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SCIENTIFIC CONTRIBUTION

Humanized birth in high risk pregnancy: barriers and facilitating factors

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Abstract The medical model of childbearing assumes that a pregnancy always has the potential to turn into a risky procedure. In order to advocate humanized birth in high risk pregnancy, an important step involves the enlightenment of the professional's preconceptions on humanized birth in such a situation. The goal of this paper is to identify the professionals' perception of the potential obstacles and facilitating factors for the implementation of humanized care in high risk pregnancies. Twenty-one midwives, obstetricians, and health administrator professionals from the clinical and academic fields were interviewed in nine different sites in Japan from June through August 2008. The interviews were audio taped, and transcribed with the participants' consent. Data was subsequently analyzed using content analysis qualitative methods. Professionals concurred with the concept that humanized birth is a changing and promising process, and can often bring normality to the midst of a high obstetric risk situation. No practice guidelines can be theoretically defined for humanized birth in a high risk pregnancy, as there is no conflict between humanized birth and medical intervention in such a situation. Barriers encountered in providing humanized birth in a high risk pregnancy include factors such as: the pressure of being responsible for the safety of the mother and the fetus, lack of the women's active involvement in the decision making process and the heavy burden of responsibility on the physician's shoulders, potential legal issues, and finally, the lack of midwifery authority in providing care at high risk pregnancy. The factors that facilitate humanized birth in a high risk include: the sharing of decision making and other various responsibilities between the physicians and the women; being caring; stress management, and the fact that the evolution of a better relationship and communication between the health professional and the patient will lead to a stress-free environment for both. Humanized birth in a high risk pregnancy is something that goes beyond just curing women of their illnesses. It can be considered as a token of caring, and continued support, which positively consolidates the doctor-patient relationship. As yet, it has not been described as a practiced guideline, due to its ever-changing complexities.

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Introduction

The majority of women experience a normal, uncomplicated pregnancy. However, approximately 15–20% of all

pregnancies are considered to be at 'high obstetric risk'. A high risk pregnancy is one in which there exists some biomedical factors, usually relating to the mother's present or previous medical condition or obstetric history, which could put the baby's or the mother's life or long term well being at risk (Levy-Shiff et al. 2002).

In general, women undergoing a high risk pregnancy will experience more hardship and negative emotions related to their pregnancy compared to the rest of the population (Gupton et al. 2001). The main emotional characteristics of high-risk pregnant women include anxiety and uncertainty (Clauson 1996). Being labeled as 'high risk' tends to render women more psychologically fragile, physically vulnerable, and generally powerless (Lindsay 2006).

Humanized birth indicates taking into consideration women's feelings, values, beliefs, emotions, dignity, and autonomy over their pregnancy and delivery (Wagner 2001). It is not strictly restricted to normal pregnancy, but it seems that when humanized birth care comes to high risk pregnancy, the concept of 'optimum care' focuses primarily on careful maternal and fetal monitoring and medical intervention (Lindsay 2006). Lindsay stated that, when encountering a woman with a high risk pregnancy, health-care providers should assess what the woman's feeling is, what are her perceptions regarding the procedures that she is to undergo, in addition to diagnosing her conditions (Lindsay 2006).

Berg's (1998) phenomenological study on women's experiences with complicated childbirths showed that most women had a desire to address the issue of being seen as women and not just patients, and to be able to have a sincere, affirmative conversation with their caregivers. It was shown that when the caregivers met these criteria, the patients generally felt more accepted as normal child-bearing women and mothers-to-be, even in the presence of the obstetric complications (Berg and Dahlberg 1998).

Another study was carried out by comparing the child-birth expectations of mothers with high risk and low risk pregnancies. The study showed that the high risk pregnant women expected to undergo more medical intervention, and to encounter more difficulty coping with pain during their labor and delivery (Heaman et al. 1992). Clauson (1996) found that the higher levels of psychological uncertainty were positively correlated with higher levels of stress in pregnant women.

Some past studies have focused on humanized birth in normal pregnancy, but no studies so far have specifically focused on humanized birth in high risk pregnancy. This raises the question: can humanized birth, as defined in the literature, apply to high risk pregnancies? What are the facilitators and barriers relating to such care?

The main goal of this paper is to define the professionals' perceptions related to humanized birth in high risk pregnancies, and the factors that may facilitate or prevent the provision of this kind of care in a high obstetric risk situation.

Methods

Study design, sample, and setting

In order to deeply describe and explore a professional's perception of humanized birth in a high risk pregnancy, we undertook a qualitative study using an open-ended semi-structural interview.

According to the principles of a qualitative research study (Miles and Huberman 1994; Crabtree and Miller 1999), predetermined, relevant samples are chosen to ensure that a diverse set of samples have been included. Thus, participants were chosen intentionally, on the basis of their previous experience in birth projects focusing on the humanization of care. They were also chosen from different disciplines with various levels of experience.

The professionals in this study consisted of: two obstetricians, one professor of health care administration, one academic midwifery professor, three clinical midwives, two focus groups of clinical midwives (each group consisting of three midwives), one focus group with nurse–midwifery students at a 1st degree Master's level that encompasses five students, and one focus group of midwives in a birthing center which consisted of three people. In the focus groups, all the participating midwives contributed freely in the discussion and none had any specific influence over the group as a whole. The midwives who enrolled from the birthing home to this study have already worked or were working in the 3rd Level hospitals too, and all had experience of providing care for high risk pregnant women.

The setting for the study consisted of two tertiary university-affiliated hospitals, one 3rd Level private hospital, two 2nd Level hospitals, a private clinic, a birthing center and two universities. The difference between maternity care centers existed at the levels. Except the birthing home that had a midwifery-led structure, all the centers had a multidisciplinary team, led by a physician. It means that the ultimate decisions were made by physician. Nevertheless, they all had a policy of presently implementing the concept of humanized care at childbirth. As a result, their professionals were familiar with the issue, and informed about its benefits and challenges. The institutions were in Tokyo, Atsugi, Kamakura, and Chiba prefectures, in Japan.

Data collection

Data was collected through focus groups and in-depth, open-ended semi-structural interviews with participants.

The interviews were conducted with academic and clinical staff during hospital and university site visits from June to August 2008.

The letters authorizing access to the hospitals and the birthing centres were obtained before starting the project. A total number of nine individual, and four focus group interviews, were conducted. The interviews were thirty to ninety minutes each in length. All the individual interviews were conducted in English; however, a translator accompanied the researcher in all interviews. For the focus group interviews, the translator did the Japanese to English translation and vice versa.

Interviews were conducted personally by the main author who has a background in midwifery. All interviews were audio taped and transcribed with the participants' consent. We used a modified standard guide of interview that had previously been used in Canada[1] to carry out a similar type of research. It was initially used during two separate interviews with the midwives in the birthing centres, and validated before being used in this study.

The main research questions asked were: what is your definition of humanized birth in high risk pregnancy? And what are the facilitators and barriers in implementing humanized birth at high risk pregnancy?

Data analysis

A content analysis was performed in order to analyze the data. It consists of a subjective interpretation of the content of text data of the transcribed interviews and focus groups through a systematic classification process of coding and identifying themes or patterns (Hsieh and Shannon 2005).

We proceeded from understanding the generalized meaning of the participants' answers, to analyzing the data by detecting codes that provide a pattern of simple meanings that were interpreted from the answers provided, and reordering these simplified codes into new themes, which highlight the essential qualitative experiences of the interviewees with regard to humanized birth. A mixed coding was used. This code structure was subsequently reviewed four times by the various researchers, and the coding and coding- inverse, were conducted by one investigator (first-author), and reviewed by another co-author. All the documents were also examined many times in several sessions, and discussed pertaining accuracy and coding logic. After achieving a consensus, the data was then entered into a software package, namely Atlas.ti 5.[2]

[1] The original guide of interview was used in the first author's PhD project entitled: "Humanized Child birth in Highly Specialized Hospitals in Quebec—Canada" (2007).

[2] A program which is designed to analyse qualitative data in an accurate and scientific way.

In order to ensure that data analysis was systematic and verifiable in this study, we consistently referenced the discussion guides and audio tapes of the interviews, as well as being meticulous with the accuracy of our coding and data analysis.

Results

A total number of 21 people participated in the present study. From this number, 17 were midwives, 2 were academic professionals, and two were obstetricians. The mean age of the participants was 34.1 years, and they ranged from 22 to 52 years old. Most midwives (70.5%) had a bachelor's degree in nursing-midwifery, and the mean clinical experience of the participants was 9.6 years, but it ranged from participants at training status to one with 30 years of experience.

The interviews themselves consisted of two main general themes: (1) the definition of humanized birth in high risk pregnancy, (2) the barriers and facilitators.

Definition of humanized birth in high risk pregnancy

Through the content analysis of the interviews, the following themes emerged from the context to describe the humanized birth in high risk pregnancy.

There exists no conflict between humanized birth and medical intervention

According to the interviewees, there is no definitive difference between a normal and high risk pregnancy with regard to the subject of humanized birth. It can be applied in any situation, or patient status, and should be available to all women regardless of their obstetric risk, without having to interfere with the necessary medical procedures.

From the interviewees' point of view, humanized birth is not perceived as a restriction in using medical intervention, but rather as a balance between medical intervention, and the perception of psychological normality in high obstetric risk cases through methods of emotional caring, continuous support, and a good women-professional relationship. In cases with severe complications, medical interventions such as a caesarean section may be difficult to avoid, but as an experienced midwife in a focus group mentioned, the way women are prepared for these interventions is the most important component in achieving a humanized birth in high risk pregnancy:

> **P13-3**: Humanized birth is not a case without any medical intervention. Sometimes we need medication […] we should marry humanized birth with medical

intervention just by explanation, communication and the maintaining confidence.

Humanized birth as a changing and endless process

Most of the academic interviewees recognized that humanized birth cannot possibly be limited to a specific definition, nor can it be seen as a long list of tasks that need to be performed. Referring to the statements below by an obstetrician (P6) and a midwife (P3) respectively, humanized birth provides endless improvements in the way health professionals promote care as one human being interacting with another human being:

P6: We think that humanization of childbirth is a process, a transition for each woman, professional, people, family. We do not define humanized care as this or as that specific action or approach. Humanization of birth affects mother and family. After birth, it continues, it is different, depending on culture and places.

P3: For me there is no specific definition, it always changes. It is important to listen to the mother's voice, to listen to the family's voice, what is best for the woman and her family.

No practice guidelines can be defined for humanized care

According to the midwives interviewed in the focus groups, humanized birth in high risk pregnancies can never be defined in formal 'practice guidelines'. It comes from love and should be individualized regarding to each specific situation. Even providing evidence based on medical study, cannot assure that a humanized birth approach is granted or impossible during a high risk pregnancy:

P13-2: In humanized care we do not have a specific systematic care. We should look for specific care in each woman separately. No two women are the same. We should see which care is better for which woman. We follow evidence based medicine but it is not strict. We should adapt them with each woman […] There is not a specific definition for humanized birth. This is the care that comes from love, there is not a manual, and there is no guide to say this is humanized birth. All the care that provides a good physical and psychological state for patients is humanized birth.

Bringing normality to the centre of high obstetric risk

According to the midwives interviewed in the focus group, humanized birth in high risk pregnancy is a way to bring normality to the centre of a high obstetric risk situation by providing emotional support, increasing the woman's confidence, providing a secure environment for the mother, and making an effort to understand and sympathise with the patient's feelings. As the most experienced midwife mentioned in the focus group, even when a pregnancy is considered to be at high risk, the care provider has the ability to reduce the risk, at least psychologically, by providing strong support and promoting a feeling of security:

P13-3: It is important to create a secure environment and to establish a relationship based on confidence between women and personnel who work in a childbirth center. Women feel themselves secure: this is very important. This is scientifically proved, if a woman is very stable and is reassured, it can have an influence on the delivery, she can have a normal delivery, from a psychological perspective, because she is in a very secure environment.

Barriers

Barriers were subsequently sub-grouped into four themes: pressure of saving a life due to a life threatening situation, lack of active involvement of the women in the decision making process, possible legal issues, and the contrast between the physician's authorities compared to the responsibilities of the midwife. The important structures emerged from these themes.

The pressure of saving a life

Almost all participants in this study expressed a constant worry related to the health of the mother and baby in high risk pregnancies. This places a pressure on physicians who may be inclined to use over-surveillance and frequent intervention.

Midwife P7: If a mother has high risk pregnancy, doctors are more worried about the woman and start to do more interventions.

An academic interviewee declared that the pressure of being in a situation that is life-threatening for the high risk pregnant woman and her baby creates a lot of stress on the medical professionals. This stress, in turn, creates a series of action-reaction chain events that creates a lot of negativity around the situation, overwhelming the mother's anxiety, and providing an almost fearful environment for the mother-to-be. He believed that the consequences of this stress can worsen the physiological processes of labor, delivery, and the postpartum:

P2: Everyone is very highly… you know… active and ready to act to any possible situation, and that highly

adrenaline environment does not help anymore in relaxing. When people experience post adrenaline moments, they are fearful, and ready to act. For the women, this may lead to problems in the physiological processes of childbirth, such as breast feeding.

The management of a high risk pregnancy requires weighing the risk vs. the benefits of medical intervention, in order to achieve the most successful outcome. Obstetricians in this study described a difficulty in providing humanized care in a high obstetric risk, and discussed that saving the mother's and the baby's life was usually their utmost responsibility.

Obstetrician P5: when the process of pregnancy is normal, there are some options. For high risk pregnancy, I do not have much time and much option, I must make decisions immediately, sometimes we must make decision fast. […] In high risk pregnancy, sometimes it is not easy to deal with the problem, some times we get confused.

Lack of women's active involvement in the decision making process

The lack of mutual decision making by women and care providers in high risk pregnancy is sought by the academics and obstetricians interviewees as a barrier for a humanized birth in high risk pregnancy. According to an academic interviewee, to actively get involved in the decision making, and before being able to make informed choices, women with high risk pregnancies must be provided with a complete amount of pertaining information about their situation:

P2: To make a decision, one has to be informed. Humans are not as animals that do everything without knowing. For us, to benefit from modern knowledge, modern medicine and technology, we have to participate. We have to know about risks, consequences and possibilities, and then make a decision.

However, most of the interviewees believed that in a high risk pregnancy, women lose control over their bodies, and are therefore not able to make an informed decision, even after being given the pertaining information:

P2: I think there are some areas where women cannot make decisions. In extreme situations, the doctor has total control, such as a woman in a high risk pregnancy. When she reaches this point, she loses control over her body and her pregnancy.

Interestingly, obstetricians and academic interviewees believed that not all women are given the choice to choose, and in most cases, someone else will decide for them. Many women are forced to make decisions unconsciously since they do not know enough about the situation to be able to decide on it. The obstetrician (P6) and the academic (P2) interviewees believed that Japanese women's decisions are profoundly influenced by culture:

P6: In Japan, not so many people decide by themselves. It is the same during pregnancy.

P2: It is more and more important that I make decisions consciously, not because everyone does it. Unfortunately this is the present situation. In Japan, women do not receive and epidural, not because this is their decision, but because it is the local culture. In French speaking Belgium, women do have epidurals, again not because it is their decision, but because everyone has one. I think we have reached the stage where everyone should make conscious decisions (about the care they get).

One of the obstetricians stated: "we have good guidelines for high risk pregnancy, but we do not actually have a single word in these guidelines indicating that women and their power should control their body without being controlled by medicine". (P6)

Legal issues

It seems that a fear of lawsuits may have motivated obstetricians to use all their medical skills in order to prevent any unwanted outcomes, but may lead obstetricians to opt for the 'cautious path', prescribing unnecessary tests or procedures for the women, without regard for their level of comfort with the procedures.

Obstetrician P5: All these problems relate to the heavy responsibility of the doctor concerning the safety of the pregnant patient and the family. Sometimes decision making is based on legal issues, not on humanized care base. Recently, law suits have been increasing in Japan.

While obstetricians describe their disappointment with the decision making experience and the treatment of having to perform medically intrusive procedures due to the pressure of legal issues, the lack of support provided to the women in these situations is of major concern. Often, obstetricians do not take care to focus their efforts to minimize stress, but rather, they bombard women with information that usually makes them more frightened and anxious.

Obstetrician P6: In high risk pregnancy, we should tell the mother the truth and also tell her that we cannot assure the result. It is because we are afraid of being sued. Many doctors prepare mother for the worst situation but I personally do not do that. Many doctors try to explain to the mother that she has high risk pregnancy and it might even happen that the baby dies

[…] even when we have to tell the truth, the way that we prepare the mother and tell her is very important. Sometimes we do not say anything and just stay there next to the mother.

Physician's authority and lack of midwife's responsibility

Obstetrician's authority and lack of the midwife's responsibility during a high risk pregnancy was described by midwives as one of the main barriers to implementing humanized birth in a high risk situation by all the midwives interviewed:

P13-2: In high risk pregnancies, doctors are powerful and do not let the midwife or nurse do anything. Doctors are so strong in using medicalized care […] in Japan, midwives cannot prescribe medication and have no authority (in the care of women with) high risk pregnancies.

Many of the midwives talked about some of the beliefs that obstetricians hold about the midwife's medical skills and normal pregnancy. One of the midwives mentioned "Doctors' lack of co-operation and the way of thinking is a barrier in humanized birth at high risk pregnancy". (P11) Most of the midwives stated that in some hospitals, when midwives provide care to high risk pregnant women, or attend deliveries, they are still under strict supervision from the obstetrician:

P3: Midwives in Japan usually cannot attend a high risk pregnancy; however, they can cooperate with the doctor. Maybe the doctor manages the treatment plan and provides treatment. Sometimes …, if the doctor is present, the midwife can attend the delivery.

One of the midwives mentioned that midwives and doctors think similarly, but they do not share the same philosophy and their communication is not so good with each other:

P3: Doctors manage treatment for high risk pregnancies but the team should share a common philosophy between midwives and doctors … to provide the best environment and a pleasant experience for women […] if we have the same philosophy, we do not need to have arguments … If (our) philosophy (is) different, it is difficult to provide such care for the patient.

Facilitating factors

The factors that facilitate humanized birth in high risk pregnancy were sub-grouped into four separate themes, which included: sharing responsibility and decision making more or less evenly between the physicians and the women, the building of a good social relationship between physician and patient, being caring, and stress management.

Sharing responsibility and decision making between the physicians and the women

According to the participating obstetricians, women's participation in the decision making process is sought to facilitate humanized birth in a high risk pregnancy. An obstetrician emphasized considering the obstetrician as the sole person responsible for another life exerts pressure and stress on the professional in these situations compared to a normal pregnancy, and the only way of diminishing this pressure is to share the responsibility equally between the professional and the patient:

P5: our staff and pregnant women and their family can have nice discussions and share the safety, responsibility, satisfaction, and decision making. Everything should be shared in this environment. If we share, we eliminate responsibility of our staff. Sometimes you can choose an option that might not be a good one. As I told you, nice communication, nice discussion, we can share the responsibility and decision making, and the difficult outcome …

According to the interviewed obstetricians, the focus, in this case, should be on helping the involvement of high risk pregnant women in the decision making process, and the pertaining negotiations, rather than just asking them for a final decision:

P6: We never from the first say which way is better for a woman. After we meet and we talk with mother and family, we gradually offer our suggestion to them as an option, for example, we say it could be better for you to choose this way. From the first, we do not ask the woman her choice or decision. We do not offer any option at the first meeting; we need more time after or before the meeting to suggest good options and to have the women and her family make a good choice.

According to the results, the mutual decision making works to enhance women's satisfaction, control, and confidence, even when there is a high obstetric risk with an uncertain outcome. The participating midwives in focus groups and individual interviews emphasised that the most important role of the care provider in aiding mutual decision making is to help the women make an informed choice, not to influence their choices:

P13-1: Personnel, medicine, midwives should not dictate to patients that you should do this, do that, while patients do not like it.

P11: we should not choose for the mother what she should do, we just facilitate her choice.

Good relationship, communication and confidence

From the point of view of the participating midwives, humanized birth in high risk pregnancy seems possible to be achieved through establishing a good relationship between care providers and women. These midwives believed that no care in a high risk pregnancy can be considered as humanized care, if the care provider does not fully understand the women's feelings, beliefs, opinions, and anxieties, and thus cannot respond appropriately to them:

> **P13-1**: In humanized care we should do consultation with patients, we should have good communication with patients. We should explain, if we do this, it's because of this. In the same time, we should ask about patient's opinion, what do patient thinks about this issue? Sometimes (when) we have to do an intervention, it is important to give an explanation (and to repeat the) explanation to (the) patient. We should establish a confidence between care provider and patient.

> **P9**: Sometimes we have to terminate a pregnancy by provoking or stimulating delivery or have some medical intervention for the mother or baby's security […], women should understand the necessity of medical intervention and the midwife should be capable to show her, (for instance) this is (the) measurement that we should take, we should be capable to give a clear explanation.

Being caring

Good communication, explanation, and emotional support towards women were the most pertinent phrases repeated by all the participants. However, they mentioned that just explaining to women that the medical interventions that they are about to undergo are beneficial to their lives and their babies is not enough to give them peace of mind. Humanized birth in high risk pregnancy is sought to be facilitated if the health care provider is caring. This involves showing care and compassion to women, and most importantly, listening to their problems. One of the midwives mentioned:

> **P9**: In high risk cases, there are not many things one can do. Perhaps the most important things are done on a psychological level: to accompany, comprehend and support the women. I try to predict the mother's feeling and all things that women desire, sometimes by looking in her face. I provide humanized care by staying beside the mother and taking care of them to feel safer. I want to stay (with her during the) whole labour and delivery … and share (her) feeling and desires toward childbirth …, more psychological support […] women usually are sad and full of stress. We should change her feeling and sensation. Sometimes women have a lot of anguish. What is important is a good understanding of the women.

Midwives and obstetricians believed that the concept of caring is not limited to pregnancy and delivery. It continues even after giving birth in order to support women's feelings and their experience of the pregnancy. When midwives participating in the focus groups understand how mothers feel in different stages of any pregnancy, it would help to reduce the gravity of the problems and would help to change the mother's expectations and behaviors towards the birth:

> **P12**: I think the care that we provide after delivery is so important for a high risk mother […] there are many things that a mother can remember and reconstruct from her high risk pregnancy for the future pregnancy and delivery if we make it a good and pleasant experience. After having delivery, midwives can talk to the mother in a natural way and try to make the mother feel good and accept her experience.

One of the obstetricians mentioned:

> **P6**: My concern is about after birth, I mean that we sometimes do not attend to, or do not know about after delivery. We treat many mothers but actually do not know what happens to mother and child after delivery. In Japan, if a baby dies, in the next pregnancy the mother prefers another doctor and hospital but most of the mothers who had stillbirth, came back to me again because I focus in dealing with grief. I try to talk about the situation and the baby that she lost and not to hide it, as the mother never forgets her dead baby. I listen to the mother's experience, her feelings and help her to pass through (the situation) and not to hide it.

Almost all the interviewees concurred that being caring in cases where women have had an urgent cesarean section, or had to be referred to hospitals from birthing centers, can prevent depression after delivery.

> **Midwife P1**: Impression and feelings of our patients are important […] these mothers would like to have normal birth but cannot, therefore, they feel guilty. Sometimes the mother has HIV and must be separated from her baby and does not breastfeed. Care providers should continue to support the women and their family even after delivery.

Stress management

According to academic interviewees, applying strategies to create a more relaxing environment during pregnancy, labor, and delivery, allows women to undergo an enjoyable birthing experience, even in the midst of a high obstetric risk situation. They believed that stress and anxiety can be

intensified either by complications, or sudden hospitalization. Therefore, any strategy that helps to separate a high obstetric risk environment from normal ones, would serve in decreasing women's anxiety levels, and can enhance their grasp of control over the situation:

> **P2**: […] consider two different environments, on the one hand you need doctors to be ready to act, so isolate it, and on the other hand, you need to create a more relaxing environment, then how to manage stress? Doctors do not need to go there. Doctors perform a good job in managing the stress. Doctors are good at acting in stressful situations. […] That is their job. When a doctor comes into a relaxing environment, a woman might feel a lot of stress and everybody experiences a stressful environment. I think, stress management needs immediate action, on the one hand, it is the family's place, the most important thing in that place is to feel less fear, to feel support, to feel relaxed, to laugh, these are the major things that bring about a better outcome. On the other hand, you need medical intervention; professionals come and act… do not mix them.

Midwives and obstetricians concurred that accompanying the patient during hospitalizations, labour, and delivery can help to decrease tension and anxiety in the patient, and to clear their minds from complications or pain. Women seem to be more relaxed, and less overwhelmed, in situations where they have company at their side:

> **Midwife P8**: Women have a lot of stress. They have to stay in bed and just go to the toilet. This situation is very stressful for mothers. They know this is for the baby, but sometimes they cannot control their mind because of stress. Sometime we need time to talk to them, sometimes talking as a friend, because they know we are so busy and do not have time to talk with them all the time. There is one mother per room. They have a lot of time but stay alone in their room…

Most of the midwives believed that hiding the machines in the labour and delivery rooms, or reducing the amount of monitoring, could provide a less stressful environment for the mothers.

> **Midwife P1**: Before 2000, we had machines everywhere in our unit, but we decided to remove all of them to provide a more natural environment which does not use as many instruments.

Discussion

The present paper has concentrated on the humanized aspect of care in high risk pregnancy. The findings of our study have yielded some important results regarding humanized care in high obstetric risk pregnancies. We have shown that the stressful nature of a pregnancy of high obstetric risk, and the emergence of more advanced obstetrical technologies to cure the problems associated with them, do not leave much time for care providers to think about their personal skills, and the psychological care of the patient. In modern times, humans have basically been replaced by machines more and more in order to bring more security to procedures and reducing risk. This leads to the justification of the over-use of clinical methods in the management of a high risk pregnancy (Hausman 2005).

The results also bring into consideration the appropriateness of medical interventions in high risk pregnancies for saving a mother's and baby's life besides a smooth communication for a successful outcome. Humanized birth in high risk pregnancy by no way opposes the use of technology alongside it. However, the fact that intervention can sometimes be life-saving does not logically imply that healthcare providers cannot apply humanized birth care approaches in high obstetric risk. The belief is that clinical intervention should be carried out, as well as making an effort to understand the women's physiological and psychological needs at this time, and allowing them to participate in the decision making process. Berg and Dahlberg (2001) in their study showed that the high risk pregnant women needed to be regarded more as human beings with needs and emotions.

The findings of our study have shown that factors such as fear of a lawsuit might act as a barrier to humanized birth in high risk pregnancy. In this way, physicians may be using more medical interventions for controlling the situation. The literature shows that there are growing numbers of women who undergo a medical intervention without an accepted 'medical indication' (Wagner 2001; Smeenk and ten Have 2003). This is a reflection of an uncertainty as the optimal approach to care. Often, this uncertainty comes from prudence with legal issues (Béhague 2002; Hausman 2005).

In our study, the stress management approach that involves separating the hospital's environments by parting the intensive care cases from the less severe cases, is considered as a type of humanized birth care, and has been seen to overcome some of the negative effects of the atmosphere experienced by a woman with a high risk pregnancy. Most of women who are labeled as having a high risk pregnancy are forced to spend some part of their pregnancy in prenatal care intensive units in tertiary hospitals, and most of them have to be isolated for a long time. The atmosphere of intensive care units is often tense, and can bring a traumatic experience for patients (Vila Vda and Rossi 2002). The family, the nurses, or the midwives can provide emotional support for the women during the hospitalization. Previous research has also shown that family

support in high risk pregnancy is a very important factor to deal with such a situation (Stainton 1994).

The findings of our study show that ‘caring’ is an essential aspect in the promotion of humanized birth in high risk pregnancies. Gairing Bürglin and Tschudin 2008 referred to obstetrics’ challenges of communicating with pregnant women and parents-to-be. Authors pointed it as crucial for patient satisfaction and safety. Their paper mentioned how it is important to convey information in a clear language for the women and to evaluate how the patient deals with it. They also emphasized the importance of showing empathy and offering support if a distressing emotion is perceived and when things are going wrong (Gairing Bürglin and Tschudin 2008). The importance of reducing anxiety, fear and discomfort by means of a humanized approach, such as verbal and non-verbal communication, has been proven in patients who are about to undergo a surgical procedure (Medina and Backes 2002).

According to Misago, ‘humanized birth is an endless process of improving care, improving system, empowering professionals and women, then it could be applied in any hospital in any level of care’.[3] She supports the beliefs that humanized care goes beyond a practice guideline for treating a disease, or whether the situation is high risk or low risk. Humanization of birth is a process which includes women and their families, as well as the physicians and their mutual environments.

Our results also showed that thinking of the concept of death, and how hard it can be to confront, can serve as a starting point when thinking about introducing humanized birth in high risk pregnancy. McCreight’s research showed that women who have experienced stillbirths, or neonatal death, felt like they were subject to rationalization during their pregnancy, rather than to much needed emotional support (McCreight 2008). In high risk pregnancies, birth and death often go together, and that is a fact that no-one can be prepared to have to be struck with, and a lot of the time, women and care providers have to silently accept this grief. Considering Irland’s speech ‘if you understand birth, you can understand grief’, women need to accept their grief, and not to hide it (Irland 2007).

Care providers who carry out their tasks in accordance with hospital’s policy and guidelines, should fully meet the needs of the mothers in high risk pregnancies in terms of: being listened to, being involved in decision making, and being offered choices. Besides, care providers should be capable of identifying a mother’s perception of risk and her feelings about her safety and that of her baby. Care providers, especially obstetricians, should provide continuing information and knowledge about the process women are experiencing in the perinatal period.

[3] Part of Dr. Misago’s previous interviews about humanized birth.

The midwives’ continuing support in pregnancy and delivery seems essential in coping with problems and reducing anxiety in normal and high risk pregnancies; however, midwives are not authorized to take care of high obstetric risk women. The midwives’ role and responsibility in high risk pregnancy is an important issue to be studied in future.

A woman’s companion and her family can provide excellent psychological support for women in a period when care providers dispense more attention to saving the lives of mother and baby. Future study needs to clarify how to encourage the family’s support in high risk pregnancy in labor and delivery room.

Finally, in our study, the participants’ difficulties to express themselves in English were the restraints experienced during the data collecting. However, the presence of the translator made us certain about the mutual understanding of the discourse during the interviews. Although the interviewed professionals in our study are not representative for all professionals, however, representativeness is not an objective of a qualitative study. Thus, the findings can bring a true brainstorm and some lessons to the investigators and to the interested public. More research is needed to explore the possible ways in which the healthcare providers’ behaviour toward a high risk pregnancy can be improved.

Conclusion

Humanized care during high risk pregnancies is a changing and developing process, and it is aimed at enhancing patient care for the amelioration of the birthing experience in hospitals. In conclusion, while high risk pregnancies leads to perform more medical monitoring and interventions, one may expect that care might be different and can be considered less humanized. On the contrary, the finding in our study dealt with the necessity of having humanized care in the presence of medical interventions by providing continued support to the patient, and developing the caregiver-patient relationship, as well as aiding in the institution of a mutual decision making process. The results of our study suggest a framework of practice in which the key concepts are continuity, consistency, development of relationships, enhancing the role of the midwife in high risk pregnancy, avoidance of high risk labelling, and recognition of the technological imperative.

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