-Physician communication and decision making.

Childbirth Educator Interview Schedule

1. Tell me about teaching CBE classes/what do you do as a CBE?
   • How long, tell me about the organization, tell me about your clients (age, parity, location).
   • What are some of the things you cover in your classes?

2. Why do people come to your/CBE classes?

3. Based on your experiences teaching and talking to prenatal clients, what do you think the communication relationship is like between clients and their caregivers?
   • Do couples talk to you about caregiver-communication issues? What kinds of questions/concerns do they typically raise?
   • What do you think are the major problems?

4. How might this communication relationship affect the birth experience?
   • Examples of good/bad communication and how that affected the health outcome?

5. Do you find that women want to become more active healthcare consumers and participate more in decision-making? Are they doing it? What do you think about that?
   • What do clients need to make informed decisions? Are they getting it?
   • What’s missing, why aren’t they getting enough, how to fill in gaps?
   • Who do they rely on for info/help in decision-making? How much do they rely on you?
   • What do you provide them with?
   • Does Informed Shared Decision Making affect health outcomes? How? Examples?

6. What are some common decisions to be made in the prenatal period?
   • What can make those decisions easier?
   • What makes them difficult?

7. Do you have a role in the communication between client and healthcare provider? Tell me about that. Do you cover communication skills in your classes?
   • If/when clients express communication difficulties with their health care provider what kinds of things might you suggest? How do you present it? What do you cover?
   • How/what kind of teaching strategies/tools do you use?
   • What is the reaction?
   • How effective do you think this is in improving client-caregiver communication?
   • Are clients able to overcome some of the problems you mentioned earlier?
   • Can you think of any other skills or strategies that could be taught in prenatal classes to help clients overcome communication problems?
   • What do you think about birth plans as a communication tool?
8. **How were communication skills covered in your training?**
   - Did you feel prepared to teach communication skills?
   - If yes—what is it that is most useful to you? If not—why? What would prepare you?

9. **Do you have anything else you’d like to share?**

   *Describe communication skills training workshops (PACE framework) and SP videos—get feedback on whether/how to adapt.*

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**Family Practitioner Interview Schedule**

1. **What is your role in the process of prenatal care and delivery?**
   - How many births do you attend in a year?
   - Tell me about your clients. How do they end up in your care? Is caring for them different if they are already clients of yours prior to their pregnancy? Do they take prenatal classes? Do you encourage/recommend classes? Which ones? Why?

2. **What do you feel is important in a good relationship between clients and caregivers?**
   - Tell me about your work environment. How does that impact your relationship with your patients?

3. **What does good communication with a client mean to you?**
   - What’s different about communicating with clients in the hospital versus in your office?

4. **Based on your experience working with prenatal clients, can you tell me about an instance when communication was good?**
   - What was the outcome?

5. **Can you think of any stories when communication between you and a client wasn’t so good?**
   - What was the outcome?

6. **What makes it hard for you to communicate with clients?**

7. **What do you think are the major problems clients experience in communicating with you or other caregivers?**
   - Can you think of an example?

8. **I’d like to hear about decision-making. What are some common decisions that your clients struggle with during the prenatal period?**
   - What strengths and weaknesses do clients have when facing health decisions?
   - How do you typically help them make those decisions?
   - What kind of information do you provide to your clients? In what format? What do they respond best to?

9. **What kinds of barriers do you and your clients face when making decisions about prenatal care?**
10. What things could clients do which would help them communicate more effectively with you/with other health professionals?
   - Can you think of examples of clients who communicate effectively and try to explain what it is about the way they communicate that makes it easier for you?
   - What is it that they do differently than some of your other clients whose communication is not so good?
   - How effective are birth plans as a communication tool?

Anything else? Describe PACE/workshops, ask for thoughts. If scenarios were adapted, how would they respond? Helpful?

Doula Interview Schedule

1. Tell me about what you do as a doula.
   - What are some of the things you discuss in your prenatal visits with clients? How many prenatal visits do you typically have?

2. Tell me about why women hire you.
   - What are they like, how recruited, who are their caregivers, age, parity, location?

3. Based on your experience, what can you say about the communication relationship between clients and their caregivers?
   - Do couples talk to you about communication issues? What kinds of questions/concerns do they typically raise? Examples of breakdowns?
   - How might this communication relationship affect the birth experience / health outcomes? Examples?

4. Do you have a role in helping clients communicate? Tell me about that.
   - What kinds of things might you suggest? How do you present it? What is the reaction?
   - How effective do you think this is in improving communication for your clients?
   - Are they able to overcome some of the problems you mentioned earlier?
   - Can you think of any other skills or strategies that clients could use to overcome communication problems?
   - What about birth plans as a communication tool?

5. Lately it seems as though women are becoming more active healthcare consumers and want to participate more in decision-making, what do you think about that?
   - What do clients need to make informed decisions? Are they getting it?
   - What’s missing, why aren’t they getting enough, how to fill in gaps?
   - Who do they rely on for info/help in decision-making? How much do they rely on you? What do you provide them with?
   - Does Informed Shared Decision Making affect health outcomes? How? Examples?

6. What are some common decisions your clients have to make in the prenatal period?
• What can make those decisions easier?
• What makes them difficult?
• Who is responsible for the process of informed shared decision making?

7. Is there anything else you’d like to share or discuss?

Describe communication skills training workshops (PACE framework) and SP videos- ask their impression.
Get feedback on whether/how to adapt.

Midwife Interview Schedule
1. Tell me about what you do as a midwife.

2. Tell me about your clients.
   • Why are they choosing midwifery care?
   • Do you have any stories about people that have switched to a midwife part way through their pregnancy? Why?

3. What do you feel is important in a good relationship between clients and caregivers?

4. What does good communication with a client mean to you?
   • What makes the midwife-client communication relationship different from the doctor-client communication relationship?
   • Tell me about your work environment. How does that impact your relationship/communication with your patients?

5. Based on your experience working with prenatal clients, can you tell me about an instance when communication was good?
   • What was the outcome?

6. Can you think of any stories when communication between you and a client wasn’t so good?
   • What was the outcome?

7. What makes it hard for you to communicate with clients?

8. What do you think are the major problems clients experience in communicating with you or other caregivers?
   • Can you think of an example?
   • Does communication between client and caregiver affect the health outcome? Examples?

9. I’d like to hear about decision-making. What are some common decisions that your clients struggle with during the prenatal period?
   • How do you typically help them make those decisions?
   • What kind of information do you provide to your clients? In what format?
   • What do they respond best to?
   • Does Informed Shared Decision Making affect health outcomes? How? Examples?
10. What kinds of barriers do you and your clients face when making decisions about prenatal care?
   • Tell me about a time when you and a client had conflicting ideas about a whether or not to do a certain procedure or diagnostic test. What happened? How was the conflict resolved?

11. What things could clients do which would help them communicate more effectively with you/with other health professionals?
   • Can you think of examples of clients who communicate effectively and try to explain what it is about the way they communicate that makes it easier for you?
   • What is it that they do differently than some of your other clients whose communication is not so good?

12. Is there anything else you’d like to share?

Describe PACE framework and existing workshops, ask for thoughts. If scenarios were adapted for prenatal clients, how do you think they respond? Do you think it would be helpful to them?

Postpartum Client Interview Schedule
1) Is this your first baby? How old is she/he? How old are you? (Try to assess demographics)
   • Can you tell me a bit about your pregnancy and birth?

2) Who were your caregiver/s? Why did you choose them?
   • How was your relationship with your caregiver/s? What was important in that relationship?

3) How easy was it to communicate effectively with them?
   • Can you think of a time when you had questions or concerns for them? Was it difficult or easy to communicate those concerns? What made it easy/hard?
   • IF HARD: What did you do? What happened? Have you ever felt that you couldn’t ask a question or express a concern? Can you think of some things that stopped you from being able to ask questions or express your concerns?

3) Did you take prenatal classes? What was your main reason for wanting to take prenatal classes? How did you choose that prenatal class? (Find out which one)
   • Do you remember learning about ways to improve communication with your caregiver? How were those skills taught? How did you find learning the skills that way? Any suggestions for improvement?
   • Did you try to use them? Did the way you communicate with your caregiver change at all after learning communication skills in class?

4) If this is not your first baby, can you describe any differences in how you communicated with your caregiver this time?
   If she saw her family doctor for your maternity care: Would you say there was a change in the relationship after you became pregnant? What’s changed? Was that a good or a bad thing?
   If she had a doula: Tell me about your doula (Is this irrelevant/too time consuming?). Why did you hire a doula? Did she have a role in helping you communicate? Providing information?
5) I would think there are a lot of decisions to be made about your care when you’re having a baby. Can you think of a decision you had to make? How did you make that decision?
   • Did you involve anyone else?
   • Where did you get all the information? Did you feel well informed?

6) How did your caregiver talk to you about the decision? Did you feel like you were on the same team in making the decision? Tell me about why or why not. Was there a conflict about what each of you wanted? What was the outcome? Did you talk about different options and why you might choose one over the other?

7) Can you think of a time when you would have liked to have more input into decisions about your care?
   • Did you try to become more involved? What worked/didn’t work?

8) What helped you make prenatal decisions?
   • What made it hard?

Are you the kind of person who wants more involvement in healthcare decisions? Have you heard of ISDM? Would you be interested in learning to become more involved? Who do you think would be a good person to teach some skills (prenatal, caregiver, doula)? Describe video/workshop-get feedback.

Focus Group Agenda/Ground Rules

6:15
Group moderators arrive to set up room, catering, equipment.

6:45 pm
Participants arrive, chit chat, refreshments, and signing of consent forms.

7:00
Moderators introduce selves (first names only), and lay out ground rules.

Ground Rules:
   • Please feel comfortable to participate in free conversation – you don’t have to respond directly to us.
   • Feel free to address one another and share your thoughts and opinions, even if in disagreement with what someone else has shared. We need to hear all viewpoints and experiences.
   • However, please don’t interrupt, if more than one person is speaking at a time, the tape recorder will not pick it up, and we will have no data.
   • Please allow everyone a chance to share their experience, and keep in mind that some people are more comfortable talking in a group than others.
   • We have a lot of topics that we want to cover in a short period of time, so it is really important that we all make an effort to stay on topic. We may have to cut short some areas and move on to the next item without everyone’s response. We hope to cover all the questions by 9pm, if not, feel free to leave at that time, or stay if you are able to.
   • If you have some experiences or personal details that you do not feel comfortable sharing with the group, please do not feel pressured to disclose anything you don’t want to.
• If someone wants to say something off the record, you may ask one of us to switch off the tape recorder momentarily.
• Everything that is said within the group tonight is to be kept confidential and should not leave the room, especially names.
• At the end of the focus group we have a short questionnaire that asks questions about demographics. This is also an opportunity for you to write any additional comments or private statements that you did not feel comfortable sharing with the group.

Focus Group Questions
1) Let’s start out with introducing ourselves. Maybe you could share how many weeks you are, and if it’s your first baby or not. If you like you might share what you do, your age, or anything else you’d like to say about how your pregnancy is going so far. (Response from everyone)

2) Have you currently or previously attended prenatal classes? Why or why not? Why did you choose the prenatal class that you did?
• What do/did you hope to get/what are you getting out of the prenatal classes?
• What skills did you learn to help you communicate with your care provider from these classes?
• How were these skills taught?

3) What kind of health care provider do you have? Why did you choose them?
• Does anyone have a doula? Why did you decide to get a doula?

4) For those of you that are seeing your family doctor for your pregnancy, has your relationship changed now that you’re pregnant?
• How has it changed?

7:30

5) How do you feel about communication with your health care provider?
• What difficulties do you experience when communicating with a health care provider?
• Can you give some examples of times when it was difficult to communicate/ask questions/get information?
• If communication isn’t going so well, what do you do? What happens? What stops you from being able to ask questions or talk about concerns?

6) Sometimes communication breaks down when something unexpected happens. Has anyone experienced a communication breakdown?
If appropriate:
• How do your health care providers try to let you know what is happening with you? Talk? Draw? Reading? Video?
• Do they review provided information, such as reading or a video with you? How?

7) Think about a time when you had to make a healthcare decision during pregnancy. How did you and your midwife/doctor make that decision? What approach / discussion did you have?
• How did you become aware that there was a choice to be made? For example, the standard of care recommends an Ultrasound at 18 weeks. How were you presented with this choice?
• Did you feel more like you were on the same team as them in figuring out what to do or were they were telling you what is going to happen? Tell me about why or why not.
• Did you and your health care provider talk about different options and why you might choose one over the other?
• When making your decision, how did you decide? Who did you rely on? What was their role?
• Where did you get information? Did information change your original viewpoint? How so?
• Looking back, is there anything you would have done differently in the decision-making process? What would you recommend to others in your shoes?
• Was there ever a conflict about what you wanted and what they wanted? What happened? Did you feel able to share your viewpoint? How was the conflict resolved?

8:30

8) Can you tell me about a time when you would have liked to have more input into decisions about your care?
• Did you try to become more involved or inquire about your options? What happened or would have happened? What worked/didn’t work to enable you to have more input?
• Did gaining information help you ask more questions or gain more input into the decision?
• Who’s responsibility is the decision-making process?

9) Would you want, or is there a need, for prenatal clients to learn more about communicating with health care providers?
• What kinds of things would help clients/patients become more involved in decisions about prenatal care/childbirth?
• How would you like this information presented? What venue would be best? Who should present this information?

Describe PACE workshop format:
• Have you used these sort of skills in communication with Healthcare providers? Examples? Would this framework have been useful to you?
• How would it have changed your relationship and the decision-making process with your healthcare provider?
• How would you want such a workshop to affect your relationship with your health care provider?
• Would you enjoy / have opportunity to attend something like this?
• Any further comments or recommendations for implementing such a workshop? Is there another way to present this information?

8:55 – Recap purpose of study – Are we missing anything? Do you have further comments?
Questionnaire

9:00 – End
Appendix B: Rationale for interviewing each subject group

Specific participant groups were chosen to provide particular insight into the topic of communication between Prenatal Clients and their Health Care Providers. The usefulness of each group to this study is as follows:

A. **Prenatal Clients (PNCs - 3 interviewed):** As the target group of this study their perspective and first hand experience regarding communication with healthcare providers is valuable. In addition they alone can provide information concerning their desire to improve communication with their care provider, willingness to gain further instruction, and which methods may be beneficial to gain such instruction during the prenatal period. Partner’s perspectives were also welcome, to complete our understanding of the communication relationship with caregivers, the need for and willingness of prenatal women to attend a workshop on health care communication. It is also suspected that partners are a key factor in contributing to women’s decision-making and communication processes in the health care setting.

B. **Postpartum Clients (PPCs - 5 interviewed):** Having recently been in a relationship with a prenatal caregiver, their perspective may be useful for revealing issues that prenatal clients have not yet experienced. In addition, their retrospection may be a useful tool to uncovering some of the issues related to client-caregiver communication. As the birth experience is the climax of this period it is hypothesized that many communication issues may not be revealed until this point.

C. **Childbirth Educators (CBEs - 6 interviewed):** One aim of this study is to consider the feasibility of development of an educational workshop on communication for prenatal clients. Hence, it is essential to learn if and how health care communication is already included in prenatal classes, and what recommendations educators offer for teaching communication skills during the prenatal period. In addition, as instructors have extensive contact with clients it is hoped that they will be able to provide third-person comment on client’s communication skills and health care communication issues during prenatal care.

D. **Doulas (Ds - 5 interviewed):** It is believed that Doulas develop intimate relationships with their clients and act as advocates between women and medical staff. As such women may confide in them about their relationship with their caregiver, and rely on them for assistance in communicating their desires to the health care provider. As a third-party observer of the birthing experience it is hoped they may provide an impartial perspective on health care communication during this time. Doulas can report on their experiences communicating with women as well as women’s experiences of communicating with a variety of care providers.

E. **Health Care Providers (HCPs):** It is important to hear their perspective on issues related to communicating with prenatal clients, their communication skills level and needs.
   i. **Registered Midwives (RMs - 5 interviewed):** The midwifery philosophy of care emphasizes rapport, trust, open communication and informed shared decision-making; hence their perspective may differ from that of other care providers. At this
point of renewed interest in midwifery, they may be in a position to share stories of women's experiences of communicating with a variety of care-providers.

ii. **Family Physicians (FPs - 5 interviewed):** As the largest group of maternity care providers in BC (UBC Family Practice lecture, 2003) their perspective on prenatal communication may be representative of the general population rather than women who self-select to midwives and obstetricians.

iii. **Obstetricians (OBs - 3 interviewed):** As they typically provide care to women in 'high-risk' situations there may be an increase in barriers to communication. In addition, good communication may become more important in these cases. Hence, the OB perspective on the communication relationship may reveal aspects not specifically addressed by other prenatal care providers.
**Appendix C: Coding Themes**

<table>
<thead>
<tr>
<th>Decision Making</th>
<th>Prenatal Classes</th>
<th>Communication</th>
<th>Training</th>
<th>Unique Experience</th>
<th>Health Outcomes</th>
<th>Background**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenges</td>
<td>Content / Skills coverage</td>
<td>Client comms. Needs*</td>
<td>Possibilities / Suggestions</td>
<td>Empowerment</td>
<td>Satisfaction / Dissatisfaction</td>
<td>CBE</td>
</tr>
<tr>
<td>Process</td>
<td>Reasons to attend</td>
<td>Instructor comms. Needs*</td>
<td>Barriers to implementation</td>
<td>Motivation</td>
<td>Clinical</td>
<td>Midwife</td>
</tr>
<tr>
<td>Common decisions</td>
<td>Gaps in training</td>
<td>Client comms. Skills / Lack</td>
<td>Potential outcomes (Feedback)</td>
<td>Barriers</td>
<td></td>
<td>Doctor</td>
</tr>
<tr>
<td>Information sources</td>
<td>Outcomes / Effectiveness</td>
<td>Care provider comms. Skills / Lack</td>
<td>Ways to adapt</td>
<td>Partner involvement (Triad)</td>
<td></td>
<td>Doula</td>
</tr>
<tr>
<td>Informed consent</td>
<td>General information</td>
<td>Misunderstandings</td>
<td>Opportunities</td>
<td></td>
<td></td>
<td>Clientele</td>
</tr>
</tbody>
</table>

* “Needs” refers to specific items in the setting or relationship that are required to ensure open communication. *This is NOT areas of communication skills that need improvement.*

** “Background” refers to demographics, training, and values of these groups.
Appendix D: List of Codes and their Definitions

Barriers/Solutions to communication:

3rd person: the ability of an additional person to help or hinder the communication, may include partner, family member, doula, interpreter, and others

Childbirth education: prenatal class attendance and its affect on communication

Caregiver selection: ability of client to choose the caregiver of their preference

Comfort level: ease and support of communication facilitated by the setting, or persons involved

Empowerment: capacity for client to act in her own best interest

Environment: physical setting or persons involved creating an atmosphere to help or hinder communication

Fatigue: physical or mental exhaustion

Fear: anxiety or fright which prevents the ability to communicate

Information sharing: opportunity for transfer of knowledge or facts through contribution or listening

Intimidation/power: perceived status imbalance

Knowledge: factors such as familiarity, education, and information that affect communication

Labour experience: factors specific to labour/childbearing that impact communication

Language/culture: differences in method or manner of communication

Loyalty: concept of wanting to please the other member such that it prevents sharing of information

Medicalization/terminology: technical aspects of medical care that are often beyond the scope of understanding for the client and can be intimidating

Paternalism: perception that the “HCP knows best"

Personal characteristics: factors that are specific to the individual, ie: philosophy, personality, insensitivity, attitude

Society: social constructs and understanding that impact communication

System: characteristics of the health care system that inhibit communication

Time: time available for communication to occur

Timing: point in time at which communication occurs

Trust/respect/honesty: factors that are important for unhindered communication

Tools: useful strategies that promote skills or opportunity for communication

Team: degree to which HCP and client are perceived as working together for the clients best interests

Client Factors: Education; Motivation/empowerment; Skills; Information seeking; Holistic; Personality (compliance, stubborn, afraid)

Assessment: Breakdown (poor); Good; OB; FP; RM

Birth Plans: Pros; Cons; Suggestions; Reactions
Appendix E: CBE Communication Skills Tools

BRA(I)WN
B-what are the benefits?
R-what are the risks?
A-what are the alternatives?
(I)-what does your intuition tell you?
W-can we wait? What’s the timeline?
N-what happens if we do nothing?

- re/postpartum-draw a circle of support and identify who the supports are-for communicating with everyone else other than HCP to assess your needs and voice them-can be hard with new baby
- questions to ask: Do I need more information to make this decision? Can you leave the room for a few minutes so we can talk about it? What would happen if we waited? Am I okay? Is the baby okay?
- Role-play-assign topic to each participant-they research it-next class they pretend to be doctor and answer questions on topic from other participants
- prearranged codes with partner to help communication during labour (ie/ certain gesture means ask a certain question)
- tool to help partners communicate with each other-each fills in separately the answers to same questions and then they come together
- role-play of C-section to show who/how many in the room, familiarize with equipment-the idea would be people will feel more comfortable in the situation and therefore able to communicate better
- question card, or specific questions to ask
- birth plan
- review options
- “3rd person” to appointment and during labour allows communication to continue when client is worn out, or to help when HCP doesn’t understand client.
- Use pre-defined codes such as “Red for Meds,” indicating the final decision to opt for use of medication during labour, to communicate with 3rd person.
- As an aid to forgetfulness and time efficiency make list of questions. Get HCP to cross out the questions as they are addressed, and keep the others for the next appointment – that way if a question has waited too long you have it on paper
- before hiring HCP get lists of questions to ask them from doula, RM or internet.
- fact sheets to be used by HCP
- use additional appointment with HCP
- Information from HCP via website, email
Appendix F: A Note on Birth Plans

One existing communication tool for prenatal clients is the Birth Plan. We asked most interviewees about this tool and its effectiveness at improving communication, and received mixed reviews. Most agreed that it can work under certain circumstances, particularly when it contains only the main things that are important to the family, and not a list of things that is the standard of care and is routinely going to happen. Another good suggestion was to write it in a way that expresses what you would like, and not what you don’t want. Some caregivers seem to be threatened by birth plans, and stories were shared about hospital situations in which clients with birth plans drew comments from staff such as demanding, unrealistic, and “the more things on the birth plan, the longer the labour.” One of the downsides seems to be when clients have unrealistic expectations about how they want things to go. If birth plans are written with the proviso that they can always be changed to match the circumstance, then they can be a useful communication tool to help the caregiver understand the clients concerns, fears, and wishes. Birth plans should be considered as a component of any future training for prenatal clients.

“I think they’re great for certain and special circumstances … writing down positions and things like that, that’s pretty standard … when we first started birth plans it was like don’t give me an enema, don’t shave me, you know, cause that was what people thought that was happening in the hospitals … now when I kind of look at that birth plan and it’s on there, I almost, I find it quite funny. I have had people of different religious backgrounds, uh, one gentleman who just said, very important, all his birth plan said was I, you know, as the baby is being born during the birth, I don’t want anybody to talk. I’m gonna be reading off a prayer. There’s no reason why we can’t do that for him. There’s no reason to talk, baby’s coming, everything’s good and do a little suctioning or whatever needs to be done, wiping and here comes the baby. That was a really easy one and everybody was very respectful of that … cutting of the cord, things like that, you know, if you want the cord to be delayed in cutting, I’d put that in my birth plan and make sure my caregiver really knew that and reminded him or her of that. Things like that that are really specific. I think that they’re a useful tool to communicate with your caregiver about the things that you want to do. But I think just direct questions are even better, like do you do episiotomies and what is your rate? Rather than I don’t want one. Because you’re not asking the question. I know you don’t want one but guess what, I do them, would be realistic. I know we don’t do them in British Columbia nearly as much as we used to but it’s one of those things where you just say well this is what I don’t want, this is what I don’t want, this is what I don’t want. It’s not gonna help you if that’s what I practice. So you should be asking it from the opposite way. CBE

Finally, many interviewees related that often expectant moms, especially primips, aren’t clear on what they want. In order for good communication to occur, the client has to be clear on her needs and desires. In this way a birth plan can be useful to get them started in thinking about what they want and what’s important to them, thus improving communication in that way, even if they don’t share their birth plan with their HCP.
### Appendix G: Table 2-Potential Community Partners

**Table 2: Potential Community Partners: Pros and Cons**

<table>
<thead>
<tr>
<th>Potential Partners</th>
<th>Information</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Douglas College</strong>&lt;br&gt;Kathie Lindstrom, perinatal coordinator/CBE/doula</td>
<td>- deliver community based prenatal classes to 4000 couples/year&lt;br&gt;- serve families in New West, Burnaby, Langley, Maple Ridge, etc.&lt;br&gt;- over 25 instructors&lt;br&gt;- DC also trains CBEs</td>
<td>- serve many couples&lt;br&gt;- perinatal coordinator has offered to pilot the project (30-45 minutes in Class 6)&lt;br&gt;- 10 sites, 4000 couples/yr-class 6 is a catch-up class in (GOOD POTENTIAL)&lt;br&gt;- many instructors teach for DC, and DC could potentially add PACE/video to CBE training&lt;br&gt;- women want training in their neighbourhood</td>
<td>- doesn’t serve Vancouver proper&lt;br&gt;- classes are already quite packed—little time available&lt;br&gt;- instructors interviewed already teach some communication skills, and it is suspected that self selection of women occurs—perhaps they already have good communication skills</td>
</tr>
<tr>
<td><strong>Lower Mainland Childbearing Society</strong>&lt;br&gt;Stephanie Ondrack—instructor/doula&lt;br&gt;Jennifer Landles, registrar</td>
<td>- deliver community based CBE to couples in Van, Richmond, all over&lt;br&gt;- serve 150 couples/year&lt;br&gt;- 3 instructors</td>
<td>- 1 instructor has expressed interest in helping develop video/adapting training&lt;br&gt;- all 3 instructors are willing to try a video in their class&lt;br&gt;- women want training in neighbourhood</td>
<td>- self selection of women with good comm. skills&lt;br&gt;- serve only 150 couples&lt;br&gt;- all 3 instructors already have several tools to teach comm. skills&lt;br&gt;- limited time available</td>
</tr>
<tr>
<td><strong>Belly to Baby CBE</strong>&lt;br&gt;Sarah Alexander</td>
<td>- 1 instructor, she is a new CBE, also L&amp;D nurse&lt;br&gt;- community based CBE</td>
<td>- this instructor said she was ‘potentially’ interested in helping develop training, and is looking for teaching ideas</td>
<td>- would reach minimal audience&lt;br&gt;- based in Port Moody</td>
</tr>
<tr>
<td><strong>St. Paul’s Hospital</strong>&lt;br&gt;Faith Kuboniwa—maternity coordinator</td>
<td>- deliver hospital based CBE (out of St Paul’s)&lt;br&gt;- 3-4 instructors</td>
<td>- classes may not cover any comm. skills (GAP?)&lt;br&gt;- many women in area take prenatal classes here—referred when they register for delivery at St Paul’s, or by HCP</td>
<td>- potential for partnership completely unknown&lt;br&gt;- may be difficult to implement changes to curriculum-hospital policy etc.</td>
</tr>
</tbody>
</table>
| **BC Women's Hospital** | - deliver CBE out of BC Women's hospital  
- many couples attend CBE here  
- serve Vancouver, and probably many high-risk cases  
- instructors are RNs, physiotherapists  
- classes may not cover any comm. skills (GAP?)  
- many women in area take prenatal classes here-referred when they register for delivery at St Paul's, or by HCP  
- may offer early pregnancy class  
- potential for partnership completely unknown  
- may be difficult to implement changes to curriculum-hospital policy etc. |
| **South Vancouver Community Birth Project** | - new maternity care project involving doctors, midwives, and doulas  
- prenatal class component is based on 'centering pregnancy' model-the women direct their own learning and share stories, while a RM or FP acts as a moderator  
- many clients with English as a second language, most mistreated clients of all- (good target)  
- many birthing women in S. Van, with little choice in maternity services  
- perhaps good potential for sustainability if women themselves can facilitate  
- not known if there is any potential for partnership |
| **Healthiest Babies Possible** | - program for at-risk pregnant women  
- high risk clientele-many disadvantaged women who may benefit most from learning new skills  
- not known what the structure is, or if there is potential for sustainability  
- no contact made yet |

**Downsides to all prenatal class partnerships**  
Only women taking CBE classes would benefit (estimated that only 30% of multiparas take CBE, probably higher in primiparas)  
There was consensus among respondents that delivering training in CBE classes would be too late for maximum benefit - women don’t take them until third trimester  

**Other suggestions** on forums for delivering training/dissemination (these forums do not suggest there would be much potential for sustainability as the facilitators are not evident, however, if we developed a format not requiring a facilitator, some of these suggestions are good)  
- Previous initiatives by CBEs and Health Region include putting together a package of info that gets handed out at first visit by doctors, so all women accessing prenatal care get one, even if they don’t take CBE classes-this may be an excellent distribution method—there is potential for inclusion of some written material in these information packages (and/or in HCP libraries)  
- BC Women's Meet the Doctor Night  
- Prenatal health fair, Welcome Wagon Baby Shower (free events)  
- Community centres, HCP libraries, health units  
- Pregnancy outreach programs, women's groups, pregnancy groups, vancouvermamas.com  
- Contact Dr. Gabor Mate: he spoke at a childbirth education event at DC and he is convinced that prenatal classes should not be about breathing and labour it should be about communication, with your partner, family, caregiver-he stressed that over and over again-he may have some good suggestions or feedback
### Appendix H Table 3: Common Challenging Decisions-Potential Video Scenarios

Table 3: Decisions women reported as being both common and challenging, as well as ideas regarding their suitability for use as a video scenario for use in a communication skills training workshop.

<table>
<thead>
<tr>
<th>Decision</th>
<th>Description</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
</table>
| Triple marker screen (maternal serum screening) | - blood test to **screen** for Down Syndrome, neural tube defects-done at lab  
- offered at 15-20 (best at 16-17) weeks to all women  
- if results are positive, women are offered amnio, detailed U/S, or chorionic villus sampling  
- accuracy is poor and depends on many factors such as gestational age and maternal age.  
- if <35y and screened positive, referral to medical genetics | - top challenging decision  
- often not offered as a choice  
- high rate of false positives-many women may not know this  
- results can be difficult to interpret  
- in this case it is important to discuss options in the event of a positive result | - I think the main reason this is so challenging is it comes down to peoples values about abortion/disabilities  
- in CBE classes, this decision has come and gone |
| Amnio-centesis                  | - usually done at 15 weeks  
- a choice for all pregnant women over age 35, or to those with a positive triple screen or family history of birth defects  
- **diagnostic** test for Down Syndrome, spina bifida  
- invasive  
- risk of miscarriage (1 in 200)  
- can find problems you might not expect | - serious decision to be made-important to know risks, what options would be if positive | - not a very common procedure  
- not relevant for women under 35 who don’t do TMS or who get negative result  
- decision in past |
| GBS testing                     | - vaginal/rectal swab offered at 35 weeks to test for presence of bacteria (natural colonist)  
- if present various protocols exist for what to do next-treatment prenatally (high rate of recolonization prior to labour), IV antibiotics during labour (potential negative consequences)  
- potential consequences of infection in newborn are extreme  
- 25% of women are GBS positive | - decision is in future  
- often not presented as a choice | |
| 18 week ultrasound | - routinely offered at 18 weeks  
- can find problems you might not expect | - many women don’t realize this is more than a look at the baby and are shocked when anomalies are found | ?very few women choose not to have this  
- decision in past |
|-------------------|---------------------------------|-------------------------------------------------|---------------------------------|
| Choosing a caregiver | - women suggested they wanted skills to make this process easier  
- possibly one of the most important decisions affecting communication | - hard to change caregiver at late stage in pregnancy  
- controversial skill to teach?  
- doesn’t fit with PACE model | |
| Pain control in labour | There is a wide range of options to be discussed  
- non pharmacological methods (massage, water)  
- sterile water injections, TENS  
- nitrous oxide, Demerol, epidural | - most women choose some form of analgesia  
- good one because these decisions have not yet been made when women are in CBE classes  
- various risks are often not discussed  
- important to discuss the risk and benefits prior to labour | - would fit well with PACE |
| Newborn procedures: Eye prophylaxis | Erythromycin put in newborn’s eyes shortly after birth  
- prevents infection leading to blindness/systemic symptoms  
- only a problem if mother has gonorrhea or chlamydia  
- required by BC law unless both parents sign an informed refusal form | - decision is in future | |
| Newborn procedures: Vitamin K | Vitamin K given by intramuscular injection or orally shortly after birth  
- prevents hemorrhagic disease of the newborn (HDN)  
- HDN is very serious, often fatal, however it is rare | | |
Appendix I: Feedback/suggestions from interviewees on training development

General:
- skills such as **what to do if you disagree with your HCP** should be taught
- questions to ask, skills for verbal and written communication (birth plans) tell women it's okay to ask questions and it's okay to say no
- teach skills on **how to choose HCP**
- there is a need because although books tell you to ask your HCP questions, this isn't realistic to expect women to be able to do that, due to the system/intimidation
- before they can ask the kind of questions they need to know, firstly they have to know that they have options and choices, they have to know what they are and then they have to know what's important to them
- one CBE mentioned in her training they looked at the International Childbirth Educators Association (ICEA) **Patients Bill of Rights**, this may be worth looking at when developing training
- see Penny Simpkin’s *Pregnancy, Childbirth and the Newborn* for sample **birth plans**
- another CBE explained that within BC Medical funding prenatal clients are able to schedule an extra appointment with their caregivers outside of their regular visits to discuss issues-she encourages her clients to make use of this extra time, and stated that most clients are not aware of this option-this may be a good piece of information to convey to participants and could help overcome the time barrier
- the theme of familiarity has come up several times, being familiar with hospital procedures, instruments, the medical system-can help women feel more comfortable-this kind of information could be shared in the training to empower women to ask questions and gain confidence
- teaching skills on how to assess the validity of different information sources might be helpful
- this group is unique in that although most pregnant women develop a relationship with the same caregiver prenatally, most often at the delivery they will be cared for by a stranger who has not been part of the negotiations leading up to this important event-this poses a point to consider while developing the framework-perhaps there are certain skills that can be taught for this unique situation.
- CBEs felt that the sharing of stories between new parents and pregnant couples is a real benefit, and the instructor can facilitate questions around the communication aspect, asking the new mom to describe how she communicated with her caregiver, did she feel listened to, etc.-may be an idea to include partners in the workshops
- encouraging clients to know what they want to get from each visit, so they leave satisfied that their questions are answered
- clients want more info/access to info on prenatal resources such as CBE classes, and education on what prenatal care looks like, options etc.
- skills learned are people skills that can be of use throughout life as a parent, partner, etc.

"The thing that I think is so crucial, it's not just prenatal, these are life skills and if you can get this kind of communication, this kind of networking, this kind of thought process going on ... for the rest of their lives. I've used my childbirth education skills more in my family and in my other life than I have in prenatal and that's what you want to get across. It's not just six weeks of classes and you're never gonna use the information. They are life skills that you can use whether it's prenatal or whether you have a stroke down the road, whatever it is. And you look at these old
people trying to communicate and make their wishes known, it's no different prenatally.”
CBE/Doula

- must be in groups-to empower each other through sharing stories/talking with groups of pregnant women helps with question asking skills

“[the training] needs to be presented in a way that’s respectful and they need to feel respected. And when they feel like that, they feel seen and cared for and that they’re not crazy or, cause often they’ll say “this may be a stupid question but,” in front of the class. So we fear we fear being judged. So we need an atmosphere where we aren’t gonna feel judged or if you want to get them to ask you can strategize and say, okay, you’ve got to ask it this way but if we’re gonna be sitting there feeling stupid and used, we’re not gonna ask. That’s a huge barrier. It’s the attitude of the caregiver. So if you do a training for people, it needs to be in groups. I think that’s a huge piece because then somebody will speak up louder than others and will ask a question that another didn’t think of and they will then see it being models about how to actually speak and they will agree with each other and be each other’s support group which provides confidence to help them when they’re in their individual scenario. I think that’s a very important piece.” CBE

Delivery:
- CBE classes are too late- women don’t come to CBE classes until the third trimester -there was consensus that early in pregnancy would be best
- many women don’t take CBE classes
- motivated people would come but not the people who really need to improve skills
- good to do in mainstream CBE classes because participants in those classes might be disadvantaged/less assertive/empowered/experience a loss of control, whereas women in alternative CBE classes are reported as already being assertive
- if in CBE classes partner could learn also
- there is a need for prenatal clients to learn communication skills-many stories were related about friends that are not involved in their care and they don’t know how to ask

“Don’t let people feel you’re stupid. There is no stupid question especially when it’s about your own care. I think that was the thing that frustrated me the most about women that I know is how readily they will go through their entire pregnancy and labour and delivery without ever asking or questioning anything and then coming out of it feeling unempowered and unhappy.” PPC

Video:
- keep it short
- as real as you can possibly get; real appointment, real doc, real pregnant woman-clients would relate better than to actors, no rehearsed lines-just throw them in and see reactions, comments, questions

PACE model:
- specific skills for communicating in labour would be good, perhaps with partner asking questions instead of the woman
- get the clients to do role-plays
- PACE is a good mnemonic, simplifies steps, but decisions in the prenatal period are complex and training would have to accommodate that
- PACE framework is good, it is important to present your philosophy to your HCP, many people have trouble checking their understanding
- PACE model may not be the most appropriate for this target group as it applies to those in a disease-state, whereas pregnant women are generally healthy
“And I think that’s the big thing to stress is that they’re not sick, they haven’t had a stroke, it’s not an illness. They’re very healthy women and they want to stay healthy.” CBE

- PACE is a good simple mnemonic to ensure question-asking, but if you’re anxious and doctor is God judging you, it’s hard to remember things

"Absolutely [the model would be effective]. Because I think everybody does it with the best of intentions, they’re listening and responding in such a, it’s a learned art. We’re not always great at it and we’re always learning and there are ways of responding that you may think are really helpful and really appropriate but if they’re dissected by a professional; or something it may not be as helpful as you think it is. And standing outside a little bit and watching that I think everybody would probably recognize the conversations, a portion of a conversation that they’ve had before and recognizing what’s good about it or realizing what maybe wasn’t good about it. I think that’s a great way of doing it.” CBE

Skills women find helpful for communication (incorporate these into training?)

"I knew that when I was gonna be a patient [give birth] that I’d probably be labelled as non-compliant … I think it’s important to be somewhat that way because otherwise you can just get passed along … in this day and age and in our health care system, you have to be your own advocate, you know.” CBE/L&D Nurse

- preparing questions/specific concerns (PACE)
- confidence to ask
- proactive/self-directed learning/reading ahead; being informed makes labour less frustrating for both patients and doctors
- check for understanding of the information your HCP provides (PACE)
- figure out where your particular needs fall
- advocate for self by asking questions/doing research/dialogue with caregiver
- educate yourself, research before your appointment to prepare for the visit, review all options, familiarize yourself with the choices so that if they do come up the decision is easier to make
- write your questions down
- know that your HCP can’t/shouldn’t make decisions for you
- find new HCP if they are not receptive to your needs, you need to feel confident in them

“Women have to learn that they’re allowed to be firm and kind of empathic about their care, that they are … the boss really. I mean you are in charge to a certain degree. I mean obviously there’s some medical situations where you have to surrender and give up to the expert but this person is being paid by you, your taxes that you pay in medical, to provide you with care and care is not just emergency care, it’s caring for you, you’re stressful sometimes. There’s a lot of things that scare people and a lot of unknowns, especially when you go into labour you need to be confident in that person so I think you have to really just sort of calmly and politely put your foot down and say no this is what I need from you.” PPC

Reservations about effectiveness:

- some women who felt they already had a strong relationship couldn’t foresee new skills making a further improvement, yet felt if they had a caregiver that they couldn’t communicate as well with, the skills would probably make them ‘more aggressive’
• learning skills would not help if the match between a woman and her HCP is not a good one: one woman already used PACE skills and practiced role-playing with her husband, yet when she went to her doctor with a list of questions they were dismissed again and again, she eventually changed HCPs
• other women agreed that skills wouldn’t help ‘if the doctor is a certain way’
• hard to teach skills effectively due to the inhibition around talking to medical personnel about very personal issues related to childbirth that are “totally taboo”
• one CBE stated that her clients wouldn't benefit because they are a unique group that have chosen their caregivers carefully and are generally happy with the communication.
• may be difficult to develop a workshop for this diverse group because there are so many variations in the way care is delivered to prenatal clients, whereas patients with certain illnesses are generally treated in a more systemic fashion
• clients that need the skills most are the least likely to attend
• more than one CBE feels it is inappropriate to place onus on client to learn skills, it should be more the responsibility of the HCP as they are the one with more power/intimidating

“If they feel confident and if they realize that their needs need to be met, their voice needs to be heard, their fears need to be listened to, that’s the best they can do but that’s only half the equation,” Communication is a two way street and both sides need to make the effort in order for the communication to succeed.” CBE

What is the reported effect of learning communication skills?

When asked if teaching communication skills was effective, CBEs said:

“I know it is. Because they come back and I've had 5000 of them tell me so after they've come back for the reunion classes or something over the years that they feel empowered and they feel not scared.” CBE

“I've certainly seen it work … at the end of a labour and delivery I'll have a doctor say … that client was really well informed … I've never had a patient ask a question about Epidurals like that before … So I really feel like I'm giving them those tools when it comes to labour and delivery.” CBE

“… they know the benefits and the risks and they have been informed, so they accept the responsibility of the decision they've made and then they process their birth better and they can't go, ‘Oh he just did that, without …’ and so you can't blame it on someone else, right? So this way by taking responsibility when you are informed of your choices, and you make decisions, then it's your responsibility for those decisions, the decisions that you made, and the outcomes as well.” CBE

A CBE/nurse commented on the difference between labouring women in the hospital who had taken a particular CBE series and those who had not:

“… myself and some of my colleagues saw a huge difference in women that came in that had taken her class and women that hadn't. [In terms of what?] Knowledge. And just like oh, okay, so this is what this is … Not that they had to understand everything about it, but just the familiarity and a confidence in the system too. Like there's a remarkable difference. And the anxiety level was just whewww [gesturing very low].” CBE/L&D nurse

Clients generally agreed with CBEs that the skills they had learned or would like to have learned would help improve their relationship with their caregiver.
"It might give me more confidence to ask and know what to … like you were saying, now that you've been here [focus group], maybe it starts to get you to think well maybe I should be asking more questions and … I'd feel like she [doctor] was more part of a team." PNC, third baby

"You know what, you've just given me so much to work with and even if I use one thing, I know that I've done something." CBE on a comment heard from participant

**Are Pregnant Women Making Informed Decisions?**

"I think in terms of choice, the only reason often that I know that things are a choice is because I've read …" PNC

"I think it's a combination of the midwife that she's so supportive and she listens and just knowing there's nothing wrong that I can ask. That kind of enables me to ask the questions and be comfortable with that and discuss things and make decisions." PNC
Appendix J: Personal Reflections of the Research Assistants

Aisia Salo

This project has taught me a lot, a lot about communication, and about myself. It felt great to become more familiar with the childbearing community, and hear so many stories from the women themselves. I enjoyed being given a task that I was not experienced in, and feeling myself becoming more and more confident. I also am grateful to have gained so much understanding about the topic we focused on; the barriers women face in system as it stands.

There was definitely a time crunch to pull together the analysis at the end. I think we got in a little over our heads with the scope and size of this project. Recruitment took a long time, and an ethics delay contributed to the speed and ease with which we could recruit participants. While researching CBE classes in Vancouver I realized the difficulty of actually getting this information. So many of the contact numbers and websites were out of date. It made me wonder whether clients also have a hard time accessing this information, and I think our data shows that some do. Early in the interviews we decided to interview postpartum clients as well as prenatal, to see if they had a different perspective, so we ended up with a total of about 30 interviews! This seems like a lot to analyze in such a short period of time. Another factor was that due to the depth of the subject (birth), each interview resulted in loads and loads of data. Which is great, but takes time to sort through.

A workshop with Ted Alexander on ATLAS.ti and data analysis was very informative and insightful and made me think very seriously about the interview questions as we had them, and how truly important they are to the whole outcome of this study! The questions needed to be modified and I guess I didn’t feel very familiar with them before, because I didn’t develop the draft, and just hadn’t done the interviews yet. I understand now that you really need to refer to research questions at all times when developing interview questions. I liked the idea of being more open with questions and letting clients say what is important, before launching into communication issues. However, this results in lots of data! After modifying the schedule I felt like I could see the questions clearly for the first time, and what I need to ask to get the right answers. This made me less nervous. Also realizing that I should not necessarily stick to the questions/wording of the draft but rather say things in my words as I would in any normal conversation was helpful. I soon became much more familiar with the questions, and the modified ones worked way better. I found at first I was so nervous that I had a hard time actually listening to the responses and delving further, but then I began taking notes on things to clarify/delve further etc. (Duh!). At first I was pretty nervous about conducting interviews, but after a couple I found I really enjoyed it. I transcribed a couple of interviews myself, which I actually enjoyed. It was nice to experience all parts of the work that goes into a research project.

We did manage to get three prenatal clients together to do a focus group, which I also really enjoyed, and was glad to have the experience of being a co-moderator. What transpired in the focus group made me happy that we are doing this project, to see with my eyes and hear with my own ears a pregnant woman shift her thinking one step towards being more involved in her own care. She was early in pregnancy and at first said that she doesn’t ask much of her doctor, and doesn’t care that they don’t have much of a relationship. After hearing the thoughts of some of the other participants, she stated that ‘oh yeah, maybe I should be asking more questions, maybe I will.’ That was a heartening experience for me.
Data analysis proved to be challenging at first, and time-consuming, and we changed tracks a couple of times before we found a method that we liked. The first day of coding we spent two hours and got through just seven pages of transcript! It was painstaking and overwhelming and confusing - hard to know where to start; are we looking to see which research question each segment answers? Are we looking at each segment on its own and figuring out the theme? This is what we tried and it was hard because there were several themes at once in each piece, and where does one continue and one end? Every piece must be coded. Next time I would probably try to group more themes together so that there are not so many codes. Navigating the ATLAS.ti program was also a challenge, as there is no one here that knows how to use it, and I am somewhat of a technophobe. We ended up with a lot of overlap in our coding, as many quotes illustrated many themes at once. A strategy to overcome this would be helpful, although I don’t know what it is! At the end, when powering through to complete the analysis and report, another hold up was the transcription, we had portions of transcripts trickling in until the very end. Cathy, Sam, and Carolyn all generously pitched in to help us complete the project on time. However, our analysis and write-up is not as thorough and professional as we would like it to be. I hope as a Work-study student I can continue with this project, and possible submit it for publication. It was hard to let go and just get done what we could in the time given, when we have worked so hard on this thing, and not be able to go into the depth that we wanted to. I also think we went beyond what the research objectives were in our interviews, and given the time constraints, this was not a wise idea. It just seems like communication and pregnancy are such complex topics that it is hard to set limits in that sense.

I struggled with the limitations of our study, mainly that the people who self-selected to be interviewed most likely have decent communication skills. I realize, however, that we can still learn from them how communication can work, and many barriers were identified nonetheless. Another example is that the only childbirth education classes that we learned about were independent of the hospital, and from second hand reports it sounds as though there is a great difference in the philosophy and content of these classes. In sum, I am happy to say I have experience participating in pretty much an entire research project, and a big one at that. I feel I have at least a grounding in what research is all about, and feel certain that I will take part in more projects in the future. I gained confidence and skills, and was glad for the opportunity to be responsible for a project with virtually no experience to my name.
Lucinda McQuarrie

From the very beginning of the summer I was excited to participate in this kind of work. I looked forward to:

- being involved in research that would have a direct impact on improving the quality of health care.
- Listening to the experiences of prenatal clients and the struggles or successes that they have had in dealing with the health care system. I anticipated that this would be beneficial in my relationship with prenatal clients and other patients by providing me with a sense awareness of their perspective.
- learning more about provision of obstetrical care to help evaluate if that was a field that I am interested in pursuing

Looking back, I am glad to say that this summer project has been beneficial for each of those reasons.

- I do feel that there is value to the study and that my work this summer will have a benefit. It is satisfying because I can imagine the benefit is not limited to the understanding of communication between prenatal clients and their health care providers. I hope this may be a piece in the puzzle of providing clients the skills to use in health care communication. I imagine the benefits of this will have not only in the lives of prenatal clients but on our society and health care system.
- From the very beginning, as I read through previous studies and then began to look at interview transcripts I found that my mind was constantly gathering information to be used in my contacts with health care clients. Such thoughts as, 'I have to be careful not to …' or 'I will …' were nearly constant in my mind. I know that I would have a tendency to be paternalistic with patients, but now I have had opportunity to think about what I can do to guard against such tendencies and how to make the patient feel valued. I often felt that this type of an experience would be beneficial for all medical students. I also wished that all medical students could become more aware of the patient; I suppose that is why the DHCC and its initiatives like the conference on bringing the patients voice into healthcare education exists. Thank-you.
- I do have a much better picture on the pros and cons of being a health care provider of obstetrical care, both as an OB and an FP. Although I know that I will continue to evaluate this, I have gained a basis for evaluating where I would be most fulfilled as a HCP.

In addition to these factors I have gained:

- Respect for qualitative research. It is something I which I have never really been exposed; I may even say something that I had little respect for in revealing what is “truth.” Although I still do struggle with this concept, I now know that when reading literature the impact that such studies will have on my knowledge and opinion will be heightened, and I will be better prepared to evaluate the findings presented by qualitative research.
- Insight into myself:
  - strengths and weaknesses working as a team member
  - willingness to be involved in research throughout my career
  - awareness that my understanding of things is limited to my experience. For example, I have gained a respect for midwifery care that was unexpected. This will help me to keep a more open mind.
**Abbreviations used in this document**

ATLAS.ti – Computer software for text analysis
CBE – Child birth educator
D – Doula
DC – Douglas College
DHCC – Division of Health Care Communications, College of Health Disciplines, UBC
FP – Family physician
HCP – Health care provider
ICEA – International childbirth educators association
ISDM – informed shared decision making
OB – Obstetrician
PACE – acronym for elements of framework for good communication with health care provider
(presenting information, asking questions, checking understanding, expressing concerns)
PNC – Prenatal client
PPC – Postpartum client
RM – Registered midwife
SP – Standardized (or simulated) patient
UBC – University of British Columbia