

Perceptions of labour: discrepancies between midwives' and patients' ratings

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Summary. Women's ratings of their experience of childbirth were compared with midwives' ratings of the women's experience. The midwives' ratings were significantly different from those of their patients. Midwives presented a more positive picture of the woman's experience than did the woman herself. Furthermore, the women reported using psychoprophylactic techniques for controlling discomfort for significantly more of the time than the midwives reported that the women used such techniques. The results are discussed in the context of similar findings reported in the literature.

The quality of much medical and nursing care depends on accurate perception of the patient's physical and psychological state. This is particularly true of the care of women in childbirth, where the midwife or doctor has to respond flexibly to differing needs for explanation, reassurance and pain relief and to a widely varying course of labour. It is therefore important to establish the degree to which midwives are sensitive to the subjective experience of their patients, particularly in view of the high levels of pain reported by women in childbirth (Reading *et al.* 1982).

The evidence from surgical patients is not encouraging. Johnston (1976) reported that nurses on gynaecology wards overestimated the worries of patients, while at the same time underestimating the duration and intensity of the pain they experienced. In a subsequent study (Johnston 1982), patients' worries were found to be recognized more accurately by other patients on a gynaecology ward than by nurses, who once

again tended to overestimate the number of worries. It is not clear from these two studies how much contact there had been between the nurses and patients involved and Johnston (1982) noted that the results may reflect stereotyped thinking on the part of nurses who had relatively little direct communication with their patients. It might be expected that midwives, who usually have more prolonged and intimate contact with their patients, should judge more accurately their patients' subjective experience.

Brewin & Bradley (1982) found that women who attended childbirth preparation classes reported that they experienced less pain in labour than non-attenders, due in part to greater perceived control over the process of childbirth. Although not discussed in this paper, it was also found that class attenders reported using techniques for controlling discomfort during labour for a greater proportion of the time than was observed and/or reported by the midwives. The present analyses were therefore designed both to determine the accuracy of midwives' perceptions of their patients' subjective experience, and to determine the extent of agreement between midwives and patients on whether

or not the patients were using techniques for controlling discomfort.

Patients and methods

Patients were indigenous English-speaking women attending a large general hospital for antenatal care. The mean age of the sample was 25.6 years (range 15–43 years). Patients were invited to participate in the study while in their 39th week of pregnancy, as described in Brewin & Bradley (1982).

Of the original sample of 78 women, 10 were single and 68 were married; 44 were having their first baby and 34 a second or subsequent baby. The hospital served a predominantly working class area, and 60 of the women had finished full-time education by the age of 16.

Immediately after delivery, the midwife completed a questionnaire which, in addition to items concerned with obstetric details, included items concerning the woman's subjective experience and use of techniques for controlling discomfort. A total of 28 midwives took part in the study. Two of the midwives' questionnaires were not returned. On the day after delivery, patients completed a similar questionnaire. Eleven of the 78 patients failed to return this questionnaire. The ward staff did not give the questionnaire to five of these 11 women, two of them were delivered by caesarean section, one had a forceps delivery and the remaining two had uncomplicated vaginal deliveries. Six women were given the questionnaire by the ward staff but did not complete them; one of them was delivered by caesarean section, two had forceps deliveries and three had un-

complicated vaginal deliveries but one of their babies was born with a hare-lip.

Obstetric management of the population studied was as follows: 23 (29%) of the women had their labours induced, 15 (19%) had labours accelerated with oxytocin, 14 (18%) had membranes ruptured; 26 (33%) of the women used epidural analgesia, 53 (68%) used pethidine, 40 (51%) used Entonox (50% nitrous oxide–oxygen); 8 women (10%) were delivered by caesarean section, 15 (19%) had forceps deliveries. It should be noted that the above frequencies are not mutually exclusive so that, for example, some women used both pethidine and epidural analgesia and forceps were used in delivery.

Questionnaires

Patients and midwives were asked whether any attempt had been made by the patient to control her discomfort. The possible responses were 'No, none of the time', 'Yes, a little of the time', 'Yes, some of the time', and 'Yes, all of the time'. Respondents were also asked to describe any techniques used. Patients and midwives were then asked to rate how satisfying the labour had been for the patient overall, the possible responses being 'very unsatisfying', 'rather unsatisfying', 'neither satisfying nor unsatisfying', 'moderately satisfying' and 'very satisfying'. Finally, both groups were asked to rate the patient's experience of labour and delivery on 12 seven-point scales representing different psychological dimensions (Table 1).

Table 1. A comparison of patients' and midwives' ratings of the patients' experience of labour and delivery

Dimension	Patients' mean score	Midwives' mean score	r	t
Unpleasant–pleasant	3.8	6.2	−0.31*	7.76***
Good–bad	3.9	2.5	0.17	5.12***
Relaxed–tense	4.4	3.3	0.23	4.07***
Comfortable–uncomfortable	4.4	3.3	0.23	3.81***
In control–not in control	3.9	2.8	0.03	3.16**
Emotional–unemotional	2.5	3.4	0.15	2.86**
Miserable–cheerful	4.5	5.1	0.18	1.99
Unhappy–happy	4.5	5.0	0.02	1.61
Interested–bored	2.3	2.5	0.20	0.93
Unsatisfying–satisfying	3.6	3.7	0.20	0.77
Negative–positive	5.0	5.2	−0.04	0.61
Active–passive	3.2	3.1	0.28*	0.43
Puzzled–understanding	5.5	5.6	0.03	0.29

Significance of differences: *** $P < 0.001$; ** $P < 0.01$; * $P < 0.05$.

Results

A comparison of the patients' and midwives' ratings of the experience of labour and delivery can be found in Table 1, which includes results for the rating of satisfaction and for the other 12 psychological dimensions.

The ratings are ranked in order of reported difference in size, the largest coming first; *t*-tests indicated that there were highly significant differences between patients and midwives on six of the 13 ratings, midwives rating the women as feeling more pleasant ($P < 0.001$), better ($P < 0.001$), more relaxed ($P < 0.001$), more comfortable ($P < 0.001$), more in control ($P < 0.01$), and less emotional ($P < 0.01$). Midwives also tended to rate the women as feeling more cheerful ($P < 0.06$). In all, the midwives' ratings were more positive on 12 of the 13 dimensions.

Table 1 also shows Pearson correlations (r) between patients' and midwives' ratings which indicate, for instance, how successful the midwives were at telling which patients found the experience more unpleasant and which patients found it relatively pleasant. Although 11 of the 13 correlations were positive, only one of them attained significance. Midwives and patients tended to agree on which women had felt more active and which more passive ($r = 0.28$, $P < 0.05$). Interestingly, this was the rating which could most easily be made by observing the patient's overt behaviour rather than by inferring her internal subjective experience. The lack of significant correlations indicates that midwives were unsuccessful in general at recognizing patients' feelings.

In one case there was actually a significant negative correlation: the more the women rated their experience as unpleasant, the more the midwives rated it as pleasant ($r = -0.31$, $P < 0.05$). In an attempt to explain this finding, patients' and midwives' ratings of pleasantness/unpleasantness were correlated with the patients' demographic characteristics. It was found that the more children a woman already had, the more she rated her own labour as pleasant ($r = 0.30$, $P < 0.02$) but the more the midwife rated it as unpleasant ($r = -0.38$, $P < 0.005$). When the effects of parity were controlled for, the negative correlation between patients and midwives on this rating did not reach significance (partial correlation $r = -0.22$, $P < 0.14$). Although parity was not systematically associated with the woman's other

ratings of her own labour, a surprising finding was that midwives were consistent in rating women of greater parity as also feeling more negative ($r = -0.27$, $P < 0.04$), more bored ($r = 0.29$, $P < 0.03$), more passive ($r = 0.29$, $P < 0.03$), and more miserable ($r = -0.28$, $P < 0.03$).

Finally, the agreement between midwives and patients on the patient's use of techniques to control her discomfort was examined. Eleven of the patients who had completed the questionnaire and eight of the midwives' replies had not specified a valid technique such as breathing, relaxation or psychoprophylaxis; their answers were excluded from this analysis leaving a total of 48 subjects where valid responses were available from both patient and midwife. Table 2 indicates that, whereas the majority of patients thought they used techniques some or most of the time, the majority of midwives thought techniques were used for little or none of the time. This difference was highly significant ($\chi^2 = 20.2$; d.f. = 3; $P < 0.001$).

Table 2. Patients' and midwives' reports of the frequency of patients' use of techniques for controlling discomfort

	None of the time	A little of the time	Some of the time	Most of the time
Patients	5	3	21	19
Midwives	12	17	10	9

$\chi^2 = 20.2$; d.f. = 3; $P < 0.001$.

Discussion

The results of this study point to important discrepancies between patients' and midwives' perceptions of the experience of labour. Midwives' ratings suggested that they had a rosier view of labour; compared with the patients' ratings, midwives underestimated the unpleasantness of the experience. These findings are similar to those of Johnston (1982) and indicate that biased perceptions on the part of medical and nursing staff existed even when there was an opportunity for more prolonged contact with patients. It should be pointed out, however, that in this study the midwife who delivered the woman and completed the questionnaire may not have been present throughout labour. It is possible that midwives who attended the patient

for longer periods would make more accurate judgments about her subjective experience.

Why did midwives adopt these rosier views? One explanation is that they were comparing each labour with many others, some of which would have been painful and traumatic. In comparison to difficult labours, the average labour may seem relatively pleasant and comfortable. For the patient, on the other hand, labour will probably be one of the most painful and uncomfortable events that she experiences. Another explanation is that midwives may find their work less distressing if they can minimize the suffering which they believe patients undergo. Such minimization would also serve to reduce the sense of obligation to take some remedial action. Similarly, Ley (1977) pointed out that while most patients wish to be told when they are dying, most doctors believe that patients would rather not know. In the case of dying patients, doctors may intend to protect the patients from distress. However, in both cases, the beliefs held by medical staff may help to make life more comfortable for the staff themselves.

In the present study, patients and midwives disagreed about the patients' use of techniques for controlling discomfort. Patients believed that they used such techniques frequently, while midwives believed their use was less frequent. This may have simply reflected disagreement about what constituted the proper use of a technique, but the fact that patients and midwives had such different views about what each patient was trying to do is disquieting. It may also help to explain why recent, carefully controlled studies of psychoprophylactic training have found little effect of preparation on obstetric outcome (Beck *et al.* 1980; Charles *et al.* 1978). Preparation may only be of value if staff on the labour ward perceive that patients are trying to use psychoprophylactic techniques and if there is a high level of understanding between staff and patients. The lack of agreement about the use of techniques may tend to nullify the advantage of psychoprophylactic training.

Poor communication is the single most common complaint of hospital patients. Improvements will probably not be brought about simply

by the provision of more information for patients about hospital and treatment procedures. What seems to be needed is for hospital staff to develop greater sensitivity to the experiences of the people in their care, recognizing the importance of two-way communication between patients and staff.

The evidence from this study and from those by Johnston (1976, 1982) suggests that nursing staff tend to think in stereotypes and misperceive the subjective experiences of individual patients.

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