# University of Alberta

Understanding Woman's Involvement in Choosing or not Choosing Epidural Analgesia during Their Labour

by

Céline Yvonne O'Brien 

A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of

Master of Nursing

Faculty of Nursing

Edmonton, Alberta
Spring, 2007

*Your file Votre référence*
*ISBN: 978-0-494-29917-3*
*Our file Notre référence*
*ISBN: 978-0-494-29917-3*

Abstract

*Background*:

The use of epidural analgesia to manage labour pain in women is quickly becoming a normalized, routine practice. There is a need to ensure that women are given a genuine and informed choice regarding epidural analgesia and not the illusion of choice.

*Purpose*:

There is little documentation about the way in which epidurals are offered to women. This is why the following question, "what degree of understanding do woman have regarding their involvement in choosing or not choosing epidural analgesia use during their labour?" was examined.

*Design/Sample*:

The study used an exploratory descriptive inductive qualitative approach. A purposive sampling approach was implemented to recruit 17 mothers and 2 fathers from *New Mom's Network* groups within the Capital Health region.

*Data Collection/Analysis*:

Data was collected through in-depth semi-structured interviews. The transcripts were analyzed for their content.

*Findings:*

Five key concepts; a) choice; b) support; c) social perspectives; d) locus of control and, e) knowledge were identified in the data analysis of this qualitative research study as being significant to understanding women's choices regarding pain management options.

Acknowledgement

To my daughter Arielle, who lights up my life and inspires me daily.

To Tim, my husband, friend, and partner, I extend my deep appreciation for your encouragement, patience and love.

To my parents Dennis and Rolande, your love and support has given me the strength to achieve my goals. Thank you for being wonderful parents and grandparents.

I owe much to my wonderful family and friends who provided encouragement and saw the humor in this adventure.

I would like to thank my advisor, Dr. Beverley O'Brien for sharing her knowledge and experience and for her constant guidance, direction and patience from beginning to completion of this research study. I would also like to thank members of my thesis committee Dr. Solina Richter and Dr. Jennifer Welchman for their time, dedication and ongoing feedback.

I would like to acknowledge the women and their partners who participated in this study. I will always be grateful for their stories and willingness to share.

Table of Contents

List of Tables

List of Figures

# Chapter 1

## Introduction

### Background/Significance

"Epidural analgesia is a central nerve block technique achieved by injection of a local anaesthetic close to the nerves that transmit pain and is widely used as a form of pain relief in labour" (Anim-Somuah, Smyth & Howell, 2005, p.1). The use of epidural analgesia to manage labour pain in women is quickly becoming normalized, routine practice. Over half of women (almost two thirds) delivering babies in North America receive epidural analgesia for pain relief during labour (Howell, 2004; Leeman, Fontaine, King, Klein & Ratcliff, 2003; Lieberman, 2004; McCool, Packman & Zwerling, 2004; Lieberman & O'donoghue, 2002). Consequently, health care practitioners working with labouring women must have the knowledge and ability to provide clients with information to make informed choices about this procedure. Women in labour must be accurately informed so that they can choose pain management strategies that are right for them. Once a technology becomes routine, its very familiarity can undermine a woman's realistic chance of refusing its use (Sherwin, 2004). Women may feel epidural analgesia is the only 'real' choice they have to manage labour pain (Beech, 2003; Goldberg, 2003; Sherwin, 2004). It is vital that health care practitioners assist women to increase their personal control during labour and delivery because personal control more strongly influences maternal satisfaction then does pain control (Goodman, Mackey & Tavakoli, 2004). Epidural analgesia to manage labour pain is so commonly used and so generally valued that refusal may result in women being judged as irrational, irresponsible or misinformed (Hodnett, 2002; Sherwin, 2004). There is a need to ensure that women are

given a genuine and informed choice regarding epidural analgesia and not the illusion of choice (Beech, 2003).

## Purpose/Research Question

Little documentation was found about the way in which epidurals are offered to women, whether informed consent is truly being obtained and what perceptions women in labour have about the use of epidurals. The purpose of this study was to pursue the following research question, "what degree of understanding do women have regarding their involvement in choosing or not choosing epidural analgesia use during their labour?"

# Chapter 2

## Review of the Literature

The focus of the literature review is on four main themes pertaining to the use of epidural analgesia. They are: a) management of labour pain; b) role of the labour nurse; c) satisfaction with the experience of childbirth and d) decision making regarding epidurals/informed consent. Articles retrieved from MEDLINE, CINAHL, PUB-MED and COCHRANE databases were reviewed to determine what is known about epidural analgesia and to identify knowledge gaps with respect to its use. Few articles were found concerning womens' perceptions of choice and the practice of obtaining informed consent for epidural labour analgesia.

### *Management of Labour Pain*

Epidural analgesia is a highly effective and prevalent method of providing pain management for labouring women in high income countries. Epidural analgesia is used by more than half (almost two thirds) of labouring women (Howell, 2004; Leeman, Fontaine, King, Klein & Ratcliff, 2003; Lieberman, 2004; McCool, Packman & Zwerling, 2004; Lieberman & O'donoghue, 2002), yet there is little consensus about what unintended effects it causes. Although epidural analgesia provides effective labour analgesia for most women, its use has potential side effects, which can lead to numerous other costly technologic interventions (Marmor & Krol, 2002; Torvaldsen, Roberts & Raynes-Greenow, 2005). Epidural analgesia is rarely a single intervention. The procedure typically accompanies an array of subsequent procedures/interventions each of which has potential negative side effects. Epidural analgesia has been associated with some adverse obstetric consequences including, higher rates of instrumental vaginal delivery (Anim-

Somuah, Smyth & Howell, 2005; Durham, 2003; Howell, 2004; Leeman et al., 2003; Leighton & Halpern, 2002; Lieberman, 2004; Lieberman & O'donoghue, 2002; Littleford, 2004; Mansoori, Adams & Cheater, 2000; Torvaldsen, Roberts, Bell & Raynes-Greenow, 2005), greater incidence of 3rd and 4th degree perineal lacerations (Leeman et al., 2003; Lieberman & O'donoghue, 2002), longer second stage of labour leading to intervention for failure to progress (Gaiser, 2005; Howell, 2004; Leeman et al., 2003; Leighton & Halpern, 2002; Lieberman & O'donoghue, 2002; Littleford, 2004; Mansoori, Adams & Cheater, 2000; Mayberry & Clemmens, 2002; Reilly & Oppenheimer, 2005), increased use of oxytocin augmentation (Howell, 2004; Leighton & Halpern, 2002; Littleford, 2004; Mansoori, Adams & Cheater, 2000; Mayberry & Clemmens, 2002), decreased rate of spontaneous vaginal delivery (Lieberman & O'donoghue, 2002), increased incidence of hypotension (Leeman et al., 2003; Leighton & Halpern, 2002; Mayberry & Clemmens, 2002), decreased ambulation, increased use of catheterization (Leeman et al., 2003), increasing incidence of pubic symphysis separation (Ruhl, et al., 2006), urinary retention (Carley et al., 2002; Ching-Chung et al., 2002; Leighton & Halpern, 2002), increased incidence of fetal mal-presentation (Durham, 2003; Howell, 2004; Le Ray et al., 2005; Lieberman, 2004; Lieberman, Davidson, Lee-Parritz & Shearer, 2005), increased incidence of intrapartum fever (Alexander, 2005; Durham, 2003; Leeman et al., 2003; Leighton & Halpern, 2002; Lierberman, 2004; Lieberman & O'donoghue, 2002; Littleford, 2004; Nystedt, Edvardsson & Willman, 2004; Reilly & Oppenheimer, 2005), increased neonatal sepsis care plans and antibiotic treatment (Leeman et al., 2003; Lieberman & O'donoghue, 2002; Reilly & Oppenheimer, 2005), meconium in the amniotic fluid (Reilly & Oppenheimer, 2005), decreased infant

sucking ability (Chang & Heaman, 2005; Nystedt, Edvardsson & Willman, 2004; Riordan et al., 2000), and hyperbilirubinemia (Durham, 2003; Lieberman & O'donoghue, 2002). The effect of epidural analgesia on rates of cesarean delivery is controversial (Leeman et al., 2003). There is inadequate data to support a direct relationship between epidural analgesia and the rate of cesarean deliveries however, vacuum and forceps extraction, fetal mal-presentation and augmentation using oxytocin increases the incidence (Lieberman, 2004; Littleford, 2004; Howell, 2004). There is also conflicting data regarding whether epidural analgesia impairs short and long-term breastfeeding success (Nystedt et al., 2004). Women with more obstetric interventions during labour are less likely to breastfeed. However, no direct relationship between epidural analgesia in relation to breastfeeding initiation and duration was found (Chang & Heaman, 2005; 2004; Riordan et al., 2000).

In spite of numerous studies, the risks and benefits of epidural analgesia remain contradictory (Leighton & Halpern, 2002). Despite the very widespread use of epidural analgesia, what is known about its unintended effects remains inconclusive (Lieberman, 2004). While epidural analgesia is an effective method of pain relief for most women in labour who choose it, it is not without possible effects on the progress of labour and delivery (Mansoori et al., 2000).

Randomized controlled trials (RCT) without crossover to compare the outcomes between women who had epidurals and women who did not have epidurals in labour were not found and are not likely to be found since, from an ethical perspective, random assignment of labouring women to epidural versus no epidural groups cannot be justified. Because labour is unpredictable, and because women in labour have the right to make

choices, women are not likely to actually receive the treatment of the group in which they were assigned (Durham, 2003). Therefore, in order to fully explore this topic, quasi-experimental designs taking into account associated threats to validity (attrition, bias, Hawthorne effect, history, instrumentation, maturation, regression to the mean and testing) are needed. A review of studies where unintended effects of epidural analgesia were documented during labour are described and presented in Table 1 (See Appendix A).

*Supportive Care*

"Widespread use of fetal monitors and other medical interventions for normal childbirth during the end of the 20th century changed the focus of intrapartum nursing to the technological rather than the supportive aspects of childbirth" (Sauls, 2002, p. 733). Despite studies showing that continuous labour support results in decreased need for medical interventions, improved maternal and newborn outcomes, and increased maternal satisfaction, few women have access to alternative labour support options (Hodnett, 2002; Hottenstein, 2005; Kanna, Kamison & Datta, 2001). It has been reported that intra-partum nurses spend 6.1 percent to 31.5 percent of their time providing hands-on direct labour support (Miltner, 2002). In a systematic review by Hodnett (2002), continuous labour support was reported to reduce the need for pain medication during labour, operative vaginal delivery, and caesarean delivery; it also resulted in more favorable maternal views of the childbirth experience (Hodnett, Gates, Hofmeyr & Sakala, 2003). "Historically, women have been attended and supported by other women during labour. However, in recent decades, in hospitals worldwide, continuous support during labour has become the exception rather than the routine" (Hodnett et al., 2003, p.1). Labour and

delivery units are beginning to operate with fewer nurses, because of the expectation that all women will use epidural analgesia during labour (Hodnett et al., 2002; Simpson, 2003). Increased technology and epidural analgesia may have contributed to the perception that a one-to-one nurse-to-patient ratio is no longer required during labour (Hottenstein, 2005; Simpson, 2003). According to the Society of Obstetricians and Gynaecologists of Canada (SOGC), women in active labour should receive continuous, close support. One-to-one nursing is recommended (Hodnett et al., 2002; Liston & Crane, 2002), however an intra-partum nurse is likely to be caring for at least two women in active labour for varying reasons such as the nursing shortage. Traditional labour support options must be available, but intra-partum nurses are monitoring women who have epidural analgesia using automatic blood pressure devices, continuous pulse oxymetry, continuous fetal monitoring, and electrocardiograms instead of being there to support patients personally during labour (Hottenstein, 2005; Simpson, 2003). If there is a technical and procedural focus, continuous supportive interventions that may better serve the needs of labouring women may be ignored (Hottenstein, 2005; James, Simpson & Knox, 2003; McCrea, 1999). "Technological, surveillance and administrative aspects of nurses' jobs leave little time for supportive care. This is unlikely to change because intra-partum nurses do not hold their supportive role in as high a regard as their technical role" (Sauls, 2002, p.739).

Patience, encouragement and support by labour nurses were identified as key attributes of letting a woman's body be the guide (James et al., 2003). It is essential for labour nurses to understand the labour process, appear calm and confident, and use a high degree of interpersonal skills when providing nursing care (Corbett & Callister, 2000).

The value of emotional support as a therapeutic nursing intervention needs to be emphasized to those who care for women during labour (Corbett & Callister, 2000). Non-pharmacologic pain relief interventions include continuous labour support, hydrotherapy, maternal movement (positioning, walking and rocking), relaxation techniques, and imagery, music, touch and massage. Such interventions are believed to reduce the need for pain medication during labour and have no associated risks. In the typical hospital environment, women rarely have access to the wide variety of comfort measures and the continuous emotional and physical support needed to give birth with limited interventions (McCrea, 1999; Simkin & O'Hara, 2002). Emphasis should be on the value of a woman's own coping resources and not availability of pharmacologic pain management (McCrea, 1999). Supportive care is of equal or greater value than technical care. "Professional knowledge and power need to be supportive, not directive of birthing processes" (Corbett & Callister, 2000, p.81). Nurses must be advocates for childbearing women. The focus should remain on quality care with the least risk and best outcomes possible for mother and baby (Corbett & Callister, 2000). A summary of research conducted to assess support during labour is presented in Table 2 (See Appendix B).

*Satisfaction with the Experience of Childbirth*

Medical practitioners frequently assume that optimum pain relief during labour and delivery is significant for labouring women (Hodnett, 2002). It has also been shown that pain and pain relief do not play a major role in patient satisfaction with childbirth (Hodnett, 2002; Kanna et al., 2001; Leeman et al., 2003; McCool et al., 2004). According to Kanna and associates (2001), women who initially planned for non-pharmacologic childbirth and who received an epidural were less satisfied with their labour and delivery

experience despite evidence of significant pain relief. Pain endured is just one aspect of the childbirth experience that contributes to satisfaction (Florence & Palmer, 2003; Marmor & Krol, 2003). Factors associated with increased maternal satisfaction include the a) amount of support women receive from health care practitioners; b) quality of the relationship between the health care practitioner and the woman; c) amount of maternal participation in decision making during labour and delivery and d) women's personal expectations (Hodnett, 2002; Leeman et al., 2003; Marmor & Krol, 2002). These factors are so essential that they override the influence of age, socioeconomic status, ethnicity, childbirth preparation, pain control and the use of medical interventions when women evaluate their satisfaction with childbirth (Hodnett, 2002). It is critical for health care practitioners to focus on factors associated with increased maternal satisfaction because a mother's positive perception of her birth experience is linked to infant attachment, and her transition to the mothering role (Goldberg, 2003). It is important to acknowledge that attitudes and behaviours of health care practitioners are powerful influences on the choices women make regarding pain management in labour (Hodnett, 2002). It is vital that health care practitioners assist women to increase their personal control during labour and delivery because personal control more strongly influences maternal satisfaction then does pain control (Goodman, Mackey & Tavakoli, 2004). A summary of research conducted to assess satisfaction with the experience of childbirth is presented in Table 3 (See Appendix C).

*Decision Making regarding Epidurals*

Few studies were found concerning the practice of obtaining informed consent for labour analgesia. Information provided to women prior to inserting the labour epidural is

inconsistent (Bethune et al., 2004; Saunders, Stein & Dilger, 2006). Obtaining informed consent in active labour is problematic as clients are dealing with the physical and psychological stresses of labour and pain management during the information exchange (Saunders et al., 2006). Because of the timing and clinical circumstances of labour, the consent process for epidurals is frequently carried out in a superficial or abbreviated manner (Mann & Albers, 1997). Women in labour are in a vulnerable state when taking in information and exercising informed consent. The primary concern of labouring women is that of safety for themselves and their babies. The topic of epidural analgesia and informed consent presents a multitude of challenges. Accurate information is vital for childbearing women and their partners to make well-informed decisions about pain control during labour (Nystedt et al., 2004). In order to give informed consent, women need to be made aware of the benefits and the possible side effects or risks of receiving either an epidural analgesia or an alternative treatment for labour analgesia including expected labour results with or without the use of epidural analgesia (Saunders et al., 2006). Subsequently, women become influential, well informed consumers with the ability to make genuine choices about how they wish to manage pain, balancing the effectiveness of pain relief against the possible side effects to maternal/infant health and effect on the progress of labour (Jackson, Henry, Avery, VanDenKerkhof & Milne, 2000; Mansoori et al., 2003).

Individual clients are asked to give informed consent for the use of epidural analgesia for pain management in labour. However, there is controversy about the optimal timing of obtaining consent in order to make informed choices. Perhaps, discussions of risks and benefits should be addressed during prenatal care (Bethune et al.,

2004; Saunders et al., 2006; Leeman et al., 2003; Mann & Albers, 1997). There is some indication that the choice for epidural use by nulliparous women during labour is often planned during the prenatal period, leading to earlier administration (Goldberg, Cohen & Lieberman, 1999). There is some discrepancy in opinions about whether women in active labour are able to give true informed consent. According to Jackson and associates (2004), the ability to understand risk is not affected by labour pain, but according to others, few women are truly in a position to weigh relevant risks and benefits in the midst of active labour, and therefore are not in a situation to execute autonomous choice at that time (Leeman et al., 2003; Lowe, 2004 & Saunders et al., 2006).

A power differential exists between the health care practitioner and the labouring woman (Goldberg, 2003). Checks and balances must be put into place to ensure that that power is not abused. Heath care practitioners' role is to involve parents in the decision making process while not becoming the decision maker. It is essential that labour nurses work collaboratively with labouring women in order to create an environment where both voices are recognized and understood (Goldberg, 2003). Women in labour should have autonomy over their own and their baby's health status (Goldberg, 2003). It must be recognized that decisions are made based on the expert knowledge, advice and recommendations provided by the health care practitioner. It is critical that health care practitioners strengthen women so that they are aware of their power to make 'real' informed choices. When women in labour are given the range of choices that are available, respect for autonomy is maintained (Breech, 2003; Goldberg, 2003; Saunders et al., 2006).

It is recommended that practitioners explore strategies to make a commitment to facilitation, not exploitation (Goldberg, 2003). Health care practitioners are advocates for patients and have a duty to ensure that manipulation of knowledge, such as omitting or overemphasizing certain information does not occur (Lowe, 2004). It is important to be aware that those who financially stand to benefit the most from epidurals are anesthesiologists. It is to their advantage to provide epidurals to women in labour, thus it is important to ensure that their power is not abused (Marmor & Krol, 2002). Increasing technologic procedures during the birth process can inhibit rational choice and encourage higher levels of intervention (Beech, 2003; Leeman et al., 2003). Health care practitioners should not be in a position to 'recommend' epidurals, but should be able to present childbearing women with the pros and cons available. Providing accurate and unbiased evidence based information regarding the risks and benefits of all pain management options for women in labour will promote informed decision-making and enhance the satisfaction of the labouring experience (Florence & Palmer, 2003; Goldberg et al., 1999). Health care practitioners should then support women in their choices on the basis of their own unique understanding of the information and knowledge garnered (Nystedt et al., 2004). "Ultimately, the nurse's role is to support labouring women to make informed choices that achieve a personal vision of birth, while ensuring the safety of both mother and infant" (Florence & Palmer, 2003, p.238). Women who choose or refuse epidurals after receiving all the available information in relation to potential risks/benefits should be fully supported in their choice (Stafford, 2002).

Is pain control more about professional control or a genuine attempt at supporting women? Health care practitioners who work with labouring women where epidural use is

common may have lost the clinical skills necessary to support women in coping with labour pain and may exert subtle pressure in favor of epidurals as a way to ease their own discomfort (Hottenstein, 2005; Mann & Albers, 1997). Is it possible that epidurals are 'recommended' to women with the rationale that it is for their benefit and that of their baby when it is really for the convenience of health care practitioners (Stafford, 2002)? It must be remembered that:

> nursing practice invites nurses to embody caring practices that meet, comfort, empower, and advocate for vulnerable others. Such a practice requires a commitment to meeting and helping the other in ways that liberate and strengthen, not in ways that impose the will of the caregiver on the patient (Benner, 2000. p.11).

A summary of research conducted to assess decision making regarding epidurals especially in regard to informed consent is presented in Table 2 (See Appendix D).

## Conceptual Framework

Allen's McGill Model of Nursing was used as the broad conceptual framework to guide this study. This model emphasizes the value of consumer choice and reinforces client/family ownership for actions and decisions. The nurse promotes strengths while managing risks. The nurse and client set goals together and work collaboratively toward building on the strengths, potential, resources and decision making abilities of the client/family. Nurses help clients/families attain their own goals, not the goals nurses feel they should have. The skill of the nurse can greatly impact the nurse-client interaction/relationship, determining the extent to which the client is assisted in developing self-management skills. The most skilled nurse will foster autonomy in ways that open and invite, rather than direct and impede (Goldberg, 2003). In this framework, health is related to potential strengths and aspirations and not to inadequacies and

limitations. The concept of health is viewed as a dynamic, multidimensional, evolving process and includes the sub-concepts of coping and development (Gottlieb & Rowat, 1987). Coping is seen as a function of successful problem solving. Development is a broader concept directed toward the achievement of life goals (Gottlieb & Rowat, 1987). According to this model, the strength of the health care system is not solely reflected in the expansion and consumption of technology and resources, but rather, in the development and strengthening of human resources by focusing on health promotion activities (Allen & Hall, 1988). Allen's McGill Model of Nursing supports the view of Goodman and associates (2004) that personal control is a strong indicator of maternal satisfaction.

*Summary*

It is unclear in the literature whether the high use of epidural analgesia is a true preference among women in North America or if it is 'chosen' because no other alternatives are presented. Could it be that women are being invited to consent to a procedure that is part of the new social norm (Leeman et al., 2003; Marmor & Krol, 2002; Sherwin, 1998)? There is little documentation about the way in which epidurals are offered to women, how informed consent is truly being obtained and what perceptions women in labor have around the use of epidurals. This lack of information underlies the need to pursue the following research question. What degree of understanding do woman have regarding their involvement in choosing or not choosing epidural analgesia use during their labour?

# Chapter 3

## Design and Methodology

### *Study Design*

In order to best answer/explore the Level I question, *What degree of understanding do woman have regarding their involvement in choosing or not choosing epidural analgesia use during their labour?*", an exploratory descriptive inductive qualitative approach was used. This was the design of choice because little is known about the degree of understanding available to women regarding their involvement in choosing or not choosing epidural analgesia during their labour. This approach is ideal for gaining insights, familiarity and a richer understanding of the phenomenon of interest (Burns & Grove, 2005; Polit, 2004; Talbot, 1995). Increased knowledge and understanding emerged using an exploratory descriptive approach. The analysis facilitated investigators in developing concepts and theories relevant to informed consumer consent (Burns & Grove, 2005; Polit, 2004; Talbot, 1995). The goal was to gain insight about how women perceive their ability to make informed choices about whether or not to receive epidural analgesia during normal term labour.

### *Sample*

A purposive sampling approach was implemented to recruit mothers. The *New Mom's Network* groups within the Capital Health region assisted with recruitment. These groups target first-time mothers with infants who are 2 weeks to 6 months of age. The *New Mom's Network* offers 8 weekly group sessions. The sessions provide an opportunity for women to connect with other new moms, discuss health issues related to early parenting and to learn about healthy growth and development. According to Burns

& Grove (2005) the above sampling approach is useful for exploratory descriptive studies. This type of sampling can be used to recruit participants who are easily accessible and available at the time of data collection (Brink & Wood, 2006). This type of sampling also involves a judgment by the researcher regarding the type of participants needed to provide the most useful information about the phenomenon being studied (Polit, 2004).

The emphasis was not on sample size but rather on the depth of knowledge obtained from the informants. The purpose of this form of inquiry is to maximize information. It is important to note however, that with this type of sampling, the researcher does not know how many informants will be required to reach saturation of the categories a *priori* (Talbot, 1995). Following the methods of purposive sampling, additional informants were available but were not required as the data analysis progressed (Morse & Field, 1995). Sampling in this study was a continuous process until data saturation occurred, where themes and categories became repetitious and redundant.

*Inclusion/exclusion Criteria*

Volunteers were selected by the researcher based on their willingness to participate and to share their experiences. The purpose was to seek out informants who a) were new mothers with a variety of demographic characteristics; b) had given birth between 35 and 42 weeks gestation and c) had spontaneous vaginal deliveries with or without epidural analgesia.

Informants were excluded from the study if they a) delivered before 35 weeks gestation, b) had elective caesarean sections, and c) did not speak English well enough to consent to participate. To describe the sample, demographic data was obtained from each

informant. This information consisted of the informant's age, level of education, marital status and setting in which they delivered their baby (See Appendix E).

*Sample Description*

Personal, face-to-face interviews were conducted with 17 women and two men, all in their homes, for a total of 17 interviews. In the interviews where the womens' partners participated, they validated the womens' answers and occasionally filled in information and sequencing of events gaps. The interviews occurred in the Edmonton and area region. Participants ranged in age from 26 to 34 years, with an average age of 30.4 years. Ages of their children ranged from 6 to 32 weeks, with an average age of 14.2 weeks. Fifteen participants delivered in a hospital setting and, 2 in a birthing centre. All but three participants received epidural analgesia for pain management during labour. All were in committed relationships either being married or living common law. Sixteen participants had post secondary education and, 1 had a post graduate degree. All but one participant appeared to be in a good frame of mind emotionally. During one interview a woman became emotionally distressed and consented to allow the researcher to facilitate appropriate referrals.

*Setting*

Interviews were conducted in the informants' home. As mothers had young infants and needed to feed their babies during the interview, their home environment was the most suitable setting to conduct the individual interviews. Feeding on demand was supported. As a mother with a young child, I was cognizant that interviews may have needed to be interrupted or re-scheduled based on the challenges that occur with being a

new mom. On several occasions, interviews were interrupted, but none needed to be re-scheduled.

*Safe Visit Plan*

Measures to include the safety of the principal investigator while conducting interviews in the home included a) calling ahead to confirm the address and to ask volunteers to have pets contained, b) having a check-in procedure in place with a family member prior to and after the home interview, c) having access to a cell phone in the event that assistance was required, d) sitting closest to the nearest exit and wearing a pair of indoor shoes in the event that a quick escape was required, and e) not entering a setting that felt threatening or unsafe (Alberta Human Resources and Employment, 2000).

*Recruitment strategies*

The researcher gained access to the population through *New Mom's Network* groups in the Capital Health region. A support letter from *Capital Health: Community Health Services-Primary Care Division* was received. *New Mom's Network* facilitators were contacted by phone by the researcher to set up a time to discuss the purpose and protocol of the research study, inclusion/exclusion criteria and the timeline/commitment with the group participants with permission from the health centre's operations manager. Information letters, recruitment flyers, and a sign up sheet were left with the *New Mom's Network* facilitator (See Appendix F & G). The sign up sheet was picked-up at the end of the session. The participants were contacted by phone within one week of signing up to see if they still wished to participate in the study. During the initial phone contact, the researcher reviewed the study and its implications, answered questions, addressed concerns and set up a mutually agreed-upon time to conduct the interview.

*Consent*

At the beginning of each in-depth interview, an explanation of the study was given, the information letter was reviewed and written consent to participate was obtained (See Appendix H). The participants were informed that a) they were not required to participate in the study; b) they could withdraw from the study at any time; c) they may stop the interview at any time and d) they could refuse to answer any question. Procedures for storing data and protecting their privacy were also explained.

## Data Collection

*In-Depth Semi-Structured Interviews*

Informants were asked to participate in one individual interview lasting from 20-90 minutes. Interviews were tape-recorded and transcribed verbatim. Informants were given time to think about and reflect upon their experiences before self-disclosing and were assured that anything they had to say was valued and respected. Data was analyzed concurrently. When new questions were discovered, they were included in the remaining interviews. Participants agreed to be contacted a second time for a follow-up telephone interview in the event that something they said needed to be clarified. Follow-up phone calls were not required; all of the data was collected during the first interview.

An initial semi-structured interview guide with general open-ended questions and more specific question stems that served as prompts was used. The guide was modified slightly as needed, based on the concurrent analysis of the data (See Appendix I). This type of interview is used when the researcher knows which questions to ask but cannot predict the answers (Morse & Field, 1995).

Open-ended questions were asked from general to specific, and from non-threatening to more threatening (McLafferty, 2004). However, these questions were only a guide, and the researcher asked other questions or used comments as necessary to stimulate discussion (McLafferty, 2004). Open-ended questions provided participants with an opportunity to explain/tell their own story in their own way (Morse & Field, 1995). This type of questioning embodies a more naturalistic enquiry, which is one of the hallmarks of an exploratory descriptive qualitative approach. As stories provide the rich descriptive context that makes qualitative research invaluable, the researcher encouraged participants to tell stories that described incidents and asked for examples and stories (Morse & Field, 1995).

## Data Analysis

All data collected during the individual interviews were tape-recorded and transcribed verbatim as soon as possible after the data are collected. According to Morse & Field (1995), the first task in analyzing interview data is to become familiar with the data. As soon as data collection began, preparation for data analysis was initiated (Morse & Field, 1995). In order to objectively record what was happening in the interview setting and to capture the impressions the researcher had, and non-verbal communication observed, fieldnotes were recorded in a loose-leaf notebook to supplement taped interviews. "Field notes are a written account of the things that the researcher hears, sees, experiences, and thinks in the course of collecting or reflecting on data in a qualitative study" (Morse & Field, 1995, p. 112).

Interviews were transcribed, checked, corrected and coded as soon as possible after the completion of individual interviews. Interviews were transcribed by a

professional transcriber. Transcriptions and interview tapes were then re read and listened to by the researcher to insure correctness and to familiarize herself with the data. Concurrent analysis of the data occurred until saturation was obtained. "Collecting and analyzing data concurrently forms a mutual interaction between what is known and what one needs to know" (Morse et al., 2002, p.12). Simultaneously listening to, reading, and correcting the transcriptions assisted the researcher in intimately getting to know the data (Morse & Field, 1995).

Content analysis was used in this study, as it enabled the researcher to sift through large volumes of data and code and categorize the data with relative ease in a systematic fashion while examining trends and patterns. Content analysis is a qualitative analysis technique used to classify words in a text into a few categories chosen because of their theoretical importance. It is a process of structuring unstructured data (Burns & Grove, 2005). The focus of this analysis was on manifest content. In this type of content analysis, less depth and level of abstraction is used in data interpretation. The focus is on analyzing what the content of the text says in order to describe visible, obvious components (Graneheim, & Lundman, 2004).

Creating categories is the core feature of qualitative content analysis. A category is a grouping of content that shares a commonality, is exhaustive and mutually exclusive (Graneheim & Lundman, 2004). After each interview, persistent words, phrases and themes were identified. These topics became the primary broad category label codes (Morse & Field, 1995). When looking over data, sometimes themes arouse naturally. At other times, decisions about how to organize the data were made (Brink & Wood, 2006). Data was sorted into 5 key concept categories. If data was to be sorted into more

categories, it would have become unmanageable and difficult to effectively or efficiently sort. If categories become too broad, saturation is achieved slowly or not at all (Morse & Field, 1995). The revision of the coding framework was ongoing and concepts were divided into subcategories or combined into larger, more abstract concepts based on the concurrent content analysis. The last step was to find relationships among categories by moving the analysis to more abstract from more concrete concepts.

> "When used properly, content analysis is a powerful data reduction technique. Its major benefit comes from the fact that it is a systematic, replicable technique for compressing many words of text into fewer categories based on explicit rules of coding" (Stemler, 2001, p.7).

To aid theme synthesis, a theme diagram was constructed to visualize the interaction of revealed themes from the combined individual interviews and written fieldnotes. A detailed, coherent and rich narrative description of the themes assisted in the dissemination of data analysis findings.

## Issues of Rigor

"Rigor is the means by which we show integrity and competence. It is about ethics and politics, regardless of the paradigm" (Tobin & Begley, 2004, p.390) and is required to prevent error. Rigor is about the reliability and validity of the study and the extent to which the research findings represent reality. Without rigor, research loses its utility (Morse et al., 2002). Lincoln and Guba (1985) developed a model that addressed the need to develop rigor in qualitative research. The model addresses four aspects of trustworthiness, a parallel term for qualitative rigor. Four aspects of 'trustworthiness'

were used for judging and evaluating the soundness of this qualitative study. They include a) credibility; b) transferability; c) dependability and d) confirmability.

*Credibility*

"Credibility (comparable with internal validity) addresses the issue of 'fit' between informants' views and the researcher's representation of them" (Tobin & Begley, 2004, p. 391). In order to ensure credibility, perspectives of the informants are reported as clearly as possible. Choosing participants who had various experiences regarding the use of epidurals in labour increased the possibility of 'shedding light' on the research question from different aspects (Graneheim & Lundman, 2004). In-depth semi-structured interviews was the most appropriate method of collecting data for the proposed research question. Using appropriate data collection methods assisted the researcher with the issue of credibility. Representative quotations from transcribed text are incorporated to illuminate developing categories and provide justification for category selection (Graneheim & Lundman, 2004).

*Transferability*

Transferability refers to the degree to which insights and understanding obtained from qualitative research can be transferred to other contexts or settings (Morse & Field, 1995; Tobin & Begley, 2004). However, as there is no single interpretation in qualitative research, transferability is primarily the responsibility of the one doing the generalizing to ensure that the study's sample and setting can be applied to a different population (Tobin & Begley, 2004). To facilitate transferability, a clear and distinct description of the participants is provided as well as a thorough description of the setting, research context and the assumptions central to the research question. A thick description of the findings is

presented. "Thick description details the affects, relationships, contexts, and backgrounds and interprets the tones of the voices, the feelings, and meaning of the situation" (Morse & Field, 1995, p.243). In this study, direct quotes or in-depth construction of the data are used whenever relevant to report results.

*Dependability*

Dependability (comparable with reliability) emphasizes the need for the researcher to account for the ever-changing context within which research occurs (Morse & Field, 1995). Changes that occur in the setting are described in field notes, however, a reflection of how these changes may affect the research are not discussed as they were not deemed significant.

*Confirmability*

Confirmability (comparable with objectivity or neutrality) refers to the degree to which interpretation of the findings can be confirmed clearly as a result of the data (Tobin & Begley, 2004). The researcher's own biases in this study are identified and the researcher ensured that the research process was logical, traceable and clearly documented for the purposes of conducting an audit trail. The researcher's thesis supervisor also assisted in ensuring that the research process was logical when selecting categories and developing emerging themes. Procedures for checking and re-checking the data are documented throughout the study.

## Ethical Considerations

This research proposal was submitted to the University of Alberta Health Research Ethics Board (Panel B) for ethical review and approval. Throughout this study,

three ethical principles were assured. They are: a) autonomy, which refers to the individuals' right to self determination and the freedom to decide whether to participate in the research study; b) beneficence, which refers to the potential benefit the study has for the research participants, society or to knowledge development. This study provided participants with an opportunity to talk about their experience but no direct benefit was anticipated. The goal is to gain understanding and increase knowledge. The final principle is c) Nonmaleficence, which refers to avoiding harm. (Brink & Wood, 2006; Talbot, 1995). It was not anticipated that any harm would occur to participants in this study but it was possible for interviews to bring back negative feelings about their labour and delivery experiences. In one instance, a participant needed assistance in dealing with negative feelings and was referred to her local community health centre and family physician for follow-up.

*Anonymity*

Research findings are reported in a way to ensure that participants remain anonymous. Every attempt to ensure that personal characteristics are not disclosed is made.

*Confidentiality*

The participants were assured that the information gathered in the study will not be made accessible to individuals not involved in this research study. Only the researcher, transcriber and thesis supervisor had access to the data. The principal investigator has the data in a locked space separate from any identifying information and shared it as needed for purposes of confirmability with the thesis committee. Transcribed interviews are saved in a password protected file on the principle investigator's computer.

Participants were offered a written report of this research. Data from this study will be stored for a minimum of 5 years in a locked cabinet in a secure area and then may be destroyed. The demographic data will be kept for 5 years in a separate and secure area. Prior to any secondary analysis of the data collected in this study for any future study, the appropriate ethics committee will need to approve.

## Timeline

An estimated timeline was developed to break down the research study into manageable steps and assisted the researcher in keeping the project focused. The proposed timeline from ethical approval to completion of data analysis and dissemination was <6 months (See Appendix J)

## Budget

Conducting research is costly in both time and money. The dollar amount budget for this study was kept at a minimum. A summary of anticipated costs is presented in Appendix K.

# Chapter 4

## Findings

In this study, the following research question, "What degree of understanding do woman have regarding their involvement in choosing or not choosing epidural analgesia during their labour?" was examined. Interest in this study seemed wide spread. Recruitment flyers were posted in two health centres and, two New Mom's Groups within the Capital Health region were given information about the study. After two weeks of recruitment, over 25 new mothers expressed interest in participating in the study. Of the initial 25, 17 consented to participate. The recruitment flyers were removed after two weeks as there were sufficient volunteers from whom a purposeful sample could be selected. An additional 10 women expressed interest during the course of the study, some who previously noticed the recruitment flyer and others by word of mouth. Of the additional 10 women that expressed interest during the course of the study, none had demographic characteristics not already represented in the sample and therefore were not interviewed. They did agree to be contacted at a later time if it was necessary to further explore or clarify emerging concepts.

During initial data analysis, major concepts emerged that influenced women's understanding with respect to consenting or not consenting to epidural anaesthesia. These included choice, support, social perspectives, locus of control, and knowledge. During subsequent analysis factors that influenced each particular concept were identified. Concepts and influencing factors are summarized in Table 1.

Table 1

Summary of Concepts and Influencing Factors

| Concepts | Influencing Factors |
|---|---|
| Choice | • Timing of Informed Consent |
| Support | • Positive/Negative Perception of Support<br>• Communication<br>• Planting the seed<br>• Bed-Side Manner<br>• Privacy<br>• Nurse Experience<br>• Advocacy |
| Social Perspectives | • Preferred Health Care Model<br>• Mastery<br>• Memorable Experience |
| Locus of Control | • Guilt<br>• Trust<br>• Compensation<br>• Sense of Urgency<br>• Self Efficacy<br>• Attitude |
| Knowledge | • Prenatal Education<br>• Link between Intervention and Epidural |

## Choice

Importance of choice transpired as a significant concept and was influenced by the timing in which pain management options were presented and consent was solicited. Women reported they wanted to have real pain management options from which to choose. Can informed consent be achieved if women are not able to choose alternative options to pain management? In some cases, women were requested by nurses to consent to epidurals for pain management but often they were not informed of the risks of complying. Overall, women who expressed feeling supported and who were presented with pain management options were more satisfied and felt they had made their own choices regarding their labour and delivery experience. The women said:

> I don't have any regrets about having the epidural, but I don't think that I made an informed choice, as they didn't really go over too many risks.
>
> Because of my medical background **I** was able to give informed consent, but there was no discussion about the procedure or a review of the potential risks and complication of the risks. Someone who didn't have the same knowledge I had going in wouldn't have been able to give informed consent based on the information that was provided to me.
>
> I wouldn't say that the nurse pushed the epidural, but at one point it was suggested that it was time for my epidural. She just said: "okay, it's time for your epidural now". It was still my choice to say no.
>
> She asked me a few times if I planned on having an epidural. I would have liked for the nurse to suggest trying something else first – I guess because the first thing that she said even before I was admitted was, "are you planning on having an epidural", so once it was suggested I just felt like I should take it. She did ask if I wanted it but because that was the only thing presented I just said, "okay" – I might have chose to wait a little longer if other options has been discussed.

### *Timing of Informed Consent*

Many women indicated that the risks of epidurals were not discussed, and if they were reviewed and discussed, the timing was not ideal. The issue of informed consent

and timing of obtaining consent was raised by the women and most felt that they were not given enough information and the timing of obtaining consent was inappropriate. Of interest is that women who felt like they had enough information to make an informed choice regarding their decision to have an epidural had an anaesthesiologist that was female. Examples of what the women said were:

> The risks were not discussed, but even if somebody would have tried to explain them, I probably wouldn't have understood them. The timing would not have been right.
>
> As far as the risks of epidurals, there wasn't a whole lot of discussion around it beforehand or during the procedure. I was REALLY uncomfortable in a lot of pain and not able to focus and they went through a sheet really, really, really fast. I would say it was brushed over, but I didn't care at that point.
>
> In order to make the information about epidurals easier to understand it should have been provided before I was in active labour, when I was in a clearer state of mind. I definitely would have been happy to have someone explain to me when my mind was clear exactly what the good, the bad and the ugly about the epidural were. I don't think I would have changed my mind about actually having it, but to have had the opportunity for a better discussion in a clearer state of mind would have been good.
>
> The anaesthesiologist reinforced what we already knew. I felt like I made an informed choice, I think they did a really good job about going over the risks, and nobody judged me for going one way or the other so that was a good thing.
> The anaesthesiologist was really good. She explained all the risks and benefits and answered any questions that I had and was very thorough actually in her explanation, so I felt like I was very much in control and that it was my decision to get the epidural. It was hard to focus certainly going through the pain and discomfort, but I did feel like I could follow what she was saying in order to give informed consent.

## Support

This concept presents the verbatim descriptions the women used to describe the support they received and what it felt like for them. When participants described their need for support or the kind of support that was provided, their comments were

influenced by the following factors; perception of support, communication with nurses, planting the seed, bed-side manner, privacy, nurse experience and advocacy.

Overall, the women expressed the need for additional continuous direct supportive care tailored to their birth plan, preferences, labour status and philosophy surrounding pain management. Of the women that discussed support, most felt there were gaps in the support that was provided to them while others noted the support they received was outstanding.

*Positive/Negative Perception of Support*

Support was perceived by women as both positive and negative. It is interesting that in describing what support felt like for them, their comments were almost exclusively related to direct nursing care. For those who described negative aspects to the support they received, they related it to the following events:

> Once I received the epidural there was a greater emphasis on monitoring all the stuff, and the nurse wasn't in the room as much. Before the epidural she was actually in the room the whole time.
>
> I think it's important that the labour and delivery team asks about your birth plan and how you want to manage the pain, because the first nurse I had never asked; she just... started hooking me up to machines.
>
> I just didn't know what else to do and I wasn't really being given any other suggestions at that time, so I asked for the epidural at that point. It really would have been good to have had more suggestions on non-medical pain management strategies. I had my own nurse and it would have been good if she could have offered more, when you're not in control and you don't know what to do to make it better um... some more guidance would have been beneficial.
>
> I was glad that we had taken that prenatal class and knew what some of my pain management options were, because I just felt like they didn't give me any options, no one talked about the ball, or shower or suggested breathing techniques, there could have been more emphasis with that, but is was more...just...kind of...you know I was hooked up to machines, I felt very detached. The nurse was more just about what she was reading on the, on that...equipment like the printouts and stuff. I think ultimately I would have ended up having the epidural. I don't think

> that would have changed, but I think I would have got further along if... the nurse had been a bit more supportive and had been able to give me and my partner a bit more guidance.

For those that described positive aspects of the support they received, they related it to increasing their feelings of confidence and strength. They related the following events:

> My primary nurse was excellent, I felt she was very qualified; she was able to put me at ease, explain things really thoroughly. She was efficient and very no-nonsense. She didn't beat around the bush and she was straight forward with her answers, so I really appreciated that. Certainly there were nurses that were less experienced but you know it's a teaching hospital, I guess you can't always have the most experienced staff working with you at all times.

> I tried different positions in the tub but things weren't progressing so they suggested other things. I had a whole cheerleading squad. I had tons of excellent support... I could not have asked for anything better. I had my nurse, my midwife, my student midwife, my doula, my mom and my husband.

> The nurses in labour and delivery were fantastic, team players, they were my cheering squad, I get teary thinking about it, because I couldn't have done it without them, they were fantastic, absolutely fantastic. The nurse was firm but in a good way, she kept telling me I could do it and that I had the strength, she kept trying to keep me focused. She was really supportive in everything I said, and whatever I wanted. Everything was presented as your choice as opposed to here we are going to do and you need to...

*Communication*

Many women expressed their desire for enhanced communication and consistent messaging. Overall, participants felt that improved communication would have increased their overall satisfaction with their labour and delivery experience. Women valued personalized information, explanations, and advice from the health care professionals. Some women reported feeling frustrated during labour due to a perceived lack of communication from health care professionals. The topic of communication was raised

by both the women and their partners. They expressed an increased need for communication at every level:

> I think it's important to assess each situation separately; some people are going to want more than others, and for us more communication would have reduced some of our tension and anxiety. It was hard because I didn't know what was going on; it would have been nice to know a little more. That was a big thing for me; I just wanted to understand what was going on. We did feel like we could ask questions but they weren't really being answered. We asked all sorts of questions but it was just... there were so many people I mean they would give a quick answer; some of them would give an answer that's not really an answer.
>
> Communication is key and I felt like I wasn't being heard. More needs to be done in the area of customer service. Poor communication certainly contributed to my feelings of powerlessness and frustration. The gap in communication is tough when you have no control.
>
> They didn't acknowledge what I was saying; it made me feel quite powerless. There was also someone in training and they didn't ask me if that was okay, they whispered a lot and that bothered me, I didn't know if it was just instructions because she was learning but I kept thinking something was wrong. My stress and anxiety level increased because I didn't know what was happening and that made the whole experience much harder. The focus seemed to be on teaching the girl, the student instead of supporting me.

*Planting the Seed*

Many women described not initially wanting epidurals for pain management in labour but being open minded to one if they felt that they were no longer coping. In many cases, epidurals were presented much earlier than they had hoped and often were offered as the only option to cope with pain. It also appears that the nurses occasionally pressured the women in this study towards choosing an epidural because of the availability of an anaesthesiologist and maybe their own uncomfortable feelings about taking care of a woman that wanted to experience labour using non-pharmacologic pain management strategies. Below exemplars of how women describe the *seeds being planted* for them to

agree to epidural analgesia for pain management during labour are presented, something that many women initially inferred being ambivalent about:

> I was being bombarded every 5 to 10 minutes. It's hard to be assertive when the nurses keep pulling the epidural card, "do you want it, do you want it now?" All you want is the pain to go away, and it's easy to cave and say "okay, fine let's do it".
>
> The nurse informed me if I didn't get the epidural labour would be awful, but she did say that if I didn't want one that was fine. From her comment, I was convinced that I wouldn't be able to get through labour naturally without having... it be a horrific painful experience. Her intention may not have been to guide me in the direction of choosing an epidural but she did.
>
> They asked me a couple of times "Are you interested in pain relief? Are you interested in having an epidural?" It kept getting brought up to me, "are you interested, are you interested?" At one point the nurse came to me and said if you're interested in having an epidural, just so you know the anaesthesiologist is going to be tied up in surgery for 3 hours so if you would like it you have to think about having it in the next little bit. At that point I thought I was managing... it wasn't intense but the thought of waiting 3 hours kind of scared me so I said, "yeah, sure, let's do it." I think there was a little bit of pressure put on, kind of was, that fear that what if an hour goes by and I'm in excruciating pain and I can't have it, so I don't think I would have had it at that exact moment. I think I would have waited a bit longer, but because he was going to be in surgery I thought, "no I'd better have it now", so – I mean I had the decision but I wasn't asking for it or begging for it. If I had to do it over I would likely say, "No I don't want the epidural right now. Let's see how things are in three hours".
>
> One nurse suggested the epidural before even asking me what I thought about pain management. It was presented as the only option to cope with labour pain. I'm sure I was asked about the epidural at least three times in the assessment room. I brought up other medications and options but the epidural was really the only option they gave me. It kind of felt forced. Once we moved into the actual delivery room, and we had one-to-one nursing it was much calmer and the nurse spent a lot of time with us, that was an awesome experience but by that point I had already had the epidural. So I don't know if the nurse we had in the labour and delivery room would have been able to coach me through labour without having any medical pain management intervention. I never had the chance to really try...different positions, walking, pressure, the shower, the ball all the things they go over in prenatal class. So I don't know if I ever would have been able to have the labour I had planned. I just don't know, it's the unknown and that's what's hard. If I would have been given the opportunity to try other techniques, and if in the end I had decided to have an epidural, then at least it would have been my choice. It is unfortunate that I wasn't able to try other pain

> management options. I think next time I'll try a midwife or a doula. I really want a different experience than the one we had this time.

*Bed-Side Manner*

Bed-Side manner of the health professional emerged as an influencing factor to the concept of support. Most who expressed an opinion were disappointed with how they had been treated by the health care professionals and felt unsupported. Women expressed resentment towards being intimidated and ignored by both nurses and physicians:

> She just wasn't the nicest. At one point during the pushing stage she turned to me and said, you're not going to get ANYWHERE that way, she could have been nicer about it.

> The nurse was very honest with us about how the anaesthesiologist was. She prepared us for how blunt he was. He apparently said to other moms, "if you move, you'll die". He was very blunt, but other than that it worked out. We got through it. I think it would have been better if the anaesthesiologist would have had a little bit more of a bed side manner and discussed a little bit more with me. It's so routine to him and he does it SO many times in a day that I think he just rushed through the discussion forgetting that this is my first baby. He may do it every day but I don't. It was the nurse that did the bulk of the discussing and encouraging. He just kind of came in, said "blah, blah, blah", rushed through the steps and then he was gone.

> When I phoned in to the hospital to tell them that I felt labour was starting they dismissed me, so whatever. Then I still felt crappy and crappy and crappy so I phoned back hoping there would be a new shift of nurses – no such luck. When I finally went to the hospital, the two mean nurses checked me into the assessment room and they were really lackadaisical about the whole thing. They weren't very nice and made me unhappy. The whole experience so far had made me stressed, which probably made my pain worse.

> I wanted my mom to leave during the pushing stage, but the nurse kept encouraging her to stay for support. I didn't feel comfortable with it, but the nurse and my mom kept trying to convince me that it was a good idea. I was annoyed by that. It put me in a weird spot.

*Privacy*

The women's comments regarding privacy were very much related to their perception of being supported. With respect to privacy, the physical environment and

proximity to other labouring women was a prominent concern or threat to privacy. They said:

> I don't think that it's really good to have all these women in labour in the same room. This is all supposed to be confidential but when you're in a room with a few beds with only a curtain separating you and the other women, you hear everything and you know what's happening. I wish they would change the way the assessment room is set up.
>
> They have one of those screens that you can pull back but half the time they left it open. I was worried, more like paranoid that my in-laws or someone was going to walk by and see EVERYTHING. I must have TOLD them at least 30 times to please shut the screen.
>
> I was sharing a room with a woman who ended up going into labour and she was like, "no, I don't want the epidural. I don't want anything." She went from this calm state and I actually watched her through the night...turn into this screaming lunatic. At that point, I decided I was going to have an epidural, no no no that wasn't going to be me. I wasn't going to be a screaming lunatic, so maybe having to listen to that woman screaming all night before they moved her influenced my decision. Maybe if I hadn't been exposed to that, I would have been less worried and scared.

*Nurse Experience*

Overall, nurse experience was valued and was linked to the participant's perception of her nurse's ability and competence. Nurses deemed to be experienced instilled confidence in these women. Overall, the women felt that experienced nurses were able to incorporate labour support into their routine practice in a way that was meaningful more easily than nurses with less experience. Exemplars from the women are as follows:

> I was surprised that the nurse who facilitated my prenatal class and the nurses I had during my labour had never had kids. They were all twenty something, and they were all good. They were really good but it seemed strange to me. I wonder if I would have been supported better if they had had their own labour and delivery experience to reflect on. Even though every woman's experience is different, they would at least have been through the whole process and there are some core issues that are going to be the same.

> All those medical interventions, instruments, tools, foetal heart monitors, epidurals are so convenient but there is nothing that takes the place of experience. And if the medical staff is allowed to spend more time with each patient then the tools... the medical things, all the monitors and stuff become nice to have instead of need to have. Time and experience allows the medical staff to focus on the patient.
>
> The younger nurses and the nurses with less experience are not used to helping women labour naturally. They have not been trained to support women with natural childbirth, so I think there is a push towards epidurals on their end because that's all they know.
>
> The experienced nurses were very encouraging and good at coaching; it felt much easier when the experienced nurse was helping me get through each contraction, one at a time. When shift changed I had the younger nurse who basically said nothing. It was much harder and then I was just like, "okay I can't deal with this, bring on the drugs". I lost my confidence so I definitely think having experienced people there telling you that you can do it and helping you through each contraction is of great value.

*Advocacy*

Advocacy emerged as an influencing factor to the concept of support. Overall women felt like they would have benefited from having someone with them who they knew; was attuned to their personal values and beliefs and could focus exclusively on attending to their needs by providing information, anticipatory guidance, supporting choices and setting the stage for realistic expectations. Mothers said:

> I would never get induced again. I think inductions are handed out a little too quickly.
>
> I guess if you had a doula, you'd kind of know her a little bit before you went into labour because you meet with them a few times during the pregnancy. They would know you and understand your personality and your birth plan, whereas with the nurses, you don't know who you're gonna end up with, so maybe having another support person be it another family member or friend who's done it before might be a good idea. I think it would be a good thing to have someone that you know to be an advocate for you.
>
> It would have been wonderful to have someone to liaison with the staff, to assist me with the "you're having a baby stuff" and to filter the ultra super medical stuff.

> Initially, I was bombarded with questions and with forms; I was SO not interested in trying to fill out those forms or in talking to her. I was going through contractions back to back and she's asking me all these questions that I'm sure had already been documented somewhere.

## Social Perspectives

This concept represents the impact that social influences, personal choice, values, opinions, and beliefs have on the woman's overall experience with pain management during labour and delivery. The influencing factors emerging from this concept are associated with the woman's preferred health care model, feelings of mastery (defeat versus victory) and desire to have a memorable experience (pain versus no pain). Many of the women perceived that accepting epidural analgesia to control pain during labour was a rational choice, and agreeing to this pain intervention was expected by friends, family and, health care professionals. Feelings of pressure, guilt and the need to be viewed positively by those around them were expressed by the participants. Below are exemplars that the women used to describe some of the truths and misconceptions that are translated into social norms:

> The only thing I had heard about pain management was through friends and relatives and they all said, "oh you gotta get the epidural, get the epidural you stupid idiot".

> I didn't want to be screaming and yelling and out of control like an animal and the nurses to be like, "oh God, look at this crazy girl". I didn't want to be that person. I wanted to be the quiet, calm and more composed woman. The epidural I thought would help me stay calm and keep me from being that irate person.

> It was more of a directive process; the focus was not on coping techniques but rather, "sign up for the epidural right now because your gonna want it, your gonna need it". I think it's kind of easier for them. I would imagine it's very hard to deal with someone who is in a lot of pain, so leading up to the birth in terms of the general atmosphere in the room, it's a lot calmer. I would imagine that's attractive for nurses.

> I think it's sort of an assumption now that people get epidurals. It's become the norm and the people that don't get them are the ones that are... looked at differently. Due to advances in medicine, pain medication for pain management is so prevalent for everything.

*Preferred Health Care Model*

The concept of social perspectives seemed to be influenced by attitudes towards medical and wholistic health care models. Of the women who raised the issue, most inferred that labour and delivery was safe only if the medical model was utilized but they didn't know where to draw the line between viewing labour and delivery as a natural process not needing intervention and viewing labour and delivery as a medial issue needing intervention.

Participants said:

> I went in thinking I wanted a medical experience; otherwise I could have got a midwife or a doula and done it at home.
>
> A lot of women feel like labour and delivery is a medical issue when really it's the most natural thing in the world. I think the labour experience has gotten too regimented and medicalized and I don't really understand why.
>
> I felt that I would be in charge of my labour *[laugh]* and I don't think I really was. I knew that I was going to have to be really assertive if I wanted to be in charge of my labour because I think that you can kind of just get swept up in the whole medical aspect of it and the patient kind of gets forgotten. It kind of snowballs, the medical aspects and nothing is ever done without your consent but... your consent is given...freely.
>
> Everything nowadays is, "take this drug and it will fix you, take this drug and it will help you." Delivering a baby is no different. It's become a medical issue versus a natural process so why not slap a drug on it and... you're good to go.

*Mastery*

Feelings of defeat emerged as a noteworthy influencing factor to the concept of social perspectives. Some of the women felt defeated by their labour experience, to the

point where they are unwilling to go through it again. As an alternative, some women discussed their decision to have a Caesarean section with their next delivery. They said:

> Because my labour experience wasn't great, next time I'm leaning towards just going for the c-section and skipping all of that – but... perhaps if things had been different, if I felt more supported or had been given more pain control options that would work I wouldn't feel that way.
>
> I have to be honest, when they told me that I needed the c-section, I was relieved. I thought "oh thank god I don't have to go through this any more." I was happy for the option to have a c-section, I know that with my next one, I will have a planned c-section, I'm not even go to try without because I couldn't... I can't handle the pain.
>
> If I had another baby, I may just schedule a c-section because of how things went. I think maybe it would just be easier to do it that way next time.

*Memorable Experience*

Some of the women related having an epidural to having a memorable experience. They did not believe that labour could be a positive and memorable experience unless they had a pain free labour and delivery, which to most meant having an epidural. The following exemplars were provided:

> I felt that if I had a pain free labour, it would make the experience more memorable; friends and family alluded to that as well.
>
> The pain became unbearable and I just wanted... I wanted to have a happy labour, if that makes any sense.
>
> I would just rather actually enjoy it with my husband than sit in a foggy haze of discomfort.
>
> When I received the epidural I was so happy. It was just so much easier. I do relate having the epidural to a positive experience.

## Locus of Control

Feelings of personal control emerged as an important concept and were influenced by other factors including; guilt, trust, compensation, a sense of urgency, self efficacy and

attitudes. Some women described lack of control over decision making as a source of dissatisfaction with labour and delivery. Other women reported a willingness to surrender control to the health care professionals. Of the women who raised the issue of personal control, some felt the need for greater or lesser degrees of control. Exemplars of perception of control are as follows:

> When my concerns were not really addressed, I felt like they were making decisions for me. The whole experience increased my perception of pain. It frustrated me that I was left out of the discussion and decision making process. I would have felt like I had more control if the nurses had been talking with me and not about me.
>
> It was all about having control over my situation so I spent the time to research and figure out what scenario I would have the most control over. I knew I didn't want somebody telling me to do this and to do that because it's my body, it's my baby. When delivering a baby, I understand that there's only so much that you can truly control, but I took the time to increase my knowledge and understanding of the health system in order to control my overall labour and delivery experience. I was able to build the situation that I wanted to be part of. That was choosing to deliver in a birthing centre and not in a hospital.
>
> I felt like I was no longer in control of my labour, my body, my baby, the moment I walked into the assessment room, laid on the bed and was strapped to the monitor.
>
> We kept leaving the room to walk around the hospital. That seemed to be the only way to stay strong mentally and to remain in control in an environment that is pro-epidural. We needed to come back ever half-hour or so just to check on things and we were okay with that.
>
> I wanted labour to be medical and I wanted people to tell me... this is the order that things happen in, so I gave my power away hoping that...you're the professionals - you tell me what to do. Knowing what I know now, they don't know, they can't know where you're at. I just don't think nurses look at every experience as unique. They tend to stick to what is considered average and don't always focus on what you're experiencing necessarily. Next time I would be a little more decisive in what I need them to do for me, a little less willing to give my power away.

*Guilt*

Some women had feelings of guilt associated with choosing epidural analgesia for pain management during labour and delivery. They said:

> I don't regret having an epidural I don't regret it at all, but I do feel a little guilty for choosing it.
>
> I kind of beat myself up over having had the epidural, but at the same time...why suffer if you don't have to either, I guess? I still feel a little bit guilty – just because I was so hard core about not having one, and then giving in.
>
> I feel like I failed. I was too weak to go through birth naturally. I guess in the back of my mind, I still feel like I shouldn't have needed it. I don't really regret it, but I feel a little bit of guilt.

*Trust*

The concept of trust was raised during some interviews. Woman needed to feel trust for providers when they relinquished control. Exemplars include:

> I had to trust the health professionals who were helping me but I also had full confidence in their competence and that they were advising me with the best... intentions in mind, you know, for my wellbeing and for the birth of our baby. I definitely had less control but I was very...confident in the health professionals around me.
>
> I think they had the epidural turned too high because I couldn't feel the contractions I didn't know when to push so...I just had to trust the nurses when they were telling me that I was having a contraction and that it was time to push.
>
> I don't know if there was really a loss of control as a willingness to turn the reins over and just trust the health care professionals to help me through this. I don't know how to cope...so I think I still had the control because I was giving the reins over. That's kind of how I saw it.

*Compensation*

Some women resented relinquishing control but felt that loss of control was compensated for by the safe birth of a healthy baby. Women portrayed compensation as a

coping mechanism for a labour and delivery experience that was a source of dissatisfaction. One woman responded,

> You're having a BABY, a new life, so who cares really – how it gets here, as long as it gets here.

Another said,

> The whole experience was kind of disappointing, but I have a healthy baby now and that was only one day in hindsight, so... "it's okay".

*Sense of Urgency*

Some women expressed a feeling of urgency by the health care professionals attached to receiving an epidural for pain management during their labour and delivery experience. One woman responded:

> I felt like there was urgency, a sense of urgency attached to the epidural.

Another woman commented:

> I would have liked to have been the one to initiate the request for the epidural. I got in the labour room and they said, "okay, we'll do up your epidural right now." I said, "Okay." There was no opportunity to try any of the coping techniques I had learned in prenatal and prenatal yoga classes. Next time I would be less willing to take the epidural right off the bat when it was offered. If I had to do it over, I would have waited a little while, tried some non-pharmacologic pain management strategies first.

*Self Efficacy*

Self efficacy was described as a key indicator to choices around pharmacologic or non-pharmacologic pain management coping mechanisms during labour and delivery. Overall, women who were less confident in their ability to get though labour without pain medication were less successful in having a natural delivery than women who were confident in their ability. Some women had anticipated that there would be pressure to choose an epidural for pain management. In most cases, the women who were determined

to go through labour without an epidural had done more research on their birth setting options, described being mentally prepared, had alternative support people in place and had done additional preparation. They described having alternative coping mechanisms and strategies planned in order to control the things that they believed they were able to control. Exemplars are as follows:

> I didn't want to go through the mental kind of stress of thinking it was gonna work and then not having it work and still have to continue going through labour at that stage. It's one of those things where if you decide in advance that you're 95 % sure that you're going to need an epidural, the decision to have one is already made. I went in thinking I was 95% sure I wasn't going to have an epidural. I knew if I asked for the epidural, it was gonna be at a stage where I absolutely couldn't handle things any more. You really need to be mentally prepared, because everyone at some point during the labour and delivery process is going to think and feel they need an epidural.
>
> I think that if you don't want to have an epidural, you have to know beforehand that you do not want an epidural and no matter what anybody says, you're not taking one; because the thing is, if you're uncomfortable, in pain... in a moment of weakness and there are plenty moments of weakness when you're in hard labour, if it keeps being offered, then... chances are your going to take it.
>
> I was mentally prepared to deal with the pain. I heard too many stories about the link between epidurals leading to long labours, vacuums, forceps, bad tears, c-sections and other interventions, and I knew that I didn't want any of those things. I was prepared to deal with the pain of delivering a child naturally over having any of that stuff done to me. The potential for a cascade of interventions; that was my biggest fear.
>
> I was getting worked up because I envisioned myself getting the epidural as soon as I started to feel any pain. I had already decided in my head that I just couldn't do it without it. When they told me that the anaesthesiologist would be unavailable for about an hour or so, I panicked. I became hysterical because I hadn't planned for anything else. Now I think that if I had planned to cope with the pain in other ways, if I had prepared myself mentally to go as far as possible without the epidural, not relying on it right from the start, maybe I would have been stronger but I just put it in my head that I couldn't do it without. I do think that might have had something to do with it.

*Attitude*

Individual attitudes, beliefs, values and personal philosophy shaped decision making. Some women felt that they needed to defend their needs, desires and right to labour without intervention. Others felt it was their right to have intervention. Attitude emerged as an influencing factor of support as it is dependant on personal characteristics of the individual woman and nurse.

Women responded:

> I imagine personal attitudes and philosophy have a huge impact on pain management during labour and delivery. My friends who had epidurals their attitudes were, "why go through the pain if you don't have too." If that's your nurses' attitude and philosophy as well, there may be an unconscious push in that direction.
>
> The nurse asked me what my plan was and I said, "I plan not to get an epidural" and she said, "why not." I was pretty sure I was going to get an epidural but I wanted to try not having one.
>
> Some of my girlfriends there're like, "What? You don't want an epidural?" They were surprised that anyone would want to try and have a natural birth. I chose to deliver with a midwife because hospitals are geared towards intervention and don't share the same philosophy that I have. I don't think I would have had a natural delivery had I been in a hospital setting. I'm just not assertive enough.

## Knowledge

Knowledge emerged as an important concept and is influenced by prenatal education. "Knowledge is power". Women who felt they had all the information that they needed to make informed decisions, regardless of how their birth went, felt good about their delivery, felt in control, felt involved and felt supported both during and following birth. The amount of information women had prior to and during their pregnancy, including formal prenatal education influenced their ability to make an informed choice about having or not having an epidural to manage labour pain. There seemed to be

awareness that neither the skill nor resources were often available in hospitals for women to have real choices with respect to pain management strategies and options. Sources of information to which women availed themselves to increase their knowledge included prenatal classes, books, the internet, and personal communication with friends and family. Exemplars from the women are as follows:

> All the equipment and tools required for medical intervention are available but there is a gap in resources to assist women with non-medical coping techniques such as labour balls. They should only be teaching coping techniques in prenatal class that are actually going to be available; we found that to be frustrating.

> I think that the supplies available while you're having a child are a bit of a joke. There is almost the assumption that women will have an epidural. I think that there should be more resources available for women who want to have a natural childbirth, be it actual squatting bars in the rooms, more accessibility to tubs, birthing balls, chairs, tens machines, doula's – whatever the case may be. I just wish the hospitals were better equipped to support women with natural childbirth.

> It's like everyone has epidurals. Most of the women I know went in and said "hook me up"... They just don't bother going through or at least trying to go through labour and delivery without having it. Women have been having babies for years and years without drugs. Our bodies are built to have a baby, but the mentality and support available to have a natural delivery has shifted. The availability of epidurals and the idea that there are relatively few side-effects to women and limited side effects to baby is too enticing.

*Prenatal Education*

Of the women interviewed, all but one attended a formal series of prenatal classes. The classes were based out of local hospitals, local community health centres and offices of for-profit providers. The majority of women felt that they received the bulk of their information and knowledge about pain management by attending prenatal classes and that the information they received assisted them in making choices around pain management. Some felt that physicians should be incorporating more prenatal teaching into women's routine prenatal visits. From what the women said, it was evident that the

information focus and messaging or interpretation of the messaging was inconsistent between prenatal educators. Some women commented more specifically on the prenatal series they attended:

> During my routine prenatal check-ups, there was no discussion from the doctor or the nurse about what my pain management options were during labour. The focus of the visits were very medical.
>
> It was really focused on breathing and the different positioning you can do...I would say they favoured the non-drug measures.
>
> There was more emphasis on pharmacological pain management options. They went through the list of everything, but there was a lot of information on epidurals, what it was, how they worked, what would happen afterwards and potential side-effects...a lot of education on that level...most of the detailed information was around epidurals.
>
> I attended two separate prenatal classes. The first was through a Doula association, and the class was anti-intervention. The emphasis was on coping through breathing, massage, water, position changes, using a ball and that kind of stuff, and that was the route we were going, au natural, until we took the class though Capital Health. At the class through Capital Health we found out that there are actually normal pain management techniques with medication and stuff. I would say the emphasis was on getting an epidural. I didn't realize that epidurals were the norm, which changed my mind completely; we shifted from going the doula route to going the epidural route.

*Link between Intervention and Epidural*

The link between epidurals and subsequent intervention was identified by some of the women, and seemed to be influenced by the degree of knowledge the women had gained through research in this area. Some women associated epidural anaesthesia with further intervention. In these cases, the women had all done extensive reading and initially had concerns with epidurals for pain management. Exemplars are as follows:

> And then later on because I had to have the c-section because he wasn't progressing and stuff, at one point I thought it was all of that pain medication and maybe I didn't really need it all, maybe I shouldn't have had it all like, did that maybe stop, you know...the natural progression. I kind of was happy on one hand

but then on the other hand I thought is that going to hinder...the birth process and then afterwards when I had the Caesarean, like the next day, after I was like..."ooh, did I cause myself to have the Caesarean because of all that pain medication?", like I kind of started to second-guess myself even though I have no regrets it all turned out to be fine, but you kind of think..."oh would he have descended better if I hadn't had the epidural".

My mother and mother-in-law were both like, "how can she not have the urge to push?" I was so numb; I thought maybe that was why I didn't have the urge to push. I just felt nothing, like I really felt like nothing was happening. I really didn't have the urge to push the whole night even though I was 10 centimetres I was fully dilated. I did wonder about the failure to descend, so I wondered if maybe the epidural had done that, if maybe that contributed to the c-section.

I kind of wonder if maybe the reason I didn't want to push was because of the epidural but on the other hand I don't have any guilt for having the c-section and that it wasn't natural or it wasn't any of those things. If I had to do it all over again, I would do the same thing.

# Chapter 5

## Discussion

The findings will be summarized and then discussed with respect to existing research and their implications for nursing practice, education and research. Data was collected from personal, face-to-face interviews with 17 women, 2 with their spouses. All interviews took place in their homes for a total of 17 interviews, which provided the database for a propositional statement (in the form of a model) that proposes an interrelationship among the overriding groups of concepts that emerged from the data analysis. In this model, each group of concepts influences and interacts with all other groups of concepts. Individual groups of concepts and concepts within each grouping do not stand alone (see Figure 1, page 52 and Figure 2, page 53). According to the propositional model presented in Figure 1, a woman's understanding regarding her involvement in choosing or not choosing epidural analgesia during labour is influenced by her; a) personal choice; b) perceived sources of support; c) social perspectives; d) locus of control and, e) knowledge (see Table 1, page 32). Figure 2 presents a more detailed breakdown of the factors that influence the 5 key groups of concepts. All influencing factors relate to one another within and outside of the circle. The concepts are dependant on the influencing factors and the influencing factors are dependant on the related concepts. When one considers all the concepts and influencing factors as a whole, the complexity of understanding all that is involved with a woman's ability to make informed choices regarding pain management during labour can be realized. While these concepts must be considered holistically, each will be presented individually for ease of readability.

Figure 1

Concepts influencing maternal choice with respect to epidural analgesia

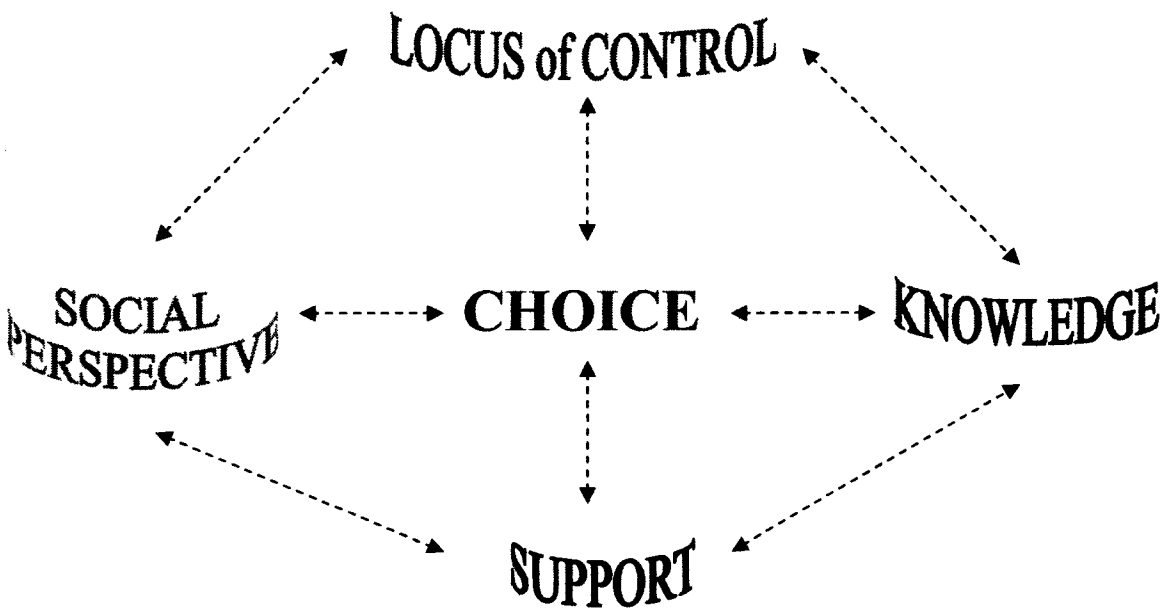
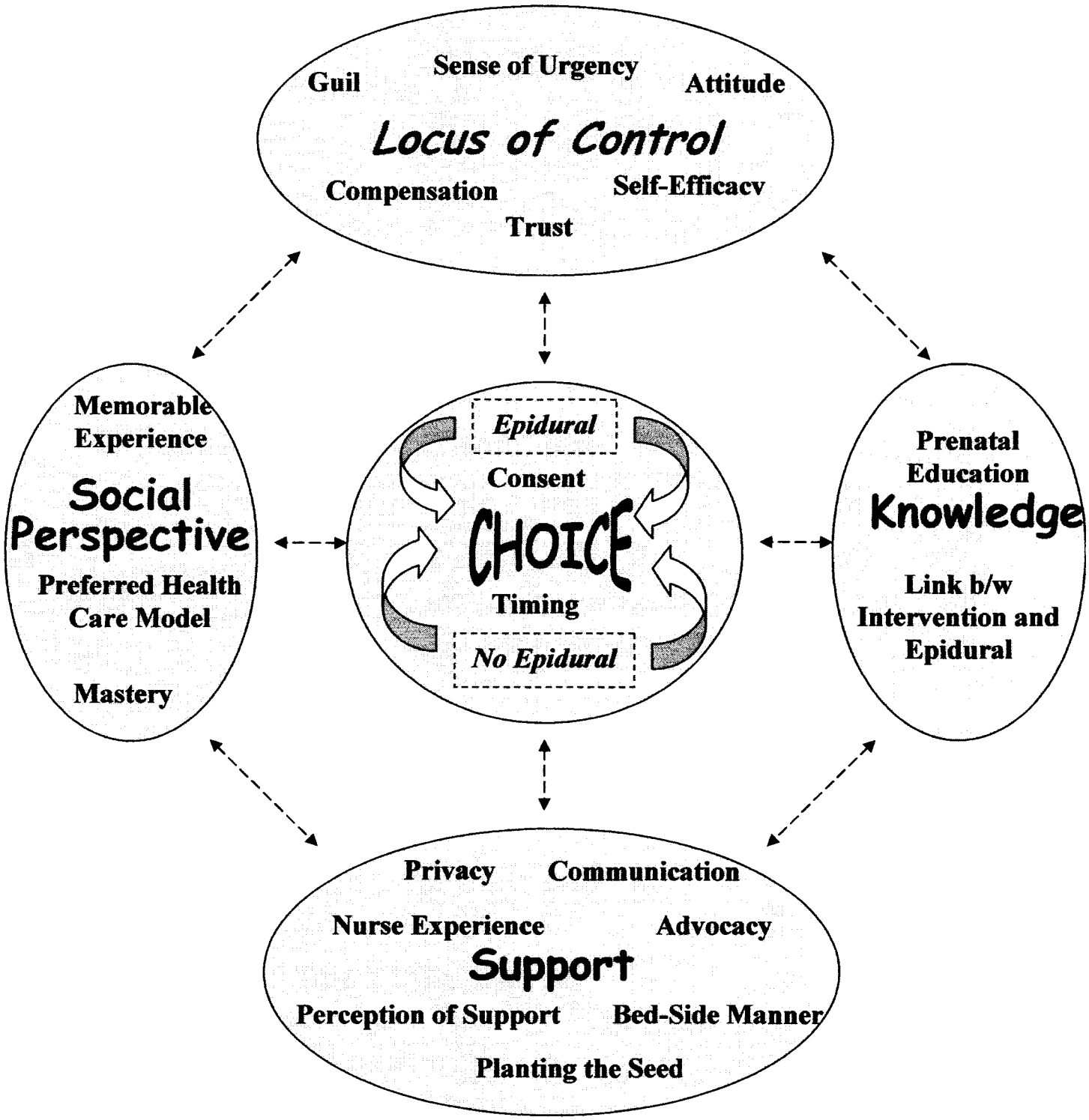


Figure 2

Factors influencing maternal choice with respect to epidural analgesia



## Choice

The concept of choice is the nucleus of the model, in that it reflects the collective dependence of surrounding concepts. Women felt that their ability to make informed choices was influenced by both the positive and negative aspects of support, by their individual views on social perspectives, by their locus of control and, their previous knowledge around pain management options. Women in this study indicated that being presented with all of the non-pharmacological and pharmacological pain management options along with potential associated risks were essential if they were to provide informed consent. Most women indicated that the epidural was presented to them by health professionals as the only real option, and, in most cases the risks were not reviewed. In order to give informed consent, women need to be made aware of the benefits and the possible side effects or risks of receiving either an epidural analgesia or an alternative therapy to manage or reduce labour pain including expected labour results with or without the use of epidural analgesia (Saunders et al., 2006). Subsequently, women become influential, well informed consumers with the ability to make genuine choices about how they wish to manage pain, balancing the effectiveness of pain relief against the possible side effects affecting maternal/infant health and effect on the progress of labour (Jackson, Henry, Avery, VanDenKerkhof & Milne, 2000; Mansoori et al., 2003).

## Support

A relationship between support and direct nursing care emerged from the findings. Significant to nursing practice is that when women describe what support felt like for them, they related it specifically to direct nursing care. In most cases, women felt

they didn't receive enough direct nursing support. The idea that pain control is more about professional control than a genuine attempt to support labouring women was raised.

Health care practitioners who work with labouring women where epidural use is common may have lost the clinical skills necessary to support women in coping with labour pain, and may exert subtle pressure in favour of epidurals as a way to ease their own discomfort (Hottenstein, 2005; Mann & Albers, 1997). "How does the nurse provide high-touch physical and emotional care with that much equipment between her and the labouring woman? Equipment that is, by the way, on a normal healthy person doing a normal healthy thing" (Ruhl et al., 2006, p. 63).

Lack of communication, information and instruction emerged throughout all interviews. All participants indicated that good communication and being part of the decision making process is essential to feeling supported and confident. It is essential for information to be offered freely rather than only provided at the request of the labouring woman because she may not be sure what questions to ask, may be too exhausted to ask questions, may feel that she is being demanding, and that she is being a burden to the caregiver by asking questions (Bowers, 2002). It is also important that caregivers assess how much the woman wants to be involved in decision making because some women prefer to delegate decision making to others during labour (Bowers, 2002). Checks and balances must be put into place to ensure that that power is not abused. Health care practitioners have the responsibility to involve the woman in the decision making process while not becoming the decision maker. It is essential that labour nurses work

collaboratively with labouring women in order to create an environment where both voices are recognized and understood (Goldberg, 2003). According to Ruhl et al. (2006), "If a woman feels she was involved, was cared for with respect, had the information she needed to make informed decisions, regardless of how her birth goes, she feels good about it, she feels supported afterwards" p. 65.

Health care practitioners need not be in a position to 'recommend' epidurals, but need to be able to present childbearing women with the pros and cons available. Providing accurate and unbiased evidence-based information regarding the risks and benefits of all pain management options for women in labour will promote informed decision-making and enhance satisfaction with the labouring experience (Florence & Palmer, 2003; Goldberg et al., 1999).

Presence at the bedside is also an important way to convey support, although in today's health care setting, one-to-one nursing care may not always be possible (Bowers, 2002). "If the nurse doesn't believe in the essential nature of labour support, supportive activities quickly go by the way-side in the context of all the other demands on the nurse's time ...one-to-one nursing can become one-to-machine nursing" (Ruhl, 2006, p.63). High touch care should begin the moment the client enters the birth setting. Non-pharmacological labour support should be the initial focus in the management of pain control (Ruhl et al., 2006). Nurses with more labour and delivery experience incorporate labour support into their practice more easily than newer nurses. High epidural rates and less opportunity for experienced nurses to role model labour support skills make it more difficult for new nurses to acquire the skills essential to provide optimal labour support (Ruhl et al., 2006).

Health care practitioners are advocates for patients and have a duty to ensure that manipulation of knowledge, such as omitting or overemphasizing certain information does not occur (Lowe, 2004). Women historically have been attended and supported by other women during labour. A shift away from continuous one-one labour support in hospitals worldwide has occurred and is now the exception rather that the rule (Hodnett et al., 2003).

## Social Perspectives

Women in this study did feel that the use of epidural analgesia to manage labour pain is quickly becoming normalized, routine practice. The issue that labour and delivery is becoming over medicalized was raised by some of the participants but was not supported by most. Many viewed inductions, epidurals, Caesarian sections and other interventions as acceptable norms versus rare exceptions. Few studies were found that further identified and discussed influences that social perspectives have on a woman's involvement in choosing or not choosing epidural analgesia use during their labour?"

## Locus of Control

Allen's McGill Model of Nursing supports the view of Goodman and associates (2003) that a sense of personal control is a strong indicator of maternal satisfaction. This idea was supported by the women in this study and is further supported by two dated but current conceptual frameworks. One is the concept of internal and external locus of control (Rotter, 1966) and the other is the degree of self efficacy one has to carry out a particular action (Bandura, 1977). The findings suggest that the amount of control that a particular woman desires is related to locus of control, which can be either internal or external.

Internal locus of control is often referred to as personal control. Individuals who are driven by an internal locus of control are more likely to meet challenges because they have the belief that they can achieve their goals and that success or failure is influenced by their own efforts, which protects them against submission to authority (Rotter, 1966). Individuals who are driven by external locus of control believe that external influences affect their ability to engage in a particular behaviour and believe that that they are controlled externally by luck, chance or powerful others (Rotter, 1966). Of significance is that women tend to have a more external locus of control than men (Fiori, Brown, Cortina, & Antonucci, 2006). If this is the case, women are more likely to be influenced by suggestive comments referred to in this study as "planting the seed" that they need an epidural. Perhaps there is a belief that powerful others (nurses and physicians) will make better decisions than the women having the experience and, therefore women withdraw from the decision making process following the advice and recommendations of their trusted health care professionals without further exploration and questioning. It also seems that many of the women did not want an epidural but also did not believe that they had the character or fortitude to endure labour without one. This is supported by Bandura's theory of *Self Efficacy*.

The primary concern of labouring women is for the safety of themselves and their babies (Nystedt et al., 2004). The issue of compensation was addressed by some of the participants in this study. Of those that raised the issue, all felt that as long as the ultimate outcome of a healthy baby was achieved, they were willing to compensate for feelings of helplessness, powerlessness and disengagement from their labour and delivery experience.

Individuals confident in their ability to engage in a particular behaviour (i.e., high feelings of self efficacy) believe that they are in control and that their personal beliefs, actions and decisions shape outcomes and goals (Bandura, 1977). High self efficacy is regarded as an important variable to increase performance and overcome obstacles; as well, it determines how much effort will be expended and the length of time that effort will be sustained in order to reach goals (Bandura, 1977). Self efficacy refers to a woman's belief in her ability to perform a task. It is of great significance that participation in decision making enhances women's feelings of efficacy and improves their feelings of satisfaction. Many women indicated that they felt removed from the decision making process. This may have contributed to women's low feelings of self efficacy. It was surprising to me that most women felt like they couldn't get through labour without having an epidural.

It is important to acknowledge that attitudes and behaviours of health care practitioners are powerful influences on the choices women make regarding pain management in labour (Hodnett, 2002). This idea is supported in the findings. Some women expressed that their personal attitudes, beliefs and philosophy surrounding pain management clashed in most cases with that of the health care professionals who remained in control. "We have this elevated opinion of ourselves as providers that we control this event. Often from a medical perspective that's the issue – a desire to get the baby delivered – it's not about the support of the woman and her baby and their process but getting her baby delivered" (Ruhl et al., 2006, p.62).

## Knowledge

A woman's decision in choosing or not choosing epidural analgesia for pain management is influenced by the information and knowledge gained prior to her labour and delivery experience. Most of the participants in this research study reported some attempt to gather information in order to increase their knowledge prior to their labour experience. It is imperative that women are assisted to establish realistic expectations before encountering the birth setting. When woman are aware of what they can expect, they can start to understand the implications of their choices and potentially choose alternative birth settings or caregivers based on acquired knowledge (Ruhl et al., 2006).

## Study's fit to the Conceptual Framework

The results of this study are congruent with the ideas reflected in the McGill model. This health promotion model was chosen for this study, there was a focus generating new knowledge to advance nursing practice and not simply to identify nursing knowledge. Decision-making is viewed as a process that requires active involvement through which families develop and/or learn ways of coping by utilizing their strengths, motivation and resources in order to achieve individual goals. Processes that support specific behaviours though problem solving, information seeking/sharing and decision making are foundational to health promotion (Ford-Gilboe, 2002). This study supports the nursing interventions in relation to the five key and interacting concepts; a) choice; b) support; c) social perspectives; d) locus of control and, e) knowledge identified in the data analysis of this study are significant to understanding women's choice regarding pain management options. The McGill model supports the idea that health is a process in which nursing actions can help promote ownership and consumer choice.

## Limitations of the Study

Limitations are factors over which the researcher has no control or purposely chooses to disregard based on cost or time. Limitations represent potential threats to rigor (Talbot, 1995). Potential limitations to this study are; a) recruitment of a volunteer sample that is fairly homogeneous was obtained, and therefore findings may not be used to provide valuable insights into the experiences around choices for pain management in other segments of the population. Every attempt to achieve a sample of maximum variation was pursued, although this was challenging based on the demographics of women who typically access the *New Mom's Network* groups in the Capital Health Region. To minimize this limitation, the researcher sampled more purposively once the initial participants were recruited in order to insure a more variable sample. However, of the 17 women interviewed, 14 had epidurals for pain management during their labour and delivery. b) The recruitment rate and attrition after demonstrated interest in study participation was thought to be a potential limitation as the target population (new mothers) are adjusting to their new role; however, this was not the case. In order to increase recruitment rates, all the *New Mom Network* groups in the Capital Health Region were to be approached. After speaking to two groups about the study, ample mothers were interested and volunteered for this study. c) The purpose of this study was to gain insights into understanding choice from an individual woman's perspective. It is acknowledged that the experiences of other caregivers and health professionals are not described. d) Women who volunteered for this study wanted or potentially felt a need to share their story about their labour and delivery experience and this study may have presented as a good opportunity for debriefing. e) Every effort was made to safeguard

against the researcher's biases because it was deemed likely that her personal philosophy around pain management could influence what participants were willing to disclose about their own choices. In two instances, women asked the researcher at the end of the interview if she had chosen an epidural for pain management during her labour. Prior to answering the question, the researcher asked if something had been communicated verbally or non-verbally to demonstrate some sort of bias. Both women indicated that they were just curious and didn't feel that the researcher's own feelings and experiences had any significant impact on the interviews. The researcher did respond to the women and indicated that she made a choice not to have an epidural.

## Recommendations

Recommendations as they relate to implications for nursing practice, education and research are presented in the following section. According to the beginning model proposed from concepts that surfaced from the data (choice, support, locus of control, social perspective and knowledge) and related influencing factors emerging from this study (See Figure 1 and 2), it is likely that controlled and tailored strategies to increase support, internal locus of control and self-awareness of individual social perspectives would increase a woman's confidence in her ability to make informed choices surrounding pain management options that best fit with her personal values, beliefs and philosophies. Further research targeted to increase support, internal locus of control and self-awareness of individual social perspectives is needed to test the interrelated concepts and influencing factors identified in this model as they relate individually and to one another.

*Implications for Nursing Practice*

Understanding women's perceptions regarding their involvement in choosing or not choosing epidural analgesia use during their labour can guide the practice of those who provide intra-partum care. In order for health care professionals to enhance the birth experience for women, they must be knowledgeable about which supportive behaviours are helpful to mothers and have the skill to translate knowledge into care that meets the needs, preferences and expectations of labouring women. Nurses, physicians, hospitals, and families would be more likely to value supportive care if they had an increased awareness of the benefits to continuous, direct labour support (Sauls, 2002). It is important to inform women of all the options and programs available to them, so that they can make an informed choice that fits with their philosophy and later avoid potentially needing to defend their needs, their desires, and their right to labour without interventions if they so choose (Ruhl, et al., 2006). It would be of fantastic value if women had the opportunity to interview their primary caregiver prior to their labour and delivery in order to better facilitate care that is supportive of their personal values, beliefs and personal philosophy (Ruhl et al., 2006).

Pain management is an essential role of the intra-partum nurse and necessitates a wide range of both supportive and technical interventions based on patient preference and labour status. Integration of supportive care by providing direct and indirect care interventions may offer the best model for providing high-quality intra-partum nursing care (Miltner, 2002). By focusing on what a woman wants, her birth plan and shifting the balance of power in order to truly be an advocate for the needs of the labouring women, it should be possible to fully support and monitor the technology in the birthing room while

successfully balancing physical, emotional, informational and instructional support. Health professionals have the responsibility to inform women about the risks, benefits and alternatives to epidurals so that women have the opportunity to freely decide what the best choice is for them.

Due to the wide-spread interest in this study, I feel there is a real need and gap in the area of postpartum debriefing. Postpartum debriefing would allow caregivers to fill in the missing pieces in the woman's recall of her experience and is needed to support continuity of care (Ruhl et al. 2006).

Appropriate anticipatory guidance should be provided to assist women in forming realistic expectations of potential labouring outcomes and needs to be the focus of prenatal classes and routine prenatal visits. Prenatal education is one way to provide this anticipatory guidance, however, the information and materials provided should present a realistic picture and be congruent with the philosophy and available resources of the birth setting (Bowers, 2002). Financial compensation for physicians is not currently available for lifestyle and preventative teaching. When funding is directed toward risk monitoring only, then teaching/guidance is likely neglected. Nurses do have the capacity and ability to transfer evidenced based knowledge, which women then can use to make important choices around pain management.

Alternative health care delivery models might decrease the burden the health care human resource shortage has placed on health systems and client care service. Nurses must advocate for their clients by encouraging and supporting partnerships between all professionals and allied health care workers invested in prenatal, labour, delivery and postnatal care. Doulas and midwives working in partnership with nurses and physicians

could be an option if it were publicly funded. That might present the perfect balance between the medical and traditional aspects of labour and delivery. There really needs to be a shift in thinking around health care to better support the needs of the labouring woman and the professionals that support her.

*Implications for Nursing Education*

Understanding women's perception regarding their involvement in choosing or not choosing epidural analgesia use during their labour can guide the practice of those who provide intra-partum education. There needs to be a greater focus in providing student nurses with skills and abilities to provide continuous high-touch labour support. This is needed whether or not the mother has an epidural. It is also imperative to provide regular professional development, in-servicing and performance appraisals opportunities in order to re-ground and educate current intra-partum providers on the basics of labour support. It also needs to be emphasized by nursing educators that labour is typically a normal, developmental event in the life of a family, since most scenarios that students are exposed to reflect catastrophic events that must shape their perception of human labour.

*Implications for Nursing Research*

Little is known about cost effectiveness and women's satisfaction with alternative intra-partum care delivery models. Questions that arose out of this study are; a) Who is the most effective caregiver in providing labour support (i.e. lay person, paraprofessional or professional)? b) What are the costs involved with birthing in a birthing centre where limited intervention is used versus the costs of delivering a baby in a hospital setting where at least one intervention is used? c) Do intervention costs decrease significantly when doulas and midwives are integrated into the hospital as an alternative intra-partum

care delivery model? d) If more direct, continuous interdisciplinary labour support was provided to women, would the rate of epidurals decrease or remain the same?

Gaps identified in what is known about this important topic could be addressed by answering the following questions; a) What pain relief options would women choose if they had a greater range of choices (Leeman et al., 2003)? What are the long-term effects of epidural analgesia on newborn behaviour, breastfeeding, and maternal/infant attachment (Howell, 2004; Leeman et al., 2003; Mansoori et al., 2003; Medves, 2002)? c) What are the direct and unintended costs of epidural analgesia for pain relief in labour versus continuous labour support and other non-pharmacologic pain relief methods (Marmor & Krol, 2002; Medves, 2002; McCrea, 1999)? d) Is there a discrepancy between what women want and what health care practitioners think that they want (King, 2002)? e) Is there an association between childbirth satisfaction and subsequent mothering activities (Goodman et al., 2004)? Although these questions were not explored as part of this research study, it is essential that they be part of a research plan to determine best clinical practice. It is essential that practice be focused on the needs of labouring women and not on those of the health care practitioner or the health care system. Because of the widespread use of epidurals, research in this area must become a high priority for the nursing profession in order to develop best practice guidelines so that they can meet the needs of labouring women and ensure healthy outcomes.

The questions that arouse out of this study and gaps identified in the literature surrounding women's understanding regarding their involvement in choosing pain management strategies can be used to test components of the proposed model. Future research could test components of the proposed model individually or as they relate to

one another. It is hypothesized that research interventions that focus on strengthening women by increasing their: knowledge level, locus of internal control, level of direct support and, individual perception of social norms would increase their belief that they can make informed decisions about the mode of pain management/relief that is right for them during labour.

## Conclusion

The routine use of medical technology, such as electronic foetal monitoring and regional anesthesia, has complicated the role of the intrapartum nurse, requiring complex cognitive, psychomotor, and psychosocial skill to fulfill its technical and interpersonal aspects (Miltner, 2002). Women in labour must be accurately informed so that they can choose pain management strategies that are right for them. Health care professionals and caregivers supporting women during their labour and delivery must understand that the birth experience is not just another day in a woman's life and acknowledge that the labour experience is a unique and important time in the development of women and their families. Information sharing between the client and health care professionals should occur at all stages of the prenatal, labour and delivery and postpartum periods. Increasing opportunities for knowledge transfer may facilitate autonomous and informed decision making regarding pain management options for women in labour. Making informed choices is a continuous and evolving process for women and requires a team approach to ensure that true informed consent is obtained. Health care professionals need to ensure that their personal values and beliefs do not interfere with providing pain management strategies that support individual women's needs, desires and choices for their labour and delivery experience. It is imperative that women are not made to feel that epidural

analgesia is their only 'real' choice to manage labour pain. There is a need to ensure that women are given a genuine and informed choice regarding epidural analgesia and not the illusion of choice.

Five key and interacting concepts; a) choice; b) support; c) social perspectives; d) locus of control and, e) knowledge were identified in the data analysis of this qualitative research study as being significant to understanding women's choice regarding pain management options. The holistic model is circular and three dimensional to represent the complexities yet seamlessness of overriding concepts and influencing factors entailed in understanding choice. No one concept stands alone, or is of more value than another. Together, they create a beginning model that may assist in providing insight to factors potentially influencing a woman's understanding of choice regarding pain management options in labour.

# References

Alberta Human Resources and Employment. (2000, September). *Working alone safely: A guide for employers and employees.* (Publication No. 1827901). Retrieved February 11, 2006, from http://www3.gov.ab.ca/hre/workingalone/index.asp

Alexander, J.M. (2005). Epidural analgesia for labor pain and its relationship to fever. *Clinics in Perinatology*, 32(1), 777-787.

Allan, J.D. & Hall, B.A. (1988). Challenging the focus on technology: A critique of the medical model in a changing health care system. Advances in Nursing Science, 10(3), 22-34).

Anim-Somuah, M., Smyth, R. & Howell, C. (2005). Epidural versus non-epidural or no analgesia during labour. *The Cochrane Database of Systematic Reviews*, 1 (4): CD000331. Retrieved February 05, 2006, from Ovid database.

Bandura, A. (1977). Self-efficacy: Towards a unifying theory of behavioral change. *Psychological Review*, 84, 191-215.

Beech, B. (2003). Challenging the illusion of choice. *Association for Improvements in Maternity Services (AIMS) Journal*, 15(3).
Retrieved February 25, 2005 from Ovid database.

Benner, P. (2000). The roles of embodiment, emotion, and lifeworld for rationality and agency in nursing practice. *Nursing Philosophy*, 1(1), 1-14.

Bethune, L., Harper, N., Lucas, D.N., Robinson, N.P., Cox, M., Lilley, A., et al. (2004). Complications of obstetric regional analgesia: How much Information is enough? *International Journal of Obstetric Anesthesia*, 13(1), 30-34.

Bowers, B.B. (2002). Mother's experience of labour support: Exploration of qualitative research. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 31(6), 742-752.

Brink, P. J. & Wood, M. J. (2006). *Basic steps in planning nursing research from question to proposal* (6th ed.). Mississauga, Ontario: Jones and Bartlett Publishers Canada.

Burns, N. & Grove, S. K. (2005). *The practice of nursing research: Conduct, critique, and utilization* (5th ed.). Philadelphia, Pennsylvania: W.B. Saunders Company.

Carley, M.E., Carley, J.M., Vasdev, G., Lesnick, T.G., Webb, M.J., Ramin, K.D., et al. (2002). Factors that are associated with clinically overt postpartum urinary retention after vaginal delivery. *American Journal of Obstetrics and Gynecology*, 187(2), 430-433.

Chang, Z. M., & Heaman, M. I. (2005). Epidural analgesia during labor and delivery: Effects on the initiation and continuation of effective breastfeeding. *Journal of Human Lactation*, 21(3), 305-314.

Ching-Chung, L., Shuenn-Dhy, C., Hing-Hong, T., Ching-Chang, H., Chao-Lun, C., & Po-Jen, C. (2002). Postpartum urinary retention: Assessment of contributing factors and long- term clinical impact. *Obstetrics and Gynaecology*, 42(4), 365-368.

Corbett, C.A., & Callister, L.C. (2000). Nursing support during labor. *Clinical Nursing Research*, 9(1), 70-83.

Durham, J. (2003). Side effects of epidurals: A summary of recent research data. *International Journal of Childbirth Education*, 18(3), 11-17.

Fiori, K.L., Brown, E.E., Cortina, K.S., & Antonucci, T.C. (2006). Locus of control as a mediator of the relationship between religiosity and life satisfaction: age, race, and gender differences. *Mental Health, Religion & Culture*, 9(3), 239-63.

Florence, D.F. & Palmer, D.G. (2003). Therapeutic choices for the discomforts of labor. *The Journal of Perinatal & Neonatal Nursing*, 17(4), 238-249.

Ford-Gilboe, M. (2002). Developing knowledge about health promotion by testing the developmental model of health and nursing. *Journal of Family Medicine*, 8(2), 140-156.

Gaiser, R.R. (2005). Labor epidurals and outcomes. *Best Practice & Research Clinical Anaesthesiology*, 19(1). Retrieved February 01, 2006, from MD Consult database.

Goldberg, A.B., Cohen, A. & Lieberman, E. (1999). Nulliparas' preferences for epidural analgesia: Their effects on actual use in labor. *BIRTH*, 26(3), 139-143.

Goldberg, L. (2003). In the company of women: Enacting autonomy within the perinatal nursing relationship. *Nursing Ethics*, 10(6), 580-587.

Goodman, P., Mackey, M., & Tavakoli, A. (2004). Factors related to childbirth satisfaction. *Journal of Advanced Nursing*, 46(2), 212-219.

Gottlieb, L. & Rowat, K. (1987). The McGill model of nursing: A practice-derived model. *Advances in Nursing Science*, 9(4), 51-61.

Graneheim, U. H. & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24(1), 105-112.

Hodnett, E.D. (2002a). Caregiver support for women during childbirth. *The Cochrane Database of Systematic Reviews*, 1 (1): CD000199. Retrieved February 25, 2005, from PubMed database.

Hodnett, E.D. (2002b). Pain and women's satisfaction with the experience of childbirth: A Systematic review. *American Journal of Obstetrics and Gynecology*, 186(5), 160-172.

Hodnett, E.D., Lowe, N.K., Hannah, M.E., Willan, A.R., Stevens, B., Weston, J.A., et al. (2002). Effectiveness of nurses as providers of birth labor support in North American hospitals. *The Journal of the American Medical Association*, 288(11), 1373-1381.

Hodnett, E.D., Gates, S., Hofmeyr, G.J. & Sakala, C. (2003). Continuous support for women during childbirth. *The Cochrane Database of Systematic Reviews*, 1 (3): CD003766. Retrieved February 15, 2006, from PubMed database.

Hottenstein, S. (2005). Continuous labor support. *Association of Women's health, Obstetric and Neonatal Nurses Lifelines*, 9(3), 242-247.

Howell. C., J. (2004). Epidural versus non-epidural analgesia for pain relief in labour. *The Cochrane Database of Systematic Reviews*, 1 (4): CD000331. Retrieved January 28, 2005, from Ovid database.

Jackson, A., Henry, R., Avery, N., VanDenKerkhof, E., & Milne, B. (2000). Informed consent for labour epidurals: What labouring women want to know. *Canadian Journal of Anesthesia*, 47(11), 1068-1073.

James, D., Simpson, K., & Knox, E. (2003). How do expert labour nurses view their role? *Journal of Obstetric, Gynecologic, and Neonatal Nursing,* 32(6), 814-823.

Kanna, S., Jamison, R.N., & Datta, S. (2001). Maternal satisfaction and pain control in women electing natural childbirth. *Regional Anesthesia and Pain Medicine,* 26(5), 468-473.

King, T. (2002). Labor pain in the 21$^{St}$ century. *Journal of Midwifery & Women's Health,* 47(2), 67.

Le Ray, C., Carayol, M,. Jaquemin, S,. Mignon, A., Cabrol, D,. & Goffinet, F. (2005). Is epidural analgesia a risk factor for occiput posterior or transverse positions during labour? *European Journal of Obstetrics & Gynecology and Reproductive Biology,* 123(1), 22-26.

Leeman, L., Fontaine, P., King, V., Klein, M., & Ratcliffe, S. (2003a). Management of labor pain: Promoting patient choice. *American Family Physician,* 68(6), 1023-1033.

Leeman, L., Fontaine, P., King, V., Klein, M., & Ratcliffe, S. (2003b). The nature and management of labor pain: Part I. Nonpharmacologic pain relief. *American Family Physician,* 68(6), 1109-1112.

Leeman, L., Fontaine, P., King, V., Klein, M., & Ratcliffe, S. (2003c). The nature and management of labor pain: Part II. Pharmacologic pain relief. *American Family Physician,* 68(6), 1115-1120.

Leighton, B. & Halpern, S. (2002). The effects of epidural analgesia on labor, maternal, and neonatal outcomes: A systematic review. *American Journal of Obstetrics and Gynecology*, 186(1), 69-77.

Lieberman, E. (2004). Epidemiology of epidural analgesia and cesarean delivery. *Clinical Obstetrics and Gynecology*, 47(2), 317-331.

Lieberman, E., Davidson, K., Lee-Parritz, A., Shearer, E. (2005). Changes in fetal position during labour and their association with epidural analgesia. *Obstetrics & Gynecology*, 105(5), 974-982.

Lieberman, E. & O'donoghue, C. (2002). Unintended effects of epidural analgesia during labor: A systematic review. *American Journal of Obstetrics and Gynecology*, 186(5 Suppl Nature), S31-68.

Lincoln, Y.S. & Guba, E. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage.

Liston, R. & Crane, J. (2002). The society of obstetricians and gynaecologists of Canada clinical practice guidelines: Fetal health surveillance in labour. *Journal of Obstetrics and Gynaecology Canada*, 148(1). Retrieved February 08, 2006, from http://www.sogc.org/guidelines/index_e.asp#obstetrics

Littleford, J. (2004). Effects on the fetus and newborn of maternal analgesia and anesthesia: A review. *Canadian Journal of Anesthesia*, 51(6), 586-609.

Lowe, N. (2004). Context and process of informed consent for pharmacologic strategies in labour pain care. *Journal of Midwifery & Women's Health*, 49(3), 251-259.

Mann, O. & Albers, L. (1997). Informed consent for epidural analgesia in labor. *Journal of Nurse Midwifery*, 42(5), 389-392.

Mansoori, S., Adams, S., & Cheater, F.M. (2000). Choice of analgesia in labour on neonatal outcomes, delivery and maternal satisfaction with pain relief. *Clinical Effectiveness in Nursing*, 1(4), 11-19.

Marmor, T. & Krol, D. (2002). Labor pain management in the United States: Understanding patterns and the issue of choice. *American Journal of Obstetrics and Gynecology*, 186(5), 173-180.

Mayberry, L.J. & Clemmens, D. (2002). Epidural analgesia side effects, co-interventions, and care of women during childbirth: A systematic review. *American Journal of Obstetrics and Gynecology*, 186(5 Suppl Nature), S81-93.

McCool, W., Packman, J., & Zwerling, A. (2004). Obstetric anesthesia: Changes and choices. *Journal of Midwifery & Women's Health*, 49(6), 505-513.

McCrea, H. (1999). Satisfaction in childbirth and perceptions of personal control in pain relief during labour. *Journal of Advanced Nursing*, 29(4), 877-884.

McLafferty, I. (2004). Focus group interviews as a data collecting strategy. *Journal of* Advanced *Nursing*, 48(2), 187-194.

Medves, J. (2002). Review: Continuous caregiver support during labour has beneficial maternal and infant outcomes. *Evidenced Based Nursing, 5*(1), 105.

Miltner, R.S. (2002). More than support: Nursing interventions provided to women in labour. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 31(6), 753-761.

Morse, J.M. & Field P. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, California: SAGE Publications Inc.

Morse, J.M., Barrett, M., Mayan, M., Olson, K. & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1(2). Retrieved November 3, 2005, from http://www.ualberta.ca/~iiqm/backissues/1_2Final/html/morse.html

Nystedt, A., Edvardsson, D., & Willman, A. (2004). Epidural analgesia for pain relief on labour – a review with a systematic approach. *Journal of Clinical Nursing*, 13(1), 455-466.

Polit, D. F. (2004). *Nursing Research: Principles and Methods* (7th ed.) Philadelphia, Pennsylvania: J.B. Lippincott Company.

Reilly, D.R. & Oppenheimer, L.W. (2005). Fever in term Labour. *Journal of the Society of Obstetrics and Gynecology of Canada*, 27(3), 218-223.

Riordan, J., Gross, A., Angeron J., Krumwiede, B., & Melin J. (2000). The effects of labor relief medication on neonatal sucking and breastfeeding duration. *Journal of Human Lactation*, 16(1), 7-12.

Rotter, J.B. (1966). Generalized expectancies for internal vs. external control of reinforcements. *Psychological Monographs*, 80, 1-28.

Ruhl, C., Adams, E.D., Besuner, P., Bianchi, A., Lowe, N.K., Ravin, C.R., et al. (2006). Labour support: Exploring its role in modern and high-tech birthing practices. *Association of Women's health, Obstetric and Neonatal Nurses Lifelines*, 10(1), 58-65.

Sauls, D.J. (2002). Effects of labour support on mothers, babies, and birth outcomes. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 31(6), 733-741.

Saunders, T.A., Stein D.J & Dilger, J.P. (2006). Informed consent for labor epidurals: A survey of Society for Obstetric Anesthesia and Perinatology anesthesiologists from the United States. *International Journal of Obstetric Anesthesia*: Jan 21; [Epub ahead of print]

Sherwin, S. (2004). Normalizing reproductive technologies and the implications for autonomy. In F. Baylis, J. Downie, B. Hoffmaster & S. Sherwin (2nd Ed.), *Health Care Ethics in Canada* (pp. 364-375). Canada, Nelson.

Sherwin, S. (1998). A relational approach to autonomy in health care. In Sherwin S. ed., *The Politics of Women's Health. Exploring Agency and Autonomy* (pp. 19-47). Philadelphia. PA: Temple University Press

Simkin, P.P., & O'Hara, M.A. (2002). Nonpharmacologic relief of pain during labor: Systematic review of five methods. *American Journal of Obstetrics and Gynecology*, 186(1), S131-159.

Simpson, K.R. (2003). Labor and birth today: How things have changed. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 32(6), 765-766.

Stafford, S. (2002). Epidurals: A concern for public health? *British Journal of Midwifery*, 10(6), 364-367.

Stemler, S. (2001). An overview of content analysis. *Practical Assessment, Research and Evaluation*, 7(17). Retrieved March 31, 2005, from htpp://PAREonline.net/getvn.asp?v=7&n=17

Talbot, L. A. (1995). *Principles and practice of nursing research* (1st ed.) St. Louis, Missouri: Mosby Inc.

Tobin, G. A. & Begley, C. M. (2004). Methodological rigor within a qualitative framework. *Journal of Advanced Nursing*, 48(4), 388-396.

Torvaldsen, S., Roberts, C.L., Bell, J.C. & Raynes-Greenow, C.H. (2005). Discontinuation of epidural analgesia late in labour for reducing the adverse delivery outcomes associated with epidural analgesia. *The Cochrane Database of Systematic Reviews*, 1 (4): CD004457. Retrieved February 05, 2006, from Ovid database.

# Appendixes

**Appendix A**: Management of Labour Pain

**Appendix B**: Supportive Care

**Appendix C**: Satisfaction with the Experience of Childbirth

**Appendix D**: Decision Making regarding Epidurals

**Appendix E**: Demographic Information

**Appendix F**: Information Letter

**Appendix G**: Sign-up Sheet for New Mom's Network Facilitator to Complete

**Appendix H**: Consent Form

**Appendix I**: Semi-Structured In-Depth Individual Interview Guide

**Appendix J**: Timeline

**Appendix K**: Budget

# Appendix A

## Management of Labour Pain

| Author(s)/Year | Purpose/Research Question | Design | Sample | Conclusions |
|---|---|---|---|---|
| Alexander, J.M. (2005) | To determine whether fever is due to the epidural or the circumstances leading to its administration. | Review | 25 Studies Range of sample size not included | The effects of epidural on maternal temperature are both direct and indirect. |
| Amin-Somuah, M., Smyth, R. & Howell, C. (2005) | To assess the effects of epidural analgesia on the mother and baby, when compared with non-epidural or no pain relief during labour. | Systematic Review | 21 RCT Studies involving 6,664 women | Epidural analgesia appears to be effective in reducing pain in labour. However, women who use this form of pain relief are at increased risk of having an instrumental delivery. |
| Carley, M.E. et al. (2002) | To examine maternal, fetal, and obstetric factors associated with postpartum urinary retention. | Retrospective Case-Controlled Study | 51 | Factors that are independently associated with postpartum urinary retention include instrument-assisted delivery and regional analgesia. |
| Chang, Z. M., & Heaman, M. I. (2005) | To examine the association between epidural analgesia during labour and delivery, infant neurobehavioral status, and the initiation and continuation of effective breastfeeding. | Prospective Cohort Study | 115 | Epidural analgesia has been shown to affect the sucking ability of the newborn; however, it does not appear to be related to the initiation and continuation of effective breastfeeding. |
| Ching-Chung, L. et al. (2002). | To investigate the relationship between various obstetric parameters and postpartum urinary retention. | Observational Prospective Study | 2,866 | Nulliparity, longer labour, instrumental delivery, extensive vaginal and perineal laceration and use of epidural analgesia were contributing factors to postpartum urinary retention. |

| | | | | |
|---|---|---|---|---|
| Durham, J. (2003) | To provide a summary of the most recent data regarding the side effects of epidural analgesia. | Review | 3 Systematic Review Articles Range of sample size 2,708-4,324 women | Side effects of epidural analgesia include: hypotension, maternal fever, increased risk of instrumental delivery, perineal lacerations, fetal malposition, increased neonatal sepsis evaluation and antibiotic treatment, decreased ambulation, urinary retention, longer second stage labour and hyperbilirubinemia. |
| Gaiser, R.R. (2005) | To examine the effect of epidural analgesia on the progress of labour. | Literature Review | 47 References | Epidural analgesia does prolong labour, although the clinical significance of this prolongation has not been shown. |
| Howell. C., J. (2004) | To assess the effects of epidural analgesia on pain relief and adverse effects in labour. | Systematic Review | 11 RCT Studies involving 3,157 women | -Epidural analgesia provides quality pain relief, however, there is evidence suggesting an increase in the length of the second stage of labour, risk of fever, need for oxytocin, incidence of fetal malposition, and use of instrumental vaginal delivery.<br>-Recommended that women need to be counseled about these risks. |
| Le Ray, C. et al. (2005) | To assess whether the station of the fetal head at epidural placement is associated with the risk of malposition during labour. | Retrospective Design | 398 | Epidural placement when the fetal head is still high is associated with an increased rate of occiput posterior presentation and transverse malpositions during labour. |

| | | | | |
|---|---|---|---|---|
| Leeman, L., Fontaine, P., King, V., Klein, M., & Ratcliffe, S. (2003) | To review non-pharmacologic and pharmacologic pain management options for women in labour. | Literature Review and Opinion Paper/ Commentary | 30 References | Although epidural analgesia clearly is a highly effective and popular method of providing labour analgesia, it has significant potential side effects. It is unclear if the high use of epidural analgesia is a true preference among labouring women to manage pain or if it is chosen because it is the only option presented. |
| Leighton, B. & Halpern, S. (2002) | To examine the intended and unintended effects of epidural labor analgesia. | Meta Analysis | 14 RCT Studies involving 4,324 women | Epidural analgesia is associated with longer second labor stages, more frequent oxytocin augmentation, and maternal fever. Epidural analgesia does not affect the rates of cesarean delivery, obstetrically indicated instrumented vaginal delivery, neonatal sepsis, or new-onset back pain. |
| Lieberman, E. (2004) | To examine the evidence regarding the presence of a casual association between epidural analgesia and cesarean delivery. | Literature Review | 62 References | There is a clear association of epidural analgesia with instrumental vaginal delivery and maternal fever. There is still inadequate data to determine the effects of epidural analgesia on cesarean deliveries. |
| Lieberman, E., Davidson, K., Lee-Parritz, A., Shearer, E. (2005) | To evaluate whether epidural analgesia is associated with a higher rate of abnormal fetal head position at delivery. | Prospective Cohort Study | 1,562 | Epidural analgesia is strongly and specifically associated with an increase in fetal occiput posterior position at delivery. |

| | | | | |
|---|---|---|---|---|
| Lieberman, E. & O'donoghue, C. (2002) | To examine the unintended maternal, fetal, and neonatal effects of epidural analgesia used for pain relief in labour by low-risk women. | Systematic Review | 9 RCT Sample size ranged from 20-869 women | There is sufficient evidence to conclude that epidural is associated with a lower rate of spontaneous vaginal delivery, a higher rate of instrumental vaginal delivery, maternal fever, and infants that are more likely to be evaluated and treated for suspected sepsis. |
| Littleford, J. (2004) | To review the effects of maternal anesthesia and analgesia on the fetus and newborn. | Literature Review | 158 References | Epidural analgesia was associated with: longer second stage labour, fetal malposition, instrumental vaginal deliveries, maternal fever, and oxytocin augmentation. |
| Mansorri, S., Adams, S., & Cheater, F.M. (2000) | To examine the use of epidural or no analgesia during labour on neonatal outcomes, delivery and maternal satisfaction with pain relief. | Prospective Cohort Study | 471 -201 women receiving epidural analgesia -206 receiving pethidine -64 receiving no analgesia | Women who had epidural analgesia were more likely to need oxytocin augmentation to progress labour, tended to have longer time in labour and were more likely to have instrumental delivery or caesarean section. |
| Mayberry, L.J. & Clemmens, D. (2002) | To profile the most common side effects associated with the use of epidural analgesia during labour. | Systematic Review | 19 RCT Studies involving 2,708 women | Oxytocin augmentation is likely to be administered after epidural analgesia. Additional research to determine actual outcome benefits with epidurals is needed |

| | | | | |
|---|---|---|---|---|
| McCool, W., Packman, J., & Zwerling, A. (2004) | To review the current knowledge regarding anesthetic and analgesic offered to labouring women. | Literature Review | 51 References | Practitioners have a responsibility to have current knowledge of the best evidence for safety and efficacy regarding pain management options, as well as the skills to effectively communicate information to clients. |
| Nystedt, A., Edvardsson, D., & Willman, A. (2004) | To review the effects and risks associated with the use of epidural analgesia for pain relief in labour and childbirth. | Systematic Review | -24 Studies<br>-Range of sample sizes 64-18,333 women<br>-4 Prospective, randomized trials<br>-7 Non-randomized prospective studies<br>-13 Retrospective studies | The use of epidural analgesia is considered to be an effective method of pain relief during labour however, information about possible associations with adverse effects in mothers and infants must be provided to expectant couples. |
| Reilly, D.R. & Oppenheimer, L.W. (2005) | To determine outcomes and effects of treatment of fever commencing during term labour without prolonged rupture of membranes. | Retrospective chart review | 161 cases<br>16 322 control subjects | Fever during labour is associated with longer labour and use of epidural analgesia. |
| Riordan, J., Gross, A., Angeron J., Krumwiede, B., & Melin J. (2000) | To examine the relationship of labor pain relief medications with neonatal suckling and breastfeeding duration. | Randomized Control Trial | 129 | Labor pain relief medications diminish early suckling but are not associated with duration of breastfeeding through 6 weeks postpartum. |

| | | | | |
|---|---|---|---|---|
| Torvaldsen, S., Roberts, C.L., Bell, J.C. & Raynes-Greenow, C.H. (2005) | To assess the impact of discontinuing epidural analgesia late in labour on rates of instrumental deliveries. | Review/ Meta-Analysis | 5 RCT Studies involving 462 women | There is insufficient evidence to support the hypothesis that discontinuing epidural analgesia late in labour reduces the rate of instrumental delivery. |

# Appendix B

## Supportive Care

| Author(s)/Year | Purpose/Research Question | Publication Type | Sample | Conclusions |
|---|---|---|---|---|
| Corbett, C.A., & Callister, L.C. (2000) | To determine which supportive nursing behaviours are perceived as most helpful to women giving birth. | Qualitative Descriptive Replication Study. | 44 | Regardless of the pain management used, nurses supporting childbearing women must not only be competent technically but also use a high degree of interpersonal skills in proving labour support. Emotional support is a key therapeutic nursing intervention. Supportive care is of equal or greater value than technical care. "Professional knowledge and power need to be supportive, not directive of birthing processes" p.81. |
| Hodnett, E.D. (2002) | To assess the effects of continuous labour support during labour on mothers and babies. | Systematic Review | 14 RCT Studies involving 5,020 women | Continuous labour support reduced the need for pain medication during labour, operative vaginal delivery, caesarean delivery, and showed more favorable maternal views of the childbirth experience. |
| Hodnett, E.D. et al. (2002) | To evaluate the effectiveness of nurses as providers of labour support in North American Hospitals. | Randomized Control Trial | 6,949 | Personal satisfaction with the labour experience was significantly higher for women receiving continuous care; however, it is not likely to improve maternal or neonatal outcomes. |

| | | | | |
|---|---|---|---|---|
| Hodnett, E.D., Gates, S., Hofmeyr, G.J. & Sakala, C. (2003) | To determine whether the effects of continuous labour support are influenced by routine practices and policies in the birth environment that may affect a woman's autonomy, freedom of movement, and ability to cope with labour. | Review/ Meta Analysis | -15 RCT Studies involving 12,791 women | In general, continuous intrapartum support was associated with greater benefits when the provider was not a member of the hospital staff, when it began early in labour and in settings where epidural analgesia was not routinely available. |
| Hottenstein, S. (2005) | To implement a theoretical framework to guide continuous labour practice and understand the necessary theory based interventions to guide nursing practice. | Review | 17 References | "The technical aspects of care become a focus for nurses since the use of epidurals and fetal monitors has increased and become common practice for labour and birth. Research supports the need to have a continuous support person as part of the birth team. Nurses need to be competent in the technology of childbirth, but physical and emotional support of the labouring women are also vital aspects of care" p. 246. |
| James, D., Simpson, K., & Knox, E. (2003) | To examine how expert perinatal nurses view their role in caring for mothers during labour and birth. | Qualitative Descriptive Study. | 54 | Expert nurses were autonomous and made decisions about the management of labour that had the potential to influence a woman's experience. It is possible that the nurses' perceptions of the amount of high-touch, low tech care was not in synchrony with the reality of the busy labour unit. |

| | | | | |
|---|---|---|---|---|
| Liston, R. & Crane, J. (2002) | To define the standards pertaining to the application of fetal surveillance in labour that will decrease the incidence of birth asphyxia while maintaining the lowest possible rate of obstetrical intervention. | Practice Guideline | -12 RCT Studies -Range of sample size not provided | #1 Recommendation: Women in active labour should receive continuous one-to-one nursing support. |
| McCrea, H. (1999) | To examine the influence of personal control on women's satisfaction with pain relief during labour. | Questionnaire-Based Retrospective Study | 100 | Women's satisfaction with pain relief involves feelings of personal control over pain experiences. Emphasis should be on the value of a woman's own coping resources and not on availability of pharmacologic pain management. |
| Simkin, P.P., & O'Hara, M.A. (2002) | To assess the safety and efficacy of 5 non-pharmacologic comfort measures for pain management in labour. Methods included continuous labour support, baths, touch and massage, maternal movement, and intradermal water blocks for back pain relief. | Systematic Review | -38 Studies -Range of sample size not provided | The incorporation of non-pharmacologic comfort measures by health care practitioners into maternity care would benefit mothers and babies by relieving pain, improving maternal obstetric and neonatal outcomes, and enhancing maternal satisfaction. |
| Simpson, K.R. (2003) | To reflect on the reality of being a labour nurse today. | Commentary | 3 References | Labour induction and epidural analgesia management have changed intrapartum nursing practice. A decrease in labour support and increased nurse autonomy has occurred in order to manage labour interventions now available due to increased technology. |

# Appendix C

## Satisfaction with the Experience of Childbirth

| Author(s)/Year | Purpose/Research Question | Publication Type | Sample | Conclusions |
|---|---|---|---|---|
| Florence, D.F. & Palmer, D.G. (2003) | To discuss various types of therapeutic options used for pain management for the relief of labour discomfort. | Literature Review | 42 References | Providing accurate information regarding medications offered to women in labour will promote informed decision-making and enhance the satisfaction of the labouring experience. Health care practitioners must present an unbiased presentation of all pain management options and collaboratively support the client in the choices that achieve a safe labour and delivery. |
| Goodman, P., Mackey, M., & Tavakoli, A. (2004) | To examine multiple factors for their association with components of childbirth satisfaction and with the total childbirth experience. | Correlational Descriptive Study | 60 | Personal control was a statistically significant predictor of total childbirth satisfaction. Helping women to increase their personal control during labour and birth may increase the women's childbirth satisfaction. |
| Hodnett, E.D. (2002) | To summarize what is known about satisfaction with childbirth, with particular attention to the roles of pain and pain relief. | Systematic Review | -137 Reports -The reports included descriptive studies, RCT, and systematic reviews of intrapartum interventions | The more interventions, the more likely it is that some dissatisfaction will be reported. Attitudes and behaviours of health care practitioners are powerful influences on the choices women make regarding pain management in labour. |

| | | | | |
|---|---|---|---|---|
| Kanna, S., Jamison, R.N., & Datta, S. (2001) | To examine how epidural analgesia for labour influences maternal satisfaction in women who initially choose natural childbirth. | Quantitative experimental design | 50 | Pain relief alone was not found to improve maternal satisfaction, 88% of women who requested an epidural for pain reported being less satisfied with their childbirth experience than those who did not, despite lower pain intensity. |
| Marmor, T. & Krol, D. (2002) | To examine which of the theoretically available options for labour pain management are typically provided to women in the US and why. | Literature Review | 25 References | What is clear is that the range of choice available is narrower that the theoretically available options. The reason being that professional training, economic rewards, and the partiality to avoid pain are all elements that support the status quo. |

# Appendix D

## Decision Making regarding Epidurals

| Author(s)/Year | Purpose/Research Question | Publication Type | Sample | Conclusions |
|---|---|---|---|---|
| Bethune, L. et al. (2004) | To assess post-partum women's awareness of the complications of regional analgesia and the level of risk at which they felt these should be discussed. | Quantitative Design | 100 | Awareness of the complications of epidural analgesia ranged from less than 10% to over 90%. The majority of women considered that the benefits of epidural analgesia outweighed each of the potential complications. |
| Beech, B. (2003) | To define standards of choice in the maternity services and to draw attention to research showing how women did not feel in control of their births. | Review of the 9th report on choice in maternity services. | N/A | "We do not believe that simply making tests available is in itself an extension of choice. Testing and screening sometimes inhibit rational choice and sometimes encourage higher levels of intervention" p. 3. For most women, giving birth is a physiological process, not an illness. |
| Goldberg, A.B., Cohen, A. & Lieberman, E. (1999) | To investigate if women's preferences for epidural analgesia in labour have an impact on the use of intrapartum epidural analgesia. | Quantitative Design (use of questionnaires and chart reviews) | 303 | A woman's antenatal plan to receive epidural analgesia is strongly associated with her likelihood of receiving it. Women who plan to receive epidural analgesia have earlier administration. |

| | | | | |
|---|---|---|---|---|
| Goldberg, L. (2003) | To explore the relationship between perinatal nurses and labouring women in connection to autonomy in making decisions regarding their labour experience. | Literature Review | 14 References | Inherent in the concept of autonomy is the view that the birthing woman is competent to make reasonable, informed, and self directed decisions regarding her own birthing experiences, provided that adequate information is presented by the health care practitioner. |
| Jackson, A., Henry, R., Avery, N., VanDenKerkhof, E., & Milne, B. (2000) | To determine what a labouring woman expects to hear about epidural analgesia before consenting, and if she feels able to understand the risks and thereby assess informed consent is truly being obtained. | Prospective Design | 60 | Labouring women are able to give informed consent. |
| Lowe, N. (2004) | To discuss the context of informed consent for pharmacologic pain management. | Literature Review | 16 References | Through the process of informed consent, health care practitioners can assist women in making decisions about pharmacologic interventions for labour pain that are consistent with their goals and expectations for labour and birth. |
| Mann, O. & Albers, L. (1997) | To review if informed consent for epidural analgesia in labour is feasible. | Literature Review | 29 References | Data suggests that recall of risk information may be greater when prenatal discussion has taken place. |
| Saunders, T.A., Stein D.J & Dilger, J.P. (2006) | To determine practices and opinions of obstetric anesthesiologists regarding informed consent for clients. | Pilot quantitative questionnaire-based study | 448 | Despite the painful, stressful circumstances confronted by clients, many respondents (76% in academic, 64% in private practice) thought that women in active labour are able to give informed consent. |

| | | | | |
|---|---|---|---|---|
| Stafford, S. (2002) | To review some of the questions the increased use of epidurals raises and to consider possible practice implications. | Literature Review | 32 References | There are many women who choose epidurals for pain relief in labour. The cost, health and psychological implications of epidurals are significant and these merit further research. |

## Appendix E

### Demographic information

1. Your age in years _____

2. The current age of your baby in weeks _____

3. The gestational age of your baby in weeks at delivery _____

4. Setting where you delivered

- ☐ RAH
- ☐ GNH
- ☐ Mis
- ☐ SCH
- ☐ Home
- ☐ Other

_____

5. Type of pain management received during labour

_____

_____

6. Marital Status

- ☐ Single
- ☐ Married/Common law

7. Education Level

- ☐ Junior High
- ☐ High School
- ☐ Post Secondary
- ☐ Post Graduate

Appendix F

Information Letter

TITLE OF PROJECT: Understanding woman's involvement in choosing or not choosing epidural analgesia during their labour

RESEARCH TEAM: Celine O'Brien, RN, BScN. MN Candidate, Faculty of Nursing, University of Alberta
Dr. Beverley O'Brien, Professor, Faculty of Nursing, University of Alberta.
Dr. Solina Richter, Professor, Faculty of Nursing, University of Alberta
Dr. Jennifer Welchman, Professor, Faculty of Arts, University of Alberta

STUDY SUPERVISOR: Dr. Beverley O'Brien
Faculty of Nursing, University of Alberta
Telephone: (780) 492-8232
E-mail: beverly.obrien@ualberta.ca

INFORMATION SHEET

DETAILS OF THE STUDY:
I am inviting you to take part in a study about the way epidurals are offered to women during labour. I want to talk to new mothers who have given birth vaginally in the last 6 months. If you decide to be in the study I will come to your house or another place that you choose to talk with you. This will take place at a time that is good for you. The talk should take about one hour, with the possibility of a second follow-up interview. Everything you say will be tape-recorded and copied word-for-word so that I can understand your experience.

RISKS/BENEFITS:
No harm should come to you by taking part in the study. If remembering what happened when you were in labour or having your baby makes you feel bad, I will help you find someone to talk to about this. Benefits may include a better understanding about the use of epidurals and informed choice in the Capital Health region.

CONFIDENTIALITY:
If you agree to take part in the study no one will know what you said, all information will be treated with confidentiality, except when legislation requires reporting (for example child abuse). I will not use your name in any spoken or written reports. If the name of anyone is mentioned during our interview it will be removed.

The tapes and written copy of what you say will be kept in a locked cabinet for at least five years after the study is finished. Only my supervisor and I will see these copies. The information you provide may be looked at again in future studies, however, it will first be reviewed by an appropriate research ethics board.

VOLUNTARY STUDY:
You can decide not to be in the study at any time just by telling me. You don't have to answer any question that you don't want to answer.

If you have any concerns about how the study is being conducted, you can contact the University of Alberta Health Research Ethics Board (Panel B) at (780) 492-0302.

Thank you,

Céline O'Brien RN, BScN
Master of Nursing Student
(780) 554-5989
E-mail: celineg@ualberta.ca

Appendix G

Sign-up Sheet for New Mom's Network Facilitator to Complete

| | Name | Phone Number | Address | Epidural Yes/No |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |
| 11. | | | | |

# Appendix H

## Consent Form

| | | |
|---|---|---|
| **Title of Project**: Understanding Woman's Involvement in Choosing or not Choosing Epidural Analgesia During Their Labour: A Qualitative Exploratory Descriptive Research Study. | | |
| **Researcher Information:** | | |
| Principle Investigator: Céline O'Brien<br>Affiliation: University of Alberta, Faculty of Nursing<br>Contact Information: Telephone (780) 634-5638<br>E-mail: celineg@ualberta.ca<br>Co-Investigator/Supervisor: Beverley O'Brien<br>Affiliation: University of Alberta, Faculty of Nursing<br>Contact Information: Telephone: (780) 492-8232<br>E-mail: beverley.obrien@ualberta.ca | | |
| **Consent of Participant/Informant** | | |
| | **Yes** | **No** |
| Do you understand that you have been asked to be in a research study? | | |
| Have you read and received a copy of the information sheet? | | |
| Do you understand the benefits and risks involved in taking part in this research study? | | |
| Have you had an opportunity to ask questions and discuss the study? | | |
| Do you understand that you are free to refuse to participate or withdraw from the study at any time without any penalty? You do not have to give a reason. | | |
| Has the issue of confidentiality been explained to you? | | |
| Do you understand who will have access to your information? | | |
| Would you like a written report of the research findings? | | |
| Do you agree that this information can be used in future research? | | |
| **Signature:** | | |
| This study was explained to me by: _____<br>Date: _____ | | |
| I agree to take part in this study.<br>Signature of Research Participant: _____<br>Printed Name: _____ | | |
| Witness (if available): _____<br>Printed Name: _____ | | |

# Appendix I

## Semi-Structured In-Depth Individual Interview Guide

1. When you were pregnant, what did you know (or understand) about how to deal with labour pain?

   Prompts:
   -What were your ideas around pain management for labour?
   -What did you know about epidurals?
   -What would you have liked to have known?
   -Where did you hear about epidurals?

2. Tell me about your satisfaction with pain control during labor? What pain control did you use?

   Prompts:
   -If you had or did not have an epidural, please describe your level of satisfaction with your decision?
   -How much choice do you feel you had with your decision to have (or not have) an epidural?

3. Tell me how the topic of pain management/epidurals was introduced?

   Prompts:
   -Tell me about how the risks and benefits of epidural analgesia were provided?
   -Tell me how easy/difficult the information about epidurals was to understand?
   -In what ways could the information about epidurals have been provided to make it easier for you to understand?
   -Do you feel you had enough information to make an informed choice regarding having or not having an epidural for pain management in labour? If yes how? If no how?
   -What was the deciding factor in your final decision to have (or not have) an epidural?

4. Tell me about any complications in your labour/delivery/ early post partum experience?

   Prompts:
   -What do you think caused the complications?

5. Looking back on your labour and delivery experience is there anything you would have changed in regards to pain management?

## Additional Prompts

1. Can you tell me more?
2. Can you be more specific?
3. I'm not sure I understand can you clarify?
4. Can you give me an example?

Appendix J

Timeline

| **Task** | **2006** | | | | | |
|---|---|---|---|---|---|---|
| | May | June | July | August | September/October | November/December |
| Proposal Defense | | | | | | |
| Ethical Review/Approval | | | | | | |
| Sample Selection | | | | | | |
| In- Depth Interviews | | | | | | |
| Transcription of Interviews | | | | | | |
| Data Analysis | | | | | | |
| Write-up | | | | | | |

# Appendix K

## Budget

| Supplies | | $ Cost | |
|---|---|---|---|
| | Stationery | $ 55.00 | |
| | Notebook for field notes | $ 2.00 | |
| | Filing Cabinet | $ 65.00 | |
| | Ink Cartridge | $ 40.00 | |
| | | | |
| Equipment | | | |
| | Computer | $ 0.00 (own) | |
| | Digital Tape recorder | $ 150.00 | |
| | | | |
| Personnel | Transcriber $17.50/hr x 35 hrs | $ 612.50 | |
| | | | |
| Travel | Mileage to participant homes | $ 120.00 | |
| | | | |
| Total Cost | | $ 1044.50 | |