2012

Registered Nurses' Perception of Hispanic Women's Use, Decline and Preference of Pain Control During Childbirth

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REGISTERED NURSES' PERCEPTION OF HISPANIC WOMEN'S USE, DECLINE AND PREFERENCE OF PAIN CONTROL DURING CHILDBIRTH

by

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A thesis submitted to the faculty of
Gardner-Webb University School of Nursing
in partial fulfillment of the requirements for the
Degree of Master of Science in Nursing

Boiling Springs, N.C.

2012

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Abstract

The purpose of this descriptive study was to identify registered nurses' perceptions of why Hispanic women use or decline pain control during the childbirth process and to identify preferences of pain control. A convenience sample of registered nurses (N = 30) from a large healthcare system in North Carolina was utilized. An 11-item questionnaire using a Likert scale was used. (Appendix A). The questionnaire instrument was developed specifically for this study, and was validated by Julie Stembridge, certified nurse mid-wife, an experienced mid-level provider in obstetrical care. (Appendix B) Demographic data was collected to provide a basis for variations in questionnaire data collected, examined and interpreted. (Appendix C) Findings revealed that 70% (21) of registered nurses agreed or strongly agreed that most Hispanic women are not using pain medication during labor. All nurses with less than 10 years of experience agreed that Hispanic women prefer to decline medication, 70% of nurses with 10 to 20 years of experience agreed with the statement, and just 45% of nurses with over 20 years of experience agreed. If medication was used, the preference was intravenous narcotics and refusal of the epidural option. Of the seven possible reasons, three do not appear to be key barriers (education of pain control options in prenatal care, having support person(s) present during childbirth and fearing modernized medicine). These can be addressed through patient education. Nurses however, were split on the remaining four possible barriers (Hispanic women's expectations changing during laboring and delivery, past experiences, cultural beliefs and cost of pain control).

Table of Contents

List of Figures

List of Tables

Chapter I

Introduction

Statement of Problem

The subject of whether or not pregnant Hispanic patients choose to control pain while going through the laboring process of childbirth has been increasingly interesting to this researcher having practiced in the specialty field of Obstetrics and Gynecology. The current generations of Hispanics are caught between two worlds. One that is steeped in Hispanic cultural, language and traditions on which their heritage and family beliefs are based; the other world is based on their lives here in the United States (U.S.) with all its culture, traditions, modern medicine and technological advances. As nurses it is part of our responsibility to ensure that patients have as much information as possible to make the most informed decision regarding the care that is being offered to them, while also being available to support those decisions and maintain the highest level of independence for the patient that they are capable of at a given point in time.

This ethnic group immigrates to the U.S. with the very real hope for a greater quality of life. Despite healthcare that is available to this population, this researcher still sees a percentage of these women arriving ready to give birth, having sought little to no care at all. This leads to a large gap of valuable prenatal/postnatal education that is missed, which in many instances results in the patient not utilizing available pain control options. Culturally, Hispanic women are expected to labor during childbirth in a calm, quiet manner that does not accept pain medications because of the harm that will come to the infant, (Transcultural Index of Hawaii, 2008).

Purpose

The purpose of this research study is to determine what is the registered nurses' perception of Hispanic women's use, decline and preference of pain control during childbirth. Once completed, the data from this study will aid in identifying specific barriers that nurses may see which can interfere with Hispanic patients making an informed decision about pain control. By identifying these barrier(s), nurses can individualize the care being given to further support and nurture a positive, supported experience resulting in an enhanced level of satisfaction and care being given.

Background/Social Significance

Factors that may be influencing the Hispanic patients' decision-making include the real possibility of being "deported back to their homeland if they are here illegally and are reported to our US government" (Slevin, 2010). When seeking care, some see this as an opportunity to be discovered, and will not run the risk of exposure. Instead, the Hispanic patient arrives in the emergency department in active labor.

These women have male partners who often make important decisions for the "family" unit, this being part of the Hispanic culture. In most instances, the man is uneducated regarding the situation and relies on what he has heard from family and friends. The information is not always accurate, therefore leaving the women at a great disadvantage.

Financial inability to pay for this aspect of care is yet another very important consideration in this study. The current economic climate makes this a very viable, and in some cases pivotal element of this equation. As this research unfolds, nothing was ruled out as a possible factor that could drive how this population makes pain control

decisions. The perspective of the labor and delivery room nurse will help to uncover the more prominent factor(s).

Glance et al. (2006) identified racial differences in the use of epidural analgesia for labor. There is strong evidence that pain is under-treated in black and Hispanic patients. Another study that complimented those findings was performed by Rust et al. (2004), which found both racial and ethnic disparities in the provision of epidural analgesia to Georgia Medicaid beneficiaries during labor and delivery. Subjects maintained identical Medicaid insurance coverage, while adjustments were made for clinical characteristics, demographics, insurance coverage, and healthcare providers. Race/ethnicity was still a significant predictor of epidural analgesia usage.

With the limited amount of available literature, healthcare systems need to be more abreast of this population's needs and cultural practices in order to improve patient-centered care.

Conceptual Framework

This study provided the vehicle to examine what the labor and delivery nurses' perspective is regarding Hispanic women's use, decline and preferences to using pain control during childbirth. Nurses help to protect, promote, and optimize an individual's health and abilities, while making sure to alleviate suffering through diagnosis and treatment of human responses, always advocating in the care of the whole being. Orem's Self-Care Deficit Theory (see Figure1) provides the constructs considered essential to adaptation, which in turn will enable the nurse to assist in greater understanding of the Hispanic patient, culture and lead to effective nursing care to foster the highest level of independence possible.

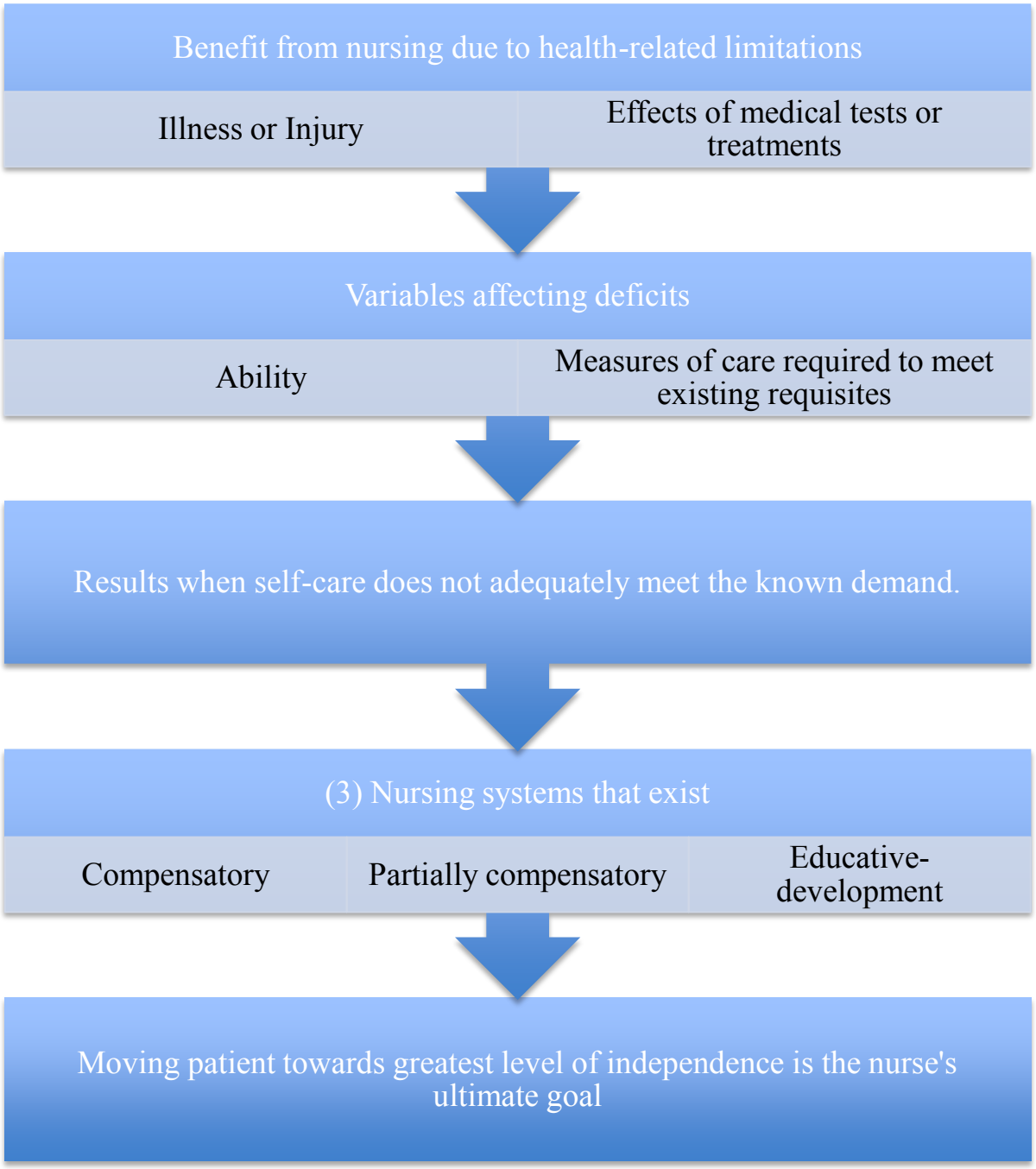

Figure 1. Orem's Self-Care Deficit Theory, McEwen and Wills (2007), p. 144-145.

Significance to Nursing

Hispanic patients have become a large portion of the population that is cared for by the U.S. Healthcare System. Understanding this patient population is an important part of being able to provide patient-centered care that conveys confidence, dependability, accuracy, and excellence. The significance to nursing is having a greater awareness of the intricacies that make up the Hispanic patient. Those steeped in traditional culture and beliefs that have just come to the US, and those that were either born in the U.S. or have been here for many years and are Americanized, but still have a Hispanic background. We currently care for both types of patients and administer nursing care in different approaches in order to meet their needs.

Being able to identify those differences by adjusting the nursing care to accommodate the individual's values, wishes, and goals during this very stressful experience ties in this researcher's use of Orem's theory of Self-Care Deficit. This is a time when the patient is unable to meet their own needs, and cannot always recognize it for the sake of their own self-preservation, rendering them incapable of the act.

As a result greater understanding will help to change polices, procedures, increase cultural and ethnic sensitivity, and improve how this population is cared for. This will elevate nursing practice as it continues moving forward with evidence-based practice (EBP) approaches and further research.

Theoretical assumptions

The Self-Care Deficit Nursing Theory by Dorothea E. Orem, was used as the theoretical framework for this study. Two of the nine concepts she identified form the conceptual framework for this research study. The concept of therapeutic self-care

demand is interpreted as a nurse's ability to meet a patient's needs when they cannot recognize it for their own self-preservation or are incapable of the act. Maintaining balance in a client's environment is a very important factor in achieving homeostasis.

The second concept that is most applicable to supporting this research is "Nursing System (the product of a series of relations between the persons; legitimate nurse and legitimate client). The system is activated when the client's therapeutic self-care demand exceeds available self-care agency, leading to the need for nursing" (McEwen & Wills, 2007, p. 146). Allowing nursing to step into assisting in care when the client's condition is such, that it is beyond his/her own ability to care for them.

These concepts provide this study a context for the identified variables to be explored through research to assist in explaining why this population may use or decline pain control options in childbirth. Most women depend on medical monitoring, support, and nurturing care throughout the childbirth process. Regardless of ethnic background, most women reach a point in the process where they are unable to meet or recognize that they are unable to meet their own self-care needs. This supports the second concept and activates the patient's therapeutic self-care demand, which turns towards the need for nursing support and care.

Research question

What are the registered nurses' perceptions of why Hispanic women use or decline pain control and what are their preferences of pain control?

Chapter II

Literature Review

Hispanic women account for a very large portion of the populations that is served in healthcare today. Childbirth is a very important part of that care, and the US prides itself, as reported by the National Institute of Health, (2011) its success in decline of infant mortality rates as compared to other countries around the world today. Understanding the Hispanic culture is an important part of care giving and customer service that cannot be ignored, but embraced.

The literature that this researcher has included reflects investigations that may pose as barriers to the Hispanic population receiving pain control support while going through the childbirth process. Limited resources were identified due to the lack of research available on the subject matter that was solely nursing care based. Those studies found and used included literature that dealt with epidural use in labor, maternal satisfaction of pain control, intentions to use pain control, relationships between beliefs childbirth and pain control, racial and ethnic disparities that may exist in receiving pain control, and maternal health insurance coverage as a determinant of obstetrical anesthesia care. This researcher's interest to begin to uncover possible barriers specific to the Hispanic population has begun with the nurses' perspective due to the close and intimate relationship that exists with the patient. Years of experience and expertise in the specialty provided a starting point that will enable this researcher to draw conclusions and detect trends that are present in this study.

Glance et al. (2007) reported that Hispanic pregnant patients typically do not chose pain control during their labor and delivery experience. Their study stated that

many wonderful things come from giving birth, both tangible and intangible, yet there are also choices that come from the experience that are not discussed in detail prior to the estimated date of confinement (EDC). The researchers explored the possibility whether patients of different races and ethnicity, after adjusting for socioeconomic status (insurance and education level), and clinical risk factors would be equally likely to receive epidural analgesia for labor had they been treated by the same obstetrician.

Glance et al. (2007) found using New York State's Perinatal Database provided them with data on 81,883 women admitted for childbirth between 1998 and 2004. Results showed that Hispanic and black patients are under-treated. Glance et al. (2007) stated that the association between race and ethnicity and the use of epidural analgesia for labor is not well described. Data collection was performed by trained data collectors' thoroughly recorded demographic information, medical, obstetric conditions, as well as maternal and perinatal outcomes. Data checks were performed by the New York State Department of Health. Regular meetings took place with hospital coders and representatives to minimize variability in the data gathering process and to maintain standardized field definitions.

Data evaluation was methodically laid out and easily understood when reading this study. Findings supported the hypothesis and documented findings of other studies of the inequities of pain control with races other than white, and minorities that have been performed earlier. Characteristics that came to light through this study included:

1. Black and Hispanic women less likely than white women to receive epidural analgesia for labor.

2. Patients with private insurance have the highest rate of epidural analgesia, whereas women without insurance coverage have the lowest rate.
3. Black patients with private insurance have the same rate of usage as white patients without any insurance.
4. No difference in rate of epidural use among blacks with Medicaid or without insurance. Glance et al. (2007)

The study concluded that racial disparities exist in health care and are due, in part, to ethnicity of the patient and financial means. After adjusting for clinical risks factors, socioeconomic status, and provider effects, patients with private insurance have the highest rate of epidural analgesia, whereas women without insurance have the lowest rate. Analysis and interpretation of this study's results poses the question: Is it dependent upon a women's racial and/or ethnic heritage that influences if they are to receive epidural analgesia for labor, when compared to their counterpart white patient? The researchers (Glance et al., 2007) found that this observational study cannot establish a cause-and-effect relation between an outcome (use of epidural analgesia) and a clinical characteristic (race and ethnicity). There is always a possibility of unmeasured variables that may have biased their findings. Lastly, this study was based on residents of New York State and may not be generalizable to other regions or states.

Halls' (2008) research identified factors, such as, pain perception, patient preferences, provider bias, cultural stigmas, cost, and lack of education in the prenatal visits as examples of reasons why certain populations do not use analgesia during labor. Halls' (2008) reported that one in four Americans currently belongs to a racial or ethnic minority group, and this number is projected to increase to one in three by the year 2025.

The researchers recognized that maternal satisfaction regarding the experience of childbirth is influenced by a unique combination of factors. Halls' (2008) research study examined a sample study comprised of mothers at a chosen hospital over a four-week period. The maternity records were reviewed with regards to features of their delivery; uptake of analgesia; and adherence to anesthetic protocol. Each mother was given a questionnaire post-delivery, asking the mother to evaluate their chosen method of pain relief; to describe the severity of pain they experienced, and to determine their overall level of satisfaction. The study took place in the United Kingdom (U.K.), where at this particular hospital, women had a number of options regarding how they wanted to manage their pain. "Of the 178 women who experienced a vaginal/failed vaginal delivery, there were a number of discrepancies between the mode of analgesia documented in the maternal notes and that acknowledged by the mother" (Halls, 2008, p.299). This appears to be attributed to some of the medication choices these women have in this country that interferes with a mother's cognitive status, especially inhibiting her memory. A questionnaire post-delivery may not have been this investigator's best choice of tools. The margin on inaccuracy in reporting did not affect a large percentage of the women (only seven), but of the 178 women who initially were participants, only 154 respondents completed the questionnaire.

The survey indicated, over the past decade, women have more choices of pain control during childbirth, but in more recent years are choosing less invasive methods. An improvement would be that women do feel that they are better educated, and therefore make informed decisions about their care. This small sample showed that "fewer women requested epidurals than those identified in Keel's (1996) research,

despite its current promotion as 'the most effective and reliable method of relieving pain' for childbirth" (Halls, 2008). Halls' research was conducted in the U.K. where obstetrical practice is different than here in the U.S. More medicine choices for analgesia are offered in the U.K. than is offered the U.S. A limitation identified by Halls was that the study did not separate women that are primipara and women who are multiparous. Halls reported that expectations regarding the pain of childbirth are considerably biased, due to previous experience.

Schytt and Waldenstrom (2010) investigated the dramatic increase in epidural rates between hospitals in Sweden in the year 2006. Schytt and Waldenstrom attempted to discover what influences women to seek pain relief while going through the childbirth process. The facilitating aspects surrounding this study is that the researchers failed to identify any obvious explanation related to catchment area and the selection of women, such as differences between urban and rural areas, socioeconomic circumstances, level of hospital, or hospital size measured by number of deliveries per year. The data collection design was a population-based cohort study. The women included in the study were collected in 2000, when the epidural rate for vaginal births in Sweden ranged from 11% to 42% in a total of 54 hospitals. Information about epidural pain relief had been given by midwives during the antenatal check-ups or in antenatal classes. Ninety-three percent (93%) of the nulliparous women in the sample and 19% of the parous women, most of who had attended classes during a previous pregnancy, attended such classes. Participants in the study completed two questionnaires. The first was completed during the antenatal visit, which was comprehensive in demographics and the perception of pain during labor prior to delivery. The second questionnaire was completed eight weeks after delivery.

Questions pertained to attendance at antenatal childbirth and parenthood education classes, whether the woman had received counseling due to fear of childbirth during pregnancy, the name of the hospital, and whether or not the woman had had epidural analgesia during labor. Results indicated differences between regions of the country. In addition, differences may have differed in the attitudes toward epidural analgesia among individual midwives and individual doctors, as well as between the two professions. This was found to be the case in prior research when investigating attitudes toward cesarean section (Schytt & Waldenstrom, 2010).

Schytt and Waldenstrom (2010) concluded that influential leadership plays an important role in use of natural childbirth or epidural analgesia. A head of an obstetric department or a delivery unit, or a strong informal leader, with a commitment to encourage natural childbirth may influence colleagues to avoid epidural analgesia, whereas a leader with a stronger focus on reducing labor pain may indirectly increase the epidural rate.

Green and Baston (2007) investigated the rising rates of cesarean section and other obstetric interventions, including the suggestion of a change in women's attitudes. The researchers examined women's changes in acceptance of obstetric interventions from 1987 and 2000. The researchers also looked at the relationship between willingness to accept obstetric interventions and mode of birth. Data collection consisted of three questionnaires, with the first two being taken on the woman's willingness to accept obstetric interventions at their 35-36 weeks gestation. The second one was administered six weeks postnatal. Participants in the study came from eight maternity units in England due to give birth in April to May 2000. Four of the maternity units used were in the south

of England where the 1987 study had occurred. An additional four maternity units serving similar populations in the north of England was included in the study. All served semirural areas where the major employment was agriculture related, light industry, service industries, or armed services.

Data evaluation was based on an average or 81% or 1330 completed returned questionnaires. Once adjustments were made to the sample group, 977 women were compared with 512 women from the 1987 study and who met similar criteria. Results revealed that women's attitudes are more favorable to interventions which has contributed to the decline in rate of unassisted vaginal births. This study highlights the medical advancements in the obstetrical specialty and the approach to education which has empowered women to help them make the "right" choice for their care.

Heinze and Sleigh (2003) examined the differences between women who labor with or without epidural anaesthesia and beliefs about childbirth and pain control choices. Demographics, personalities characteristics, amount of support from outside sources, level of education in the childbirth process are just a few of the factors that were identified. This was a partial replication of a study done by Poore and Foster (1985) that allowed these investigators to pick up where it left off. The researchers examined factors that were new to childbirth and the specialty of obstetrical medicine, as well as those that had remained constant over time.

This study was comprised of a very small group of women who had given birth within the six months prior to participating. Twenty-six women received an epidural, and 20 did not. All but two participants were white/Caucasian living in the U.S. One woman was Indian and one was German" (Heinze & Sleigh, 2003). This was a three-part study

with the first part of the survey focusing on demographics, support available for childbirth process and type of pain control used. The second part of the study conducted by Poore and Foster (1985) examined beliefs and perceptions about childbearing and used the published scale'The Utah Test for the Childbearing Year: beliefs and perceptions about childbearing". The final portion of the survey focused on the amount of knowledge the women had of the potential side effects of epidural use. Comparison of these surveys found that women surveyed almost two decades earlier had similar responses in study by Heinze and Sleigh (2003), indicating that perhaps women's attitudes may not change as quickly. The study also supported the argument that a women's choice about pain control is more closely related to her ideologies about childbirth than to her physical situation during childbirth. Limitations identified in the study were: lack of diversity in the sample, small sample size, and the women were visitors of a website related to pregnancy issues.

Williams, Povey, and White, (2008) focused on predicting women's intentions to use pain relief medication during childbirth based on the theory of planned behavior (TPB) and self-efficacy theory. The study examined whether antenatal beliefs about pharmacological and non-pharmacological pain management strategies predicted women's intentions to use Entonox, Pethidine, and epidural analgesia during childbirth. The study was performed in the United Kingdom (U.K.) where Entonox (equal measures of nitrous oxide and oxygen) was inhaled by the patient through a mouthpiece or mask, as and when needed. Pethidine, an opioid analgesic, was administered via intramuscular or intravenous injection. One hundred women planning their vaginal births during their third trimester of pregnancy were included in the study. Overall response rate of the eligible

women was 59.3%. Data evaluation consisted of intentions to use all three medications significantly correlated with the three components of the TPB. The strongest correlation was with the epidural analgesia; the use of Pethidine was most strongly correlated with subjective norm and intention to use nitrous oxide and oxygen was most strongly correlated with attitude. Analysis and interpretation indicated that in this investigation the TPB was an accurate predictor of which medicine would be used according to patient beliefs about pain management. However, the investigators discovered that the self-efficacy theory was not an accurate predictor of the women's beliefs about using non-pharmacological pain management strategies.

Rust et al. (2004) focused on racial and ethnic disparities in the provision of epidural analgesia given an extremely large study sample available for exam. This data was collected from the state of Georgia's Medicaid beneficiaries and allows a glimpse of where percentages fall in the scheme of black, Hispanic, Asian, white, non-Hispanic, as well as rural and urban classifications and their use of this type of pain control. The purpose of the study was to measure racial and ethnic differences in the proportion of Medicaid patients who receive epidural analgesia during labor and delivery. Medicaid claims data from the 1998 State Medicaid Research Files (SMRF) was used to identify racial and ethnic differences for epidural procedures among all Medicaid-insured women aged 15 to 44 years who experienced normal labor and vaginal delivery during the calendar year 1998 in Georgia. There were 29,833 subjects who met study criteria, of whom 15,936 had epidural analgesia. Data evaluation was performed in a very meticulous and methodical approach beginning with separating out normal vaginal deliveries that received epidural analgesia. The investigators maintained the racial and

ethnic differences from the beginning of the data evaluation, which made the process more approachable in deciphering out the particulars considered. Analysis and interpretation began with establishing that the labor pain did not differ among race or ethnic difference between women. Results showed a significant disparity in the provision of epidural analgesia to Medicaid-covered women from the same state. Rust et al. (2004) reported that physicians provide care differently to patients of differing race or ethnicity for conditions such as chest pain, kidney failure, and cancer. As this study stressed, a variety of factors influence any woman wanting an epidural which include provider influence, demographics, culture, parity, financial, etc. Assumptions or stereotypes about patient preferences or pain tolerance may be another factor to be considered and may be more common. Some providers or hospitals may also devalue patients who are uninsured or who are receiving Medicaid (Rust et al., 2004). Another factor considered was the shortage of anesthesiology personnel in some parts of the country and in some counties in states across the U.S. A final consideration noted was the severe under representation of black non-Hispanic and Hispanic physicians in the U.S. It is presumed that clinicians of the same racial or ethnic group as the patient would be more responsive to those patients' expressions of pain and needs (Rust et al., 2004).

The population-based study by Obst, Nauenberg, and Buck, (2001) measured the effect that insurance status has as a source of variation in obstetric pain management. The researchers utilized Medicaid insurance covered women in upstate New York during 1992. The researchers stated that there has been evidence that lack of prepayment; having to pay cash for the procedure; a sort of cost sharing arrangement, or simply due to the fact that these women had Medicaid coverage put them at a disadvantage in receiving

pain relief. Data collection occurred through two main sources which included (1) the 1992 New York State Department of Health (NYSDOH) live birth registry for residents of upstate New York and (2) the 1992 American Hospital Association (AHA) Annual Survey of Hospitals database. The final study population consisted of 121,351 singleton live births. Ninety nine percent of the population examined reported some type of medical insurance. Of that percentage, 81% received local, general, spinal, or epidural analgesia. Findings suggest that the use of obstetrical pain control techniques is influenced not only with the type of maternal health insurance but also with maternal ethnicity among those who deliver a singleton live-born infant with either a vaginal or cesarean method of delivery. The study also revealed a significant variation in anesthesia use by ethnicity.

This literature review shows that particular patients with certain types of insurance may be less informed on choices during the laboring process, therefore possibly becoming a factor in their decision-making of patients, or allowing the medical system to make them for the patient.

Summary

The literature reveals several concepts related to possible barriers associated with use or decline of pain control options in childbirth, as well as preferences if they choose to use medication. There exists the likelihood of black and Hispanic women not receiving labor analgesia compared to Caucasian women with similar socioeconomic and clinical risk. Researchers recognized that maternal satisfaction regarding the experience of childbirth is influenced by a unique combination of factors, one dominant component being pain control during the process. An increase in epidural rates has occurred but may

not be used in certain ethnic or financial groups. There is a need to identify the influences on women seeking pain relief while going through the childbirth process. Medical advancements in the obstetrical specialty and the approach to education have empowered women to the "right" choice for their care. Beliefs about pharmacological and non-pharmacological pain management strategies may predict women's intentions to use certain pain management interventions.

The concepts determined from the literature relate to the possible barriers that Hispanic women may encounter in understanding their pain control options in childbirth. Labor and delivery room nurses have an influence on whether this population receives pain control medication and their preference largely in part to years of work experience and the close intimate relationship that is formed while care giving. The proposed research will aid in establishing the nurse's role in meeting patient's needs, as well as being able to recognize when the client's condition is such that it is beyond her own ability to care for herself as defined through Orem's Self-Care Deficit Nursing Theory.

Chapter III

Method

Setting

This study took place in a large acute care hospital system that provides obstetrical care to Hispanic women in North Carolina.

Subjects

Subjects were registered nurses working in a labor and delivery unit with a variety of years of work experience specific to this specialty area.

Sampling

A descriptive study design utilizing convenience sampling was used to sample nurses in North Carolina. Approximately 30 subjects were obtained.

Instrument

The questionnaire tool was developed by this researcher, and then validated by an experienced mid-level provider whose specialty is obstetrical care. It is comprised of six demographic questions, followed by 11 questions specific to their perspective of why Hispanic women use or decline pain control in childbirth. It also includes their preference of pain control if they chose to use medications. A Likert scale was used to measure responses that offered the respondents the amount of agreement or disagreement they had to the question.

Procedure

All participants were volunteers who responded to the questionnaire distributed by the researcher. Participants were recruited using face-to-face recruitment and

snowballing. Informed consent was implied from return of the survey. Participants in the study were not excluded based on race, age, gender or work shift.

Ethical Consideration

Prior to conducting this survey, permission was obtained from the Internal Review Board (IRB) for Gardner-Webb University. This study did not pose any risk to its subjects, nor did it involve any deception of any kind. At any time during the study, the participant had the option to decline to continue participation. No incentives were used.

Data Collection

Surveys were distributed in an unmarked envelope, which participants returned without disclosing their completion of the survey. The participants were instructed to refrain from placing identifying marks on the survey. The data set did not include encrypted subject identifiers. Data was reported as aggregate data only.

Data Analysis Procedures

The response on the questionnaire received coding that coincided with the participants given response. This allowed for data to be more easily inputted into a statistical formatting that identified those variables that were most influential in the nurses' decision-making. All statistically significant variables were tested by logistic regression analysis, and presented with 95% confidence interval (CI's).

Chapter IV

Results

Demographic Characteristics

The data sample included a convenience sample of registered nurse participants with (N=30) from North Carolina, without decline of participation. Demographic characteristics were collected of the data sample's education, years of experience as a nurse, years of experience in labor and delivery, and what shift they worked most of the time. Of the 30 nurses interviewed, 28 were Caucasian females therefore, differences in perceptions by the gender or ethnicity of the respondents was not possible. There was variation across the 30 nurses in terms of education, years of overall experience, years of labor and delivery experience and work shift (see Table 1). When notable differences in responses exist across these nurse-specific dimensions, we note these in our key findings below.

Table 1

Registered Nurses' demographics in terms of education; years of overall experience and of labor/delivery experience; and work shift.

Education	
Diploma	1
Assoc	10
BSN	14
MSN	5

Work Shift	
Day	17
Night	13

Years of Experience	
Under 10	9
10 to 20	10
Over 20	11

Years of L&D Experience	
Under 10	12
10 to 20	9
Over 20	9

Statistical Presentation

The objectives of this study were to assist the researcher in identifying registered nurses' perceptions of why Hispanic women choose to use or decline pain control in

childbirth. In-person surveys were conducted with 30 registered nurses working in labor and delivery units at a large hospital in eastern North Carolina. Data was collected from June 19, 2012 to June 27, 2012.

In examining the responses to the question "Are Hispanic women using pain medication during labor and, if so, what type?, the finding was that most Hispanic women are not using pain medication during labor. As expected, the majority of nurses (70%) 21 agreed or strongly agreed that most Hispanic women prefer to decline pain medication with the goal of a "natural" childbirth (Question 8)." It was felt that the patients are avoiding epidurals altogether, and if they do use pain medications, will rely on just narcotics. The data also indicates that all the nurses believe that the small minority of Hispanic women who do receive pain medication strongly prefer using just intravenous narcotics, avoiding epidurals and narcotics and epidural combinations (Q. 5, 6 & 7). Refer to Tables 2-4 for comparison of the variables of patients' past experience, patients' culture, and cost and years of experience of nurse.

Table 2

Comparison of the variable of patients' past experience and years of experience of nurse.

Q4 (Patient's Past Experience) and Years of Experience of Nurse

Count of ID	Column Label		
Row Labels	SD + D	SA + A	Grand Total
Under 10	56%	44%	100%
10 to 20	50%	50%	100%
Over 20	73%	27%	100%
Grand Total	60%	40%	100%

Group Differences in % Agreeing	
"Over 20 v "10 to 20"	"Over 20" v "Under 10"
- 0.23	- 0.17

Table 3

Comparison of the variable of patients' culture and years of experience of nurse.

Q10 (Patient's Culture) and Years of Experience of Nurse

Count of ID	Column Label		
Row Label	SD + D	SA + A	Grand Total
Under 10	67%	33%	100%
10 to 20	60%	40%	100%
Over 20	55%	45%	100%
Grand Total	60%	40%	100%

Group Differences in % Agreeing	
"Over 20 v "10 to 20"	"Over 20" v "Under 10"
0.05	0.12

Table 4

Comparison of the variable of patients' cost and years of experience of nurse.

Q11 (Cost) and Years of Experience of Nurse

Count of ID	Column Label		
Row Label	SD + D	SA + A	Grand Total
Under 10	56%	44%	100%
10 to 20	50%	50%	100%
Over 20	64%	36%	100%
Grand Total	57%	43%	100%

Group Differences in % Agreeing	
"Over 20 v "10 to 20"	"Over 20" v "Under 10"
- 0.14	- 0.08

Why are so many Hispanic women choosing not to use pain medications, especially epidurals? Of the seven possible reasons, three do not appear to be key barriers for Hispanic women using pain medications during labor - most of the nurses interviewed agreed or strongly agreed that Hispanic women are:

1. receiving prenatal care that has included available pain control education options,
2. have support person(s) with them during childbirth, and
3. do not fear modernized medicine for themselves and their infant. (Qs. 1, 2, and 9).

While it would be important to hear directly from Hispanic women on these issues, particularly the actual quality of the prenatal care they feel they're getting and level of support from the person with them, that is outside the scope of the current study.

Importantly, the nurses were (roughly) evenly split on the importance of the four reasons that appear to be the primary barriers for Hispanic women using pain medications. Data collected indicated that 57% (17 out of 30) of the nurses felt that Hispanic women's "expectations change during the process of labor, resulting in a request for pain medication," that in most cases appear to be made too late in the process (it would be interesting therefore to see if the rates of pain medication use increases during subsequent births once they're more experienced and know what to expect) (Q. 3). The data also revealed that 40% (12-13 out of 30) of the nurses also agreed or strongly agreed that past experiences, cultural beliefs and the cost of pain control may be significant barriers for pain medication usage among Hispanic women. (Qs. 4, 10 and 11)

Chapter V

Discussion

Interpretation of Findings

Are there nurse-specific attributes that could explain Hispanic women's lack of use? While we see no significant differences by the education or type of work shift among our nurses, there is a very clear and important pattern with respect to the nurses' years of overall and labor and delivery experience: Whereas 100% of nurses with under 10 years of experience agreed that Hispanic women prefer to decline pain medication, only 70% of nurses with 10 to 20 years of experience agreed with that statement, and just 45% of nurses with over 20 years of experience agreed.

This clear difference may suggest that more experienced nurses are more successful at educating and persuading Hispanic women to use medication. In addition, Hispanic women may simply feel more comfortable and/or are more likely to trust the advice of older, more experienced nurses when discussing the use of pain medication.

Finally, nurses with over 20 years of experience are much less likely to agree that it is the Hispanic woman's past experience or concern about affordability that is preventing her use of pain medication during labor, and slightly more likely to agree that it is the woman's cultural beliefs that are the key barriers. We suspect that more experienced nurses have a greater knowledge and appreciation for these cultural barrier and may be more successful at overcoming them during the labor process.

Implications for Nursing

The findings from this study gives obstetrical nurses at the bedside information, that in some cases they already knew, that most Hispanic women are not taking pain

medication for childbirth. In the instances that they do request medication, they prefer intravenous narcotics only, and decline epidural placement. Despite a language barrier at times, this optimizes Orem's self-care deficit nursing theory by providing the support these women need and want during the childbirth process.

There were four aspects that were identified by the nurses as being so important as to act as a possible barrier for these women not receiving pain medication through the childbirth process. Identifying that this population's expectation changes during the process, resulting in a request for pain medication, and in most instances it being too late to help. Being too late to help is determined in regards to maintaining the safety of the infant and the administration of intravenous narcotics to the mother too close to delivery. It may jeopardize the infants' respiratory effort upon delivery. Having nurses begin to pay closer attention to what their expectations are upon admission, if possible and being given the appropriate amount of time, solely based on how uncomfortable they are and do they have the mechanisms in place to cope with the process.

The study also brought forth the consensus of a women's past experience, cultural beliefs and the cost of pain medication as all being possible barriers. The resounding difference was revealed in the amount of experience nurses have, which enables them to more successfully educate and persuade these women to use pain medication when appropriate. What our profession can do for those nurses that don't have much experience in this specialty is provide them with culturally sensitive education and evidence-based practice approaches so they may guide these women through the process of making that decision sooner than later. This will have an overall positive impact for the women and her reflection upon her birth experience. In theory, this should translate

into more positive customer service scores and greater satisfaction with the healthcare systems' performance.

Implications for Further Research

Recommendation for further research includes an increase in the sample size which would yield an increase in the number of participants who work in this specialized area of nursing while giving the researcher greater, more comprehensive bases of findings.

Equally as important, provide a questionnaire to the Hispanic women and capture their feelings and determine whether being in the US longer has changed their thought process about taking pain medication. Does this population feel like they are getting enough prenatal education of their options before they arrive to the hospital for childbirth? Do their cultural beliefs play a part in their decision-making process and if so, what are those determinants? Does the cost of pain medication or fear play a role in their decision-making regardless of it being based on harming the infant or possibly becoming paralyzed from the placement of an epidural?

Answers to all of these questions will undoubtedly help nurses take better care of this population by increasing our understanding of who they are as individuals and there Hispanic origin. These may or may not be variables that could be addressed during prenatal care visits. It will hopefully facilitate our healthcare systems to recognize and readjust their programs to better inform and serve their needs. It may also increase their compliance with prescribed prenatal care, resulting in higher scores on customer satisfaction evaluations, greater neonatal outcomes, and full reimbursement to our healthcare systems for the excellent care they are giving to this population.

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Appendices

Appendix A

Registered Nurses' Perspective Questionnaire

Registered Nurses' Perspective Questionnaire

Registered Nurses' Perception of Hispanic Women's Use, Decline and Preferences of Pain Control during Childbirth

You are being asked to complete this survey to assist the Primary Investigator (PI) in identifying a Registered Nurses' perception of why Hispanic women use or decline pain control in childbirth and their preferences. As you move this questionnaire, please focus on Hispanic women in general, based on your years of experience as a Labor and Delivery room nurse.

Reasons for Use	**Strongly Disagree**	**Disagree**	**Strongly Agree**	**Agree**
Most Hispanic women have received prenatal care that has included available pain control options.				
Most Hispanic women have support person(s) with them during childbirth.				
Most Hispanic women's expectations change during the process of labor, resulting in a request for pain medication.				
Most Hispanic women base their decision on a past (positive or negative) experience.				

Their Preferences				
Of those Hispanic women that receive pain medication, they prefer using intravenous narcotics only.				
Of those Hispanic women that receive pain medication, they prefer using only an epidural.				
Of those Hispanic women that receive pain medication, they prefer a combination of intravenous narcotics and epidural placement.				

Reasons for Decline				
Most Hispanic women prefer to decline pain medication with the goal of a "natural" childbirth				

Most Hispanic women fear modernized medicine for themselves and their infant.				
Most Hispanic women's cultural beliefs prohibit her from receiving pain medication in childbirth.				
Most Hispanic women feel like they cannot afford the cost of pain control during childbirth.				

Appendix B

Validation Tool Letter

6/9/2012

To Whom It May Concern,

I Julie Stembridge, having worked as a Certified Nurse Midwife for 5 years in women's health and obstetrical care, find this assessment tool valid. Its focus is on a Registered Nurses' perception of Hispanic women's use, decline and preferences of pain control during childbirth. The Likert scale offers respondents the amount of agreement and disagreement they have to the question being asked. This would be an effective measurement tool in research.

Regards,

Julie Stembridge, CNM
(Electronically signed)

Appendix C

Demographic Questionnaire

Demographic Questionnaire

Registered Nurses' Perception of Hispanic Women's Use, Decline and Preference of Pain Control during Childbirth

Demographic Data Sheets

Years of Experience as Registered Nurse:_____

Years of Experiences working in Labor and Delivery: _____

Educational Level: Diploma _____
Associate Degree _____
Bachelor Degree_____
Master's Degree_____
Doctoral Degree_____

Shift primarily worked: 7a to 7p _____
7p to 7a _____

Ethnicity: Caucasian_____
African American_____
Hispanic_____
Asian_____
Other_____

Gender: Female_____

Male_____