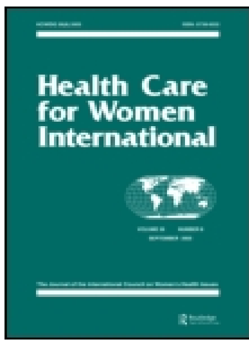

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Perception of Humanization of Birth in a Highly Specialized Hospital: Let's Think Differently

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Our goal for this article was to identify the perceptions of health care professionals, administrators, and women concerning the humanization of childbirth care in a tertiary hospital. A single-case study design and a qualitative approach were used. We collected data through semistructured interviews, participant observation, field notes, and a questionnaire. The humanization of birth in a tertiary hospital is identifiable by several key characteristics such as personalization, recognition of women's rights, human caring, women's advocacy and companionship, and a balance between medical care and comfort, safety, and humanity.

Researchers have focused on the concept of humanization of birth in normal pregnancy cases or at low obstetric risk, but to our knowledge, they have not yet specifically focused on the humanization of birth in both high-risk and low-risk pregnancies in a tertiary hospital. Women undergoing a high-risk situation have more difficulty coping with their diagnosis and thus the humanization of care in high-risk pregnancy cases should go beyond simply curing women of their illness. One can question the nature of care that is sought by women confronted with a high-risk pregnancy or labor. Can the humanized birth care approach, as defined in the literature, apply to

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their case? What kind of care would women with complicated or without complicated pregnancies or deliveries expect in a highly specialized hospital? What are the perceptions of health care professionals and administrators toward humanized birth in such an institution? Our present study attempts to answer all these questions, while contributing to the development of previous knowledge regarding the characteristics of humanized childbirth.

Technology and scientific development have provided tremendous advances in the quality of obstetric care. The evolution of modern obstetrical practice, including the ready availability of caesarean section, has resulted in a reduction in maternal and perinatal mortality and morbidity (Castro & Clapis, 2005). The excessive use of medical interventions and operative births without evidence-based indications, however, has resulted in iatrogenic morbidity and contributed to dehumanization of care (Villar, Valladares, & Wojdyla, 2006).

In tertiary hospitals, the physical environment is typically equipped with machines that controll blood pressure and monitor fetal heart rate and contractions. This supposition shapes in the human mind that care might be generally more medicalized, and less humanized, in both low and high-risk pregnancy cases. The typical childbirth experience in the United States has been transformed into a technocratic birth in which healthy women are immobilized by wires, tubes, and machines (Masciale, 2006). When machines are used during both low- and high-risk birth, are clients treated as objects of technical intervention and are the individual's psychological care given less importance?

In the context of a tertiary hospital, significant proportions of pregnancies are at increased risk and require special attention. Previously, researchers argued that the barriers to providing effective psychosocial adjustment for high-risk pregnancy women in intensive care units include hospital policies and procedures, technology-focused care, inadequate staffing, and a lack of continuity of care (Campbell & Rudisill, 2006). They also note that women on bed rest experience an increase in stress, loneliness, boredom, and a feeling of powerlessness (Maloni & Kutil, 2000), and that hospitalization often leads to a loss of autonomy and control, as well as an increase in women's sense of dependency on medical interventions.

A lack of privacy, together with feelings of guilt, helplessness, depression, and anxiety, have been shown to contribute to psychological problems in women who are at obstetric risk (Campbell & Rudisill, 2006; Richter, Parkes, & Chaw-Kant, 2007). Providing care for a high-risk pregnant woman can present both challenges and opportunities for care providers accustomed to caring for these women (Campbell & Rudisill, 2006; Leon & Knapp, 2008; Soeffner & Hart, 1998). Nevertheless, although care providers are often aware of the psychosocial problems faced by women with high-risk pregnancy and their difficulties coping, sensitivity to the severity of these problems is often lacking (Maloni, 1998).

The humanization of childbirth is considered a complementary or alternative model to the medical and technocratic model of care (Castro & Clapis, 2005). The researchers' findings are quite diverse on the concept of humanized birth; however, most of them described it as respect toward a woman's values, culture, beliefs, dignity, as well as desire for control over her childbirth to allow for her contribution regarding the decisions of what happens to her and her baby (Deslandes, 2005; Kuo, 2005; Page, 2000; Umenai & Wagner, 2001). Misago and colleagues defined the humanized birth as a "safe and satisfied birthing experience" (2001). A women-centered care approach is considered a key concepts of humanized birth care (Jones, 2002; Misago, et al., 2001; Page, 2000; Umenai & Wagner, 2001).

Lindsay (2006) introduced the humanized birth approach in high-risk pregnancies. She emphasizes promoting the mother's psychological and physical well-being, giving her confidence in her abilities as a woman and as a mother in identifying her personal perception of risk, coping mechanisms, and exploring her personal feelings about her baby as well. This approach also aims to provide continuity of care and support during pregnancy and all the way into the postnatal period (Lindsay, 2006). There is little research, however, on the concept of humanized birth in high-risk pregnancies, and no research seems to have been published about tertiary hospitals on this issue.

Presented with the fact that each professional, each team, and each institution has, on the concept of humanization of care, its unique definition, and even philosophy, it was necessary to gain a thorough understanding of humanized birth care in a tertiary hospital. Once the perception of the concept of humanized childbirth has been acknowledged, practice can eventually change accordingly to enhance the quality of maternity care.

Our purpose for this article therefore is to identify the perceptions of professionals, administrators, and women, on the humanization of childbirth care in one particular tertiary hospital to identify the factors that might have hindered the implementation of such care in these hospitals.

METHOD

Study Design, Setting, and Participant Sample

For the purpose of our present study, a single case study design was chosen. Such design is used to facilitate exploration of a phenomenon and ensures that the phenomenon is explored through a variety of lens within its context using a range of data sources (Yin, 2003). The case under study was a tertiary university affiliated hospital in Montreal, Canada. Comparing with level 1 or level 2 hospitals, tertiary hospitals have the necessary equipment and staff required to manage very complicated births, including those with a risk of serious illness or abnormality requiring intensive care for the mothers or the

newborns. The tertiary hospitals also offer care to uncomplicated pregnant women.

The chosen hospital was part of the Mother and Children's Network of Quebec, with 450 beds including 30 beds at the Intensive Care Unit (ICU). The hospital was receiving 19,000 in-patients yearly. The childbirth rate was about 4,000 per year, and almost 40% of all pregnancies were complicated.

The sample in the study consisted of the following (a) professionals: six nurses, three obstetricians, one pediatrician, and one anesthetist; (b) six administrators from different hierarchical levels of the hospital, including executive management of client programs, quality and risk management, management of clinical services, and management of nursing care; and (c) 10 primipara and multipara women.

The professional and administrative participants were intentionally chosen from different disciplines with varied levels of work experience. The women participants were purposefully recruited to the study to obtain a broad diversity in pregnancy and delivery types. To be included, the women had to be 18 years or more, be hospitalized in the first stage of labor or planned to have cesarean section in the same day of hospitalization, have single or twin pregnancies with or without history of medical complication during pregnancy, and, finally, be able to speak, read, and write in French or English.

Data Collection

Ethical approval was obtained from the Health Research Ethics Boards of a Hospital affiliated with the Université de Montréal (IRB-2549). Informed consent was obtained from all the voluntary participants. The data were collected by the investigator who was a doctoral candidate with a background in midwifery.

Most of the data were collected through in-depth, open-ended, semistructured interviews with the participants. Interview guides were initially used during separate interviews with two professional nurses and two women in birthing centers and were pretested and validated before being used in this study. Meanwhile, the interviews were transcribed, and then transferred into QDA Miner (version 3.2.3) for analysis. After reflection on preliminary data collection from those four interviews, and identifying strengths and weaknesses of questions, we reviewed the initial interview guides with two investigators for further probing of the data.

The data-collection period spanned November 2007 to March 2008, and it continued until a sufficiently rich description of the concepts under study was achieved. "Theoretical saturation, in effect, is the point at which no new insights are obtained, no new themes are identified, and no issues arise regarding a category of data" (Strauss, 1990).

Collected data regarding health care professionals and administrator participants. The interviews were 40 to 90 minutes in duration. We conducted all interviews in French and later translated into English for publication. To validate the translations, the translator translated the English versions into French to be sure about their accuracy. We performed and audio-taped the interviews with the participants' consent.

The main questions that we addressed to the professionals and administrators during their interview were the following: Could you please explain your definition of humanized care? Do you have any specific philosophy in this hospital regarding humanized childbirth and care? What are your opinions on the subject of humanized care in high-risk pregnancy cases, as well as low-risk pregnancy cases in this hospital? What do you consider to be a barrier or facilitator for humanized birth care regarding high- and low-risk pregnancies in this hospital?

Collected data regarding women participants. After having the care provider's permission, the investigator approached the women in their labor and/or in preoperation waiting room; she explained the project and invited them to participate. All the participant women were asked to carefully read and voluntarily sign the consent form in which they allowed the investigator to be present as a participating observer during their labor, delivery, and the first few hours of postpartum. Moreover, the participant women did consent to participate in a semistructured interview within 24 to 72 hours of birth and filled out a self-administered questionnaire. Only after having a woman's consent, the investigator had permission to attend the labor and delivery to fill out an observation sheet and provide the field notes. In case there was a cesarean section, the investigator attended in the operation room from the beginning of the preparation for operation to the childbirth.

We conducted all interviews with the participant women at their beside in the postpartum unit, at the hospital, at a time that was convenient for both women and their families. To understand the way birth is experienced by women and also the beliefs and values that exist around birth, the women were asked some questions about their needs and values (e.g., value a natural birth or medicalized birth, technocratic model of birth or naturalistic one) and their expectations from the specific hospital that they chose to be their birth setting. The main questions that the participant women were asked were the following: Could you tell me about your personal experience during pregnancy and delivery? Do you have any specific values or preferences regarding the childbirth practice of this hospital?

We then requested that all the interviewed women (10) fill out a self-administered questionnaire during their postpartum stay and return it back to the investigator before their discharge. The self-administered questionnaire that we used had been developed in the context of a study that assessed midwifery practice in Quebec, comparing it with the standard obstetrical care provided in the province (De Koninck, Blais, Joubert, & Gagnon, 2001).

The questionnaire was adapted for the needs of the present study and was written in both English and French. The questionnaire encompassed 94 open and closed questions, including questions about the obstetrical care received during the perinatal period, as well as the sociodemographic questions. The questionnaires were used later for triangulation of data.

Data Analysis

As a whole, we audiotaped and transcribed 27 interviews. The field notes were also entered into a qualitative software. Inductive content analysis was performed in this study. In inductive analysis, the themes are strongly linked to the data themselves (Patton, 2002). The main investigator proceeded from understanding the generalized meaning of the participants' answers, marked them by codes that provided a pattern of simple meanings, and reordered these simplified codes into new themes and subthemes that highlighted the essential description and perception of the interviewees regarding humanized birth. We performed the content analysis first for a random sample of seven interviews. After an 8-week interval, the same samples of interviews were recoded by the same investigator to achieve an intracoder reliability coefficient. To obtain a reliability coefficient, the authors used the simple following formula:

$$\frac{\text{\# of Interviews coded the same by A in the 1st and 2nd coding}}{\text{\# of Interviews coded by A in the 1st coding}}$$

The intracoder reliability coefficient was shown to be 0.80 or higher for all the samples. In our study the various sources of evidence were complementary to a good case study; since they could help us to deal with the problems encountered in establishing the validity and reliability of case study evidence. We were able to perform a triangulation of the data sources, from interviews, field note, observation, and questionnaires, which deepened the understanding of the concept under study as well as reduced the chance of bias.

To ensure that the data analysis in this study was thoroughly systematic and valid, all the tapes recorded, interview transcripts, and matrices were examined several times. The investigators also discussed the accuracy of the data as well as the coding logic to be sure that the code system was in fact accurately measuring what the investigators wanted to measure.

A coding consistency and its recheck was done many times, and new codes were added since the original consistency was checked. The investigator examined and reexamined the codes for withdrawing themes, which may reveal actual analytical messages of the regularities and relationships

between the codes. We redefined systematically the category system to reflect the purpose of the content analysis.

RESULTS

The participant professionals' mean age was 44 years, and they range 23 to 56 years. Four had a bachelor's degree, one a college diploma, and one a master's degree in nursing. Of the other five, three had an MD, and two had an MD and a PhD. The mean age of the administrators was 49, with a range from 38 to 60. Of these, four had a master's in science, one a bachelor's degree, and one a graduate diploma in health care administration. Two of the administrators had a background in nursing. The sociodemographic and obstetrical characteristics of the women are shown in Table 1.

TABLE 1 Sociodemographic and Childbirth Characteristics of Women Participants

Characteristic	*N*(10)	Characteristic	*N*(10)
Age		Complication during pregnancy	
Minimum	22	Twin, hypertension, preterm labor	1
Maximum	40	Diabetes	1
Mean	31.4	Incompetent cervix	1
Nationality		Fibroma	1
American citizen	4	High-risk pregnancy	
Canadian French citizen	4	Yes	4
European citizen	2	No	6
Education		Onset of labor	
Secondary	1	Not started	1
College	3	Spontaneous	2
University/college	6	Induced	7
Marital status		Mode of delivery	
Married	5	Vaginal	7
Single	1	Caesarean section	2
Conjoin	4	Operational vaginal delivery	1
Job		Epidural analgesia	
Yes	5	Yes	7
No	5	No	3
Annual family income		Electronic fetal monitoring (EFM)	
Less than $20,000	2	Yes	9
$20,000 to $49,000	2	No	1
$50,000 and over	6	Reason for caesarean	
Number of deliveries		Failure in progress of labor	
One	6	Planned caesarean for fibroma	1
Two	3	Complication during labor or delivery	1
Three	1	or postpartum	
History of previous caesarean		Yes[1]	1
Yes	0	No	9
No	10		

[1]Third degree laceration.

TABLE 2 Overview of Themes and Categories Regarding Perception of Humanized Birth

Themes	Categories
Personalized care	• Care that is tailored for and responds to women's needs
Recognition of women's right	• The right to choose and participate in the decision-making process; • Women's right in high-risk pregnancy
Humanely caring	• To have a more human manner • Good communication as a humanistic approach
Family centered care	• Involvement of whole family in care
Women's advocacy and companion	• Comprehension and support • Companion and continued support
Compromise between medical care and security, comfort, and humanity	• A secure, confidential, and assuring environment • Comfort and humanized care • Prioritizing saving lives over humanized care

Humanized birth care is identifiable by several key characteristics: personalization; recognition of women's rights; human caring; family centered care: women's advocacy and companionship; and a balance between medical care and comfort, safety, and humanity (Table 2).

Personalized Care

Care that is tailored for and responds to women's needs. The obstetricians stated that the care provider's speech, approach, and care should be adapted to each person. They perceived personalized care as "a care that is tailored to the needs and expectations of the individual":

> *Prof 8:* Having a human approach for me is to consider the other person, and all the differences and peculiarities which are connected with this particular person, a human being. (*Obstetrician*)

The professional and administrator participants concurred that care provision should be adapted to women's desires and should meet both their physical and spiritual needs. According to a nurse professional, to have humanized birth, all the bio, psycho, social, and cultural dimensions should be considered. When it came to high-risk pregnancies, administrator participants expressed that care should be even more personalized regarding these individuals, and the specific needs of a person facing such difficulties:

> *ADM4*: I do not put all patients who experience a high-risk pregnancy in the same group at all. Every woman, every family is different. . . . So it is us that should adapt to all and respond . . . but at the same time, not give the same thing to everyone and really adapt to the needs of families. (*Administrator*)

The analysis of women's narratives showed that nine of 10 interviewed women qualified the received care as a personalized or very personalized one.

Recognition of Women's Rights

The right to choose and participate in the decision-making process. Administrators, professionals, and women with high and low-risk pregnancies perceived the humanization of birth as reception of care that includes dignity and respect, and that also considers women's right to choose and participate in the decision-making process. An administrator described humanized birth as "defending women's rights to control her body, to relieve pain, to give birth according to her wishes" (ADM1). Both women at low and high-risk emphasized the importance of making the decisions by themselves, as well as being heard:

> *Parturient 1*: It needs to respect the woman, if she does not want drugs or medication, it is perfect, and we respect her decision. If she wants them, perfect, she is respected as well. Her needs are really her needs, because she experiences all. (*Woman at high-risk*)

Despite the belief that humanized care included women's right to control their bodies, women did not in fact always benefit from that belief. For instance, no woman had a choice regarding the place to give birth; only one had a choice about the birth position. Wherever it was possible, however, the women were still being respected in their choices. Moreover, three of 10 women interviewed did not participate in every decision being made.

The findings also showed that it was the care providers who proposed most of the choices, and that, sometimes, they were quite directive. Some women felt that they were under too much pressure to start breastfeeding in the early moments after giving birth. A low-risk woman complained that her nurses did not let her adapt to the new situation and put pressure on her or her baby to have breastfeeding at small intervals.

The spouse of one of the low-risk women mentioned that the physician did not spend enough time describing procedures or assuring his wife before making the right decision about an epidural. He complained that the physician put his wife in a position to choose an epidural too early. Even though the epidural method of relieving pain was strongly suggested by care providers, however, not all women would have chosen it and care providers respect their choices:

> *Parturient 5*: I did not want to do it, so they left and they accepted my decision because I wanted to leave it normally, as it must be natural. I can give birth naturally with the pains that come with it. We have accepted the situation, and we must pass through it. (*Woman at low risk*)

Women's rights in high-risk pregnancy. Women at high-risk needed to share their choices and decisions with a familiar and trusted care provider. Lack of transparency in providing knowledge to a high-risk woman was considered as a barrier to humanized birth:

> *Parturient 6*: They were hiding the truth from me and it made me so angry. I thought that if they told me everything, and allowed me to decide about my own situation, I would have been happier and more satisfied. (*Woman at high-risk*)

The other high-risk woman said that she would like to participate in the decisions that must be taken, whilst keeping her privacy and boundaries respected by professionals in a perfect way. Nevertheless, not all the participants agreed with full decision-making rights for the women where a high-risk pregnancy was involved. The anesthetist professional restricted the decision-making right to women who do not have a high-risk pregnancy or particular problem.

An administrator stated the following:

> *ADM2:* In my opinion (in high obstetric risk) there is not enough room for choice and humanized care. Even mothers feel they lose control or hand over control to the experts. So, it looks like the couple abandons the desire a little bit in a way to put things in the hands of the experts for the well-being of the infants. (*Administrator*)

Humanely Caring

To have a more humane manner. Most of the participants at the studied hospital perceived humanized birth care as an optimum caring of women and their families. Some of the recorded sentiments on humane caring included the following: "a warm and intimate contact"; "attention"; "physical contact"; "an adaptive care toward the family as if they were our mother, or our father, or sister"; "caring for the individual and the family who are in front of us"; "taking care of someone when you hear her in her full definition"; "providing humanized care for someone"; and "when one forgets oneself and thinks of others." The women participants in this study experienced humanization of birth as a certain kind and gentle behavior shown by professionals who assist them during labor and delivery:

> *Parturient 2*: Women need someone human, someone who has a heart, a certain gentleness, someone who knows how to behave. It's like a psychologist; she chooses words to relieve us, despite our pain. ... It makes you calm, it makes you smile, it gives you a sign that she really is there to help. (*Woman at low risk*)

Nursing professionals stated that humanized care manifests itself in the nurses' attitude, behavior, and even gestures and words. Obstetricians particularly experienced humanization of birth care as a dimension of care rather than a technical or robotic one. With regards to high obstetric risk women, professionals mentioned that everything depends on how the care providers act, and how they could adapt the medical dimension of care to one with a more humanistic approach for high-risk pregnancy cases.

Good communication as a humanistic approach. Almost all the professional participants concurred that having good communication with the women and their families, and explaining to them the interventions that they are about to undergo, would largely facilitate humanized birth care, especially in high-risk pregnancies:

> *Prof 10:* I explain what happens during an epidural, how they will feel when they go into labor. ... I will reassure them when patients are not adequately relieved, I'll explain why, what happens inside them, why they have pain, what we can do for them. When there are caesarean sections, I will explain what happens. (*Anesthetist*)

The humanization of birth in tertiary hospital is perceived as a way to deal with the modern technology while being able to keep an interpersonal relationship and good communication between care providers and women. According to professionals' descriptions, providing enough explication about every medical intervention and having women's informed consent before applying any invasive monitoring make medicalized inseparable from humanized aspects of care at birth. In general, obstetricians concurred that having good communication and mutual respect between care provider and women leads to achieve the goal of humanization at birth in tertiary hospitals. They emphasized the importance of communication whether for the announcement of bad news or the management of patients with particular problems.

Both women with low- and high-risk pregnancies emphasized the importance of receiving information and explanations during labor and delivery as a factor of humanized care. Most of the women participants mentioned that they received explanation about the prescribed tests and the ongoing interventions and most of them described the information as complete and clear. They believed that medical procedures are better justified when information is communicated:

> *Parturient 1*: I also believe that humanization involves allowing someone who may be unfamiliar with the human body to understand what is going on and be able to make the right decisions by oneself. (*Women at high-risk*)

Family-Centered Care

Involvement of whole family in care. The humanization of birth was considered as family-centered care where the integration, collaboration, and cooperation of the concerned family are institutionalized by means of discussions with the parents and their involvement in decisions and care of their baby. One of the administrators mentioned the specific needs associated with the integration and major involvement of families in child care. He emphasized that a focus on families has proved to be a very helpful approach toward the achievement of humanized birth care not just in maternity care, but also in pediatric care:

> *ADM5:* I think they (parents) want to understand what happens to their child, as well as observe and ask questions. When parents are involved with the care they receive, it diminishes all the stressors. (*Administrator*)

According to the professionals and administrators, it is necessary to adapt to the rhythm of the family and respect them in their journey. This is defined as working with the family's goals in mind and respecting their beliefs and philosophy in life:

> *Prof3:* This is not just about being a person who dictates what will be done with the woman, but it is also about working with them according to their beliefs and desires, as well as their routine. To me, that is humanization. (*Nurse*)

The family-centered care approach was considered even more important by the administrator and professional participants when dealing with high-risk pregnancy cases. They explained the importance of adopting different protocols and guidance rules whilst dealing with each family.

The expressions such as,: "being at the center of our concerns," "welcoming parents to be there," "being included in the care," "being able to be with the baby throughout all the assessments," "being included in the decision making," and "having their concerns listened to" were mentioned by most of the participants; however, "family-centered care" was the issue least raised by women participants. For some women and professionals, sharing responsibility and empowering the family were perceived as form of humanized care. A husband of a woman at high risk stated his experience:

> My involvement in care has become an experience for us. She must continue bed rest (at home). This allows the fathers to be educated quickly, to do all the things needed. I'll also be able to help mother at home after. For me, this is much more humanized care.

Women's Advocacy and Companionship

Comprehension and support. The women participants' perception of humanized birth focused more on comprehension and emotional support. Their perceptions of humanized birth were such as "feeling understood," "feeling surrounded," "feeling empathy," "assistance or support," and "women's advocacy." The low-risk and high-risk women stated humanized care as having a staff member on their side throughout the labor who understand and support them, either morally or otherwise. Professionals expressed the fact that women in high-risk pregnancy needed more sympathy and support:

> *Prof10*: I think there is a sense of guilt for those who have experienced epidurals, or those who need a caesarean. I think women would like to give birth as naturally as possible. When things do not happen that way, they think it's their fault, they take it personally, and the people here need to ensure them that they should not feel like that, this happens often. (*Anesthetist*)

Companionship and continued support. Some of the nurse health care participants conceptualized humanized birth as "being with the woman, being present, ability to be with the family, and being available on demand." The lack of continued emotional and physical support caused one of the women participants to make the decision to have an epidural analgesic during the early stages of labor.

Women participants did appreciate it when the nurses were present more for company, rather than just being called for services each time. A woman at low risk explained her experience of the first phase of labor: "I thought we were a little lonely me and my husband, because the nurse was not there all the time."

Almost all the observed labors by the investigator were going the same way, and the women were told by the nurses that they could call for anything at any time, but they were not present continuously during labor. During active labor, however, the nurses were always nearby. Some of women participants in this study expressed feeling abandoned by nurse and experienced stress when they had to wait until their nurses came to their room:

> *Parturient 5*: They were still there, but it's not the same as having someone by your side, I do not know how it happened for the others, but it was always like that. When I rang, however, she came. She still took time to come, but she came anyway. (*Woman at low risk*)

Another woman stated:

> *Parturient 7*: I was with my husband; I felt a pressure on my rectum and vagina, a very intense pressure, it was painful. . . . There was no interval

> time between the 2 or 3 minutes contractions. At this moment, I pressed the button to call the nurse. I checked the monitor for tension. . . . The baby's heart beat was going up too much. It exceeded 160, and I got worried, a little panicked. (*Woman at low-risk*)

Another low-risk woman stated that it would have helped if the nurse had been there throughout the first stage of labor. Moreover, she stated that the presence of a knowledgeable and experienced nurse gave her a higher sense of security, assurance, and support than did her husband's presence:

> *Parturient 3*: My husband and I would not talk the same way because we know each other, unless it promotes relaxation. It would prove more relaxing, however, to talk to someone who has already experienced childbirth and who is used to giving advice. (*Woman at low risk*)

A Compromise of Security, Comfort, and Humanity

A secure, confidential, and assuring environment. Providing a safe and secure environment for women was described as humanized care by some of the professional and administrators. One of the administrators emphasized that the presence of technology and competent professionals is not only a convenient factor, but, in fact, it is a kind of humanized care, since it saves lives and thus brings reassurance to women:

> *ADM3:* Is she feeling reassured? Does she have confidence in me? Does she feel good? All this is what makes it humanized care. . . . .When we are providing health care, even if we use a lot of technology, the women still say that they feel safe, confident. (*Administrator*)

The anesthetist participant expressed the fact that a humanistic approach regarding a high-risk pregnancy involves the presence of an expert or experienced care provider around woman during labor and delivery to bring more assurance and security to her. Being in a tertiary hospital and being assured by a competent professional was perceived as the ultimate idea of birth care and humanized birth for both the women participants at high and low-risk!. The women participants did not feel anxious about the outcome of the pregnancy or the baby's safety. For the high-risk pregnant women, it was important to be surrounded by experts and competent professionals, as they felt if anything happened to their baby, they had a specialist with them and no need to transfer the child:

> *Parturient 10*: Feeling safe in the operations that occur, because so many things can happen. It can move quickly, it can go well, it can go badly,

> and it can be complicated. At the same time, we know we're in the right place for all eventualities; that's how I felt. (*Woman at low risk*)

Two women at high-risk stated that the use of technology and high monitoring was reassuring as it eliminated their uncertainty and answered their questions about the baby's safety:

> *Parturient 6*: I heard the heartbeat, I felt no movement in my belly, but I heard the heartbeat, so I knew somehow that all was going well". (*Woman at high-risk woman*)

> *Parturient 4*: We had ultrasounds every two weeks. We knew there was no problem with them (twin babies), so that was reassuring. That meant that I had fewer questions, since we really followed the development from week to week. We were reassured. (*Woman at high-risk*)

Comfort and humanized care. Seven out of 10 women received epidural analgesia. Four out of seven reported some disadvantages, such as feeling pain during the injection, numbness on one side of their body, and the need to repeat the injection twice. Dizziness, lack of control during contractions, and second- and third-degree lacerations were also reported. Most of the women, however, were satisfied with the consequences of the epidural as it meant pain relief.

Observations of labors showed that most of the women were calm and relaxed and even fell asleep between contractions. Some women were talking with companions; one was even watching a movie with her husband. The women's childbirth experiences are shown in Table 3. Most of the women who received an epidural considered it to be a humanistic approach to birth as it allowed them to enjoy their childbirth experiences more:

> *Parturient 10*: I was able to live in the moment, to interact with people. . . . I could talk to the doctor, I could ask questions, I could be there in the action; otherwise I'd just have had a desire of "give me something." It is my conception of this relief, even to live it humanely, to live the present moment, to be present. Before that, I was not present. (*Woman at low risk*)

The professional anesthetist believed that the epidural is a convenient factor for mothers, and a way to make birth more humanized:

> *Prof 10:* There are some people who say that an epidural (analgesia) is not humanized because it is not natural. It is an invasive technique in a certain way, but it is true that removing pain helps the woman; perhaps it makes her more ready to handle her baby. (*Anesthetist*)

TABLE 3 Some Women's Childbirth Experiences During Labor and Delivery

Characteristic	*N*(10)	%
Care provider		
OBGYN male	7	70
OBGYN female	3	30
Number of caregivers during labor and delivery		
1	3	30
2	3	30
3	4	40
Position during delivery		
Lying down	7	70
Semireclined position	3	30
Position suitable by woman		
Very well	8	80
Fairly well	1	10
A bit	1	10
Possibility of eating during labor		
Yes	1	10
No	9	90
Women's participation in decisions		
Yes, every time a decision had to be taken	5	50
Yes, but not for every decision	3	30
No, there were no decisions to take	2	20
Woman disagreed with interventions		
No	10	100
Women discussed about treatment		
Always	3	30
Often	5	50
Once in a while	2	20
Women's bring up a question		
Very often	5	50
Often	4	40
Never	1	10
Women's qualification of received information		
Very complete	4	40
Complete	6	60
The information was		
Very reassuring	5	50
Reassuring	5	50

Prioritizing saving lives over humanized care. Many of the professionals stated that in high-risk pregnancies, the most important thing for them is to provide proper care for the mothers and to take good care of the baby. They mentioned that they lose humanization of care during risky obstetric situations because they experience more stress, and they must respond more quickly.

An obstetrician emphasized urgent situations as a barrier to humanized birth, as he does not have much time to develop a confident relationship with the woman or have much time to explain everything:

> *Prof 8:* I'm sure that my approach may seem, outwardly, to be less humanized because I'm pressed by time and I do not know the women. It happens in an emergency or where I have to take action to save her life and her baby's, so it's really an obstacle, it's hard to be human, to sit, to take the hand of the patient, to listen to her. When we must say things, such as, "Madam, I must put you to sleep quickly, not 5 minutes from now." (*Obstetrician*)

A nurse stated that in a difficult situation, especially when the baby's heart decelerates, they must intervene quickly for the benefit of the baby, and the humanization of care at that time could be given less priority. The analysis of data also showed that in emergency cases, care providers concentrate more on the task at hand, focus less on the individual, and forget the patient. The nurse professionals stated that in emergency cases it will all be too focused on the issue of the health of the patient rather than the human side. Nevertheless, some nurses were critical of themselves as they believed even an urgent situation needed to be explained to the women and their families if they were supposed to be approached with a humanistic birth care plan:

> *Prof 5*: Sometimes we feel we should do everything quickly and without explanation. If we took just a few minutes with the patient to explain what we're doing to them, I think it would eliminate tension, and bring about a greater sense of security. (*Nurse*)

DISCUSSION

Achieving the humanization of birth in a tertiary hospital implies a profound reflection on the perceptions and values of its individuals, meaning the administrators, professionals, and the women, as the agents who guide the transformation of birth practices in the workplace.

The professionals and administrators' perceptions of humanized birth care in the studied tertiary hospital mostly focused on personalized and family-centered care. The perceptions of the women participants on humanized birth care, however, focused more on having security and being assured by an expert professional. The pressure of saving lives was considered the biggest barrier in the provision of such care in the cases of risky pregnancies and deliveries.

The available technology, the presence of specialist care providers, the existence of the neonatal ICUs, and the opportunity to have a painless birth brought satisfaction and reassurance to all the women. Similar to our results, Jimenez's study in Canada illustrated that women wanted to be reassured, and, for many of the women who chose hospital, it remained "the ultimate safe place to bring a child into the world" (Jimenez, Klein, Hivon, & Mason, 2010). Maloni and colleagues study (2000) revealed high-risk

women's concerns for their own safety, as well as for their babies (Maloni & Kutil, 2000).

Rutherford's study also showed how the marketing of hospitals attempts to represent hospitals as an ideal place for birth, and how it rationalizes the hospital's environment as the best place for maternity care, while maintaining a promise to bring security and to "re-humanize the birth experience with a sense of social bonding." Moreover, the presence of family and loved ones portrays the hospital birth experience as a familial event (Rutherford & Gallo-Cruz, 2008).

The use of technology and medical intervention in our study was not considered as a form of dehumanized birth care by the participant interviewees. Our previous study on humanized birth in high-risk pregnancies, in fact, showed that "humanized birth care is not a case of no medical intervention" nor does it oppose the use of technology alongside it (Behruzi et al., 2010a, 2010b). Nagahama and Santiago's study revealed that women's satisfaction their birth has not been related to the absence of pain, but with the ability to cope with pain through the support received from the care providers (Nagahama & Santiago, 2008). In contrast, most of the women participants in this study expressed their satisfaction with painless birth and perceived it as a sort of humanistic care approach, as it relieved their pain and suffering and allowed them to live through a better child birthing experience.

The findings of our study have revealed that life-threatening and emergency situations in the case of high-risk pregnancies act as a barrier to humanized birth by physicians in a tertiary hospital. Our previous and present findings similar to Hausman's study, show that obstetricians have difficulty in providing humanized care for high obstetric risk patients where life threatening conditions arise (Behruzi et al., 2010a; Hausman, 2005).

The participant women in the present study believed that to provide humanized birth care, the professionals should be caring toward the women and their families and work from the heart, not merely carry out tasks. Richter and colleagues (2007) concluded the same, and mentioned that caring for high-risk women can be improved if nurses gained more insight into everyday tasks (Richter et al., 2007). The humanized care is not a trick, or a tool, and it is not limited to the interventional dimension, but it is more of a feeling of closeness and manifests itself in their day-to-day activities at the workplace (Backes, Lunardi, & Lunardi, 2006).

The findings also showed that women perceived humanized birth as receiving good physical and emotional support by the presence of a care provider. Similarly, MacKinnon and colleagues' study (2005) showed that women highly valued the support and the presence of their nurse during the intrapartum period (MacKinnon, McIntyre, & Quance, 2005). Some of the researchers have shown that supporting and accompanying women during labor and delivery was considered a humanistic approach, as it enhanced

women's psychoemotional well-being and helped them experience less pain and consequently a lesser demand for pharmacological methods of painrelief (Davim, Torres Gde, & Melo, 2007; de Paula, de Carvalho, & dos Santos, 2002). Nevertheless, Gagnon and Waghorn's (1996) study in Canada shows that nurses spend 6% to 9% of their time providing support for women in labor.

Our study had some limitations. In this study, we only present the perception of participants on the humanization of childbirth in one tertiary hospital, and it cannot be generalized to include all highly specialized or tertiary hospitals. The diversity of the participants in this sample, however, helped us to explore the experiences and perceptions of humanized birth from many different viewpoints. Moreover, the primary author's background as a midwife and her previous knowledge on the subject of humanization of birth helped her accurately to describe her reflections and conclusions.

Clinical Relevance and Implications for Future Studies

Our findings would be useful to clinician obstetricians and gynecologists as well as to midwives, nurses, and health providers in general. The maternity care professionals would be better informed about the institutional barriers and facilitators present to the humanized birth care in the tertiary hospitals, as well as the optimal provision of quality support for childbearing women. Considering that all organizations are faced with a challenge of growth, development, and effectiveness, we hope that our findings help managers and leaders of these institutions to identify specific actions based on their organizational needs. Considering our finding, women in tertiary prenatal centers can receive the humanized birth care that respects their level of obstetric risk as well as their expectations.

The cultural values and beliefs of the women studied in our research, as well as the health care providers' views regarding birth, were found to be important factors in the promotion of the of technocratic childbirth in the tertiary hospital studied in Montreal, Canada. In contrast to our present findings, the findings of our previous research on humanized birth care in Japan showed that none of the tertiary Japanese hospitals had implemented strategies for the routine use of medical technology on normal pregnant women or the provision of epidural analgesia on request (Behruzi et al., 2010b). Thus, we can conceive how the culture of a birthplace and its individuals can influence childbirth experiences in different countries. For future research on this topic, we suggest a comparison of the perception of humanized birth among different level hospitals in different other developed or underdevelopment countries. The authors have also suggested further research in tertiary hospitals as well as further verification of the themes that have been unearthed in our study.

CONCLUSION

The health care professionals who provide humanized birth care to women in a tertiary hospital setting should consider all the physiological, as well as psychological aspects of birth care including respect of the fears, beliefs, values, and needs of women and their families. The continued presence of a care provider during labor and the reception of continued physical and psychological support is the best advocate of humanized births in a tertiary hospital. Promoting family-centered care strategies in the sense of strengthening the family's bond with the baby, participating in the care and sharing responsibilities whenever possible, as well as providing a link of communication between family and care provider are shown to be facilitating factors for a humanized birth care approach in both cases of low and high obstetric risk. Nevertheless, the perceptions of humanized birth in a tertiary hospital cannot be understood without the notion of security and reassurance.

REFERENCES

Backes, D., Lunardi, V., & Lunardi, W. D. F. (2006). [Hospital humanization as an expression of ethics]. *Revista Latino-Americana de Enfermagem*, *14*(1), 132–135.

Behruzi, R., Hatem, M., Fraser, W., Goulet, L., Ii, M., & Misago, C. (2010a). Facilitators and barriers in the humanization of childbirth practice in Japan. *BMC Pregnancy and Childbirth*, *10*(1), 25.

Behruzi, R., Hatem, M., Goulet, L., Fraser, W., Leduc, N., & Misago, C. (2010b). Humanized birth in high risk pregnancy: Barriers and facilitating factors. *Medicine, Health Care, and Philosophy*, *13*(1), 49–58.

Campbell, P., & Rudisill, P. (2006). Psychosocial needs of the critically ill obstetric patient: The nurse's role. *Critical Care Nursing Quarterly*, *29*(1), 77–80.

Castro, J. C., & Clapis, M. J. (2005). [Humanized birth according to obstetric nurses involved in birth care]. *Revista Latino-Americana de Enfermagem*, *13*, 960–967.

Davim, R. M., Torres Gde, V., & Melo, E. S. (2007). Non-pharmacological strategies on pain relief during labor: Pre-testing of an instrument. *Revista Latino-Americana de Enfermagem*, *15*, 1150–1156.

De Koninck, M., Blais, R., Joubert, P., & Gagnon, C. (2001). Comparing women's assessment of midwifery and medical care in Quebec, Canada. *Journal of Midwifery and Women's Health*, *46*(2), 60–67.

de Paula, A., de Carvalho, E., & dos Santos, C. (2002). The use of the "progressive muscle relaxation" technique for pain relief in gynecology and obstetrics. *Revista Latino-Americana de Enfermagem*, *10*, 654–659.

Deslandes, S. F. (2005). Humanization of care in maternity hospitals in Rio de Janeiro from the administrator's perspective. *Revista Ciência & Saúde Coletiva*, *10*, 615–626.

Gagnon, A. J., & Waghorn, K. (1996). Supportive care by maternity nurses: A work sampling study in an intrapartum unit. *Birth*, *23*(1), 1–6.

Hausman, B. L. (2005). Risky business: Framing childbirth in hospital settings. *Journal of Medical Humanities*, *26*(1), 23–38.

Jimenez, V., Klein, M. C., Hivon, M., & Mason, C. (2010). A mirage of change: Family-centered maternity care in practice. *Birth*, *37*, 160–167.

Jones, R. H. (2002). *Humanização do parto: Qual o verdadeiro significado?* [Humanization of childbirth: What is the true meaning?]. Retrieved from http://www.amigasdoparto.com.br/ac015.html.

Kuo, S.-C. (2005). [Humanized childbirth]. *hu li za zhi*, *52*(3), 21–28.

Leon, A. M., & Knapp, S. (2008). Involving family systems in critical care nursing: Challenges and opportunities. *Dimensions of Critical Care Nursing*, *27*(6), 255–262.

Lindsay, P. (2006). Creating normality in a high risk pregnancy. *The Practicing Midwife*, *9*(1), 17–20.

MacKinnon, K., McIntyre, M., & Quance, M. (2005). The meaning of the nurse's presence during childbirth. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *34*(1), 28–36.

Maloni, J. A. (1998). *Antepartum bed rest: Case studies, research, and nursing care*. Washington, DC: Association of Women's Health, Obstetric, and Neonatal Nurses.

Maloni, J. A., & Kutil, R. M. (2000). Antepartum support group for women hospitalized on bed rest. *The American Journal of Maternal Child Nursing*, *25*, 204–210.

Masciale, E. (2006). *Technology-intensive childbirth is the norm for great majority of primarily healthy women*. Retrieved from http://www.childbirth connection.org/article.asp?ck=10396

Misago, C., Kendall, C., Freitas, P., Haneda, K., Silveira, D., Onuki, D., . . . Umenai, T. (2001). From "culture of dehumanization of childbirth" to "childbirth as a transformative experience": Changes in five municipalities in north-east Brazil. *International Journal of Gynecology & Obstetrics, 75*(Suppl. 1), S67–72.

Nagahama, E. E. I., & Santiago, S. (2008). [Childbirth practices and challenges for humanization of care in two public hospitals in Southern Brazil]. *Cadernos de Saúde Pública*, *24*, 1859–1868.

Page, L. (2000). Human resources for maternity care: The present system in Brizil, Japon, North America, Western, Europe and New Zealand. *International Journal of Gynecology & Obstetrics*, *75*, S81–S88.

Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Richter, M. S., Parkes, C., & Chaw-Kant, J. (2007). Listening to the voices of hospitalized high-risk antepartum patient. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *36*, 313–318.

Rutherford, M., & Gallo-Cruz, S. (2008). Selling the ideal birth: Rationalization and reenchantment in the marketing of maternity care. *Advances in Medical Sociology*, *10*, 75–98.

Soeffner, M., & Hart, M. A. (1998). Back to class, helping high risk moms cope with hospitalization. *AWHONN Lifelines*, *2*(3), 47–51.

Strauss, R. P. (1990). Culture, health care, and birth defects in the United States: An introduction. *Cleft Palate Journal*, *27*, 275–278.

Umenai, T., & Wagner, M. (2001). Conference agreement on the definition of humanization and humanized care. *International Journal of Gynecology & Obstetrics*, *75*(Suppl. 1), S3–S4.

Villar, J., Valladares, E., & Wojdyla, D. (2006). Caesarean delivery rates and pregnancy outcomes: The 2005 WHO global survey on maternal and perinatal health in Latin America. *Lancet*, *367*(9525), 1819–1829.

Yin, R. K. (2003). *Case study research: Design and methods* (3rd ed.). Thousand Oaks, CA: Sage.