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Obstetric care: challenges for quality improvement

Cuidado obstétrico: desafios para a melhoria da qualidade

Atención obstétrica: desafíos para la mejora de la calidad

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The point of departure for the following commentary is a research-intervention project focused on improvement of obstetric care in public maternity hospitals in a large Brazilian city from 2015 to 2017, in which we aimed to understand the context for implementation of the intervention. The sources were interactions with administrators from the Municipal Health Department and the maternity hospitals, and especially interviews with administrators, physicians, nurses, and postpartum primiparous women in the hospitals.

The participating maternity services all had what they perceived as adequate infrastructure and were all engaged in the Brazilian National Policy for Humanization of Childbirth. The deliveries were attended by obstetric nurses and physicians [1]. All of the maternity services complied with the Brazilian Ministry of Health guidelines to reduce obstetric interventions and increase the use of evidence-based practices to manage labor and delivery in low-risk pregnant women [1,2]. These maternity services have cesarean rates from 30 to 35%, lower than the national average for the public sector, which is 43%, and less than half the extremely high average of 88% in the private sector [3].

It is beyond the scope here to make generalizations, but we believe that the questions and comments addressed can contribute to dealing with prevalent problems in the management of childbirth in Brazil and in improving the quality of care.

One issue that deserves attention is the coexistence (although with little integration) of the model of childbirth care conducted by obstetric nurses and the more traditional and interventionist model conducted by obstetric physicians. There is a clear power struggle with inter-professional tension, undermining what could otherwise be a desirable form of complementary work. Mutual distrust often appears between physicians and nurses, which hinders timely action in situations in which a delivery initially assessed as low-risk evolves to a situation of greater risk, making medical intervention necessary. Physicians claim to be called in too late in such situations and are quick to point out that they are subject to professional liability. Nurses complain that doctors take too long when called in. It may be difficult to distinguish precisely between the two roles, and thus each professional needs to be more tolerant in dealing with ambiguous situations, without losing sight of readiness, quality of care, and patient safety for mothers and infants. Patient-centered care should be the cornerstone for these professionals, with teamwork as the basis [4].

In Brazil, efforts to reverse the high rates of unnecessary interventions have been based especially on evidence from the UK which indicates that the care provided by professional midwives with

specific higher-level training reduces obstetric interventions without increasing the clinical risk for women and their infants [5,6]. In the British model, midwives and obstetric physicians have well-defined roles, with the midwives in charge of attending women and infants during normal pregnancy, childbirth, and postpartum, and obstetricians involved when there are complications. About 75% of births in the UK are attended by midwives [7]. In Brazil, from 2011 to 2012, nurses attended approximately 16.2% of all vaginal deliveries, with a significantly higher rate of such practices as ad libitum diet, patient mobility during labor, use of nonpharmacological pain relief measures, and use of the partograph, besides fewer interventions such as anesthesia, lithotomy position, fundal pressure, and episiotomy [8].

There is still a long way to go for the model of low-risk childbirth care attended by obstetric nurses in Brazil to be as widely accepted as the original model that inspired it. Different contextual characteristics and conditions at least partially explain the observed difficulties.

The shortage of adequately trained nurses for work in obstetrics is certainly still a problem in Brazil; this shortage is even greater considering the role that they should perhaps play in covering prenatal care. The interviews contained frequent references to the poor quality of prenatal care and the deficient training of the general nurse practitioners in charge of conducting it.

The capacity for readiness and action by the multidisciplinary team, consisting of at least a nurse, an obstetric physician, and an anesthesiologist in critical situations, also proved to be compromised by issues ranging from distrust to two totally parallel hierarchies for physicians and nurses.

There is no equivalent in Brazil for the midwife's role in coordinating the entire line of care from the prenatal period through childbirth and postpartum. Midwives in the UK are responsible for accompanying women through what are classified as low-risk pregnancies, as well as for engaging the medical team when they detect the need for more complex care. The role of coordinating care is crucial to guaranteeing continuity, and in the context of the health system it cannot be assigned to the obstetric physician, a scarcer and more expensive human resource with skills better suited to situations outside the normal range.

In the reality we studied, despite efforts at greater coordination between primary healthcare services that provide prenatal care and the maternity hospitals, including a visit to the referral hospital by the expecting mother prior to labor and childbirth, there are no strategies for guaranteeing the patient's continuity of care. Communication is precarious in relation to the clinical status of the woman and the infant. The woman's prenatal card often tells very little, and when it does provide information on conditions requiring special attention, it frequently fails to document the measures that have been taken.

It is impossible to ignore physicians' resistance, as a professional class, to deliveries attended by nurses, or even resistance to such deliveries by society at large in a culture that takes medical interventions for granted. The solution to these problems requires more than rules and protocols. It involves a redistribution of power, building relations of trust for multidisciplinary teamwork, as well as trust between healthcare professionals and patients. It requires understanding and realizing that unnecessary interventions can in fact lead to an unfavorable balance between risks and benefits. There are already social movements that increasingly demand normal childbirth. In all the maternity hospitals, we heard reports of a contingent of middle-class patients that wanted precisely the possibility of normal delivery, given the difficulty in identifying physicians in the private sector that were willing to perform it. At any rate, whatever the woman's wishes, she should be informed and have her right to sharing decisions about her care guaranteed.

The postpartum women in our study raised questions that showed how far we are from providing patient-centered care. The women detected inconsistencies in the information provided by different members of the health team, revealing flaws in communication and resulting in a feeling of insecurity for the patient. The women pointed out that the right to have an accompanying person in the maternity hospital is still compromised in some situations, including the inadequacy of the physical space itself. And they revealed how important pain management is for a positive experience during labor and childbirth, supporting the application of nonpharmacological pain-relief alternatives while emphasizing the need for greater availability of anesthetics and anesthesiologists.

Some issues need to be addressed in order to design interventions capable of changing the current scenario.

Roles assigned to leaders and health professionals engaged in the provision of prenatal, childbirth, and postpartum care must be clearly defined, without losing sight of the need to facilitate the coordination and continuity of individual care, with constant attention to the level of risk involved. Investment in multidisciplinary teamwork is crucial. In the medium and long term, changes are needed in university training to foster multidisciplinary work with an emphasis on not only technical skills but also relational/social skills. In the short term, regular training courses should be performed, centered on improving team communication and realistic simulations of critical clinical situations. Another key aspect is the promotion of more structured communication to actually facilitate the detection of problems and the use of timely interventions.

Beyond the need to maintain adequate structures, the scenario illustrates the complexity and the backing needed for interventions to implement changes and thereby guarantee safe, patient-centered, effective, and equitable obstetric care in a Brazilian metropolis. The scenario also highlights the challenge of conceiving quality improvement in a context of such disparate and unequal regional and local realities in Brazil.

Contributors

M. C. Portela, L. G. C. Reis, M. Martins and S. M. L. Lima participated in designing and performing the study and writing the manuscript. J. L. S. Q. Rodrigues participated in the study with postpartum women and writing the manuscript.

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