

Midwives' expectations from pregnant women regarding their participation in safe delivery: a qualitative study

Roghieh Bayrami

Urmia University of Medical Sciences School of Nursing and Midwifery

Rahim Baghaei (✉ baghaei.r@umsu.ac.ir)

Urmia University of Medical Sciences School of Nursing and Midwifery

Research article

Keywords: Patient participation, Safe delivery, Qualitative study

Posted Date: May 12th, 2020

DOI: <https://doi.org/10.21203/rs.3.rs-26635/v1>

License:  This work is licensed under a Creative Commons Attribution 4.0 International License.

[Read Full License](#)

Midwives' expectations from pregnant women regarding their participation in safe delivery: a qualitative study

Roghieh Bayrami¹, Rahim Baghaei^{*2}

1-Assistant professor in Reproductive health, Department of Midwifery, Patient Safety Research Center, School of Nursing and Midwifery, Urmia University of Medical Sciences, Urmia, Iran;

2- Associate professor in Nursing Management, Patient Safety Research Center, School of Nursing and Midwifery, Urmia University of Medical Sciences, Urmia, Iran;

Corresponding Author: Rahim Baghaei

E-mail: baghaei.r@umsu.ac.ir, rbaghaei@yahoo.com

Abstract

Background: Pregnant women's participation in safe delivery is associated with safety assurance and improvement. Safety and care quality improvement in developed countries has so far been based on research and clinical evidence. Nonetheless, stakeholders' preferences and expectations were not much taken into account. This study aimed to explore midwives' expectations from pregnant women regarding their participation in safe delivery.

Methods: This qualitative study was conducted in 2019 in three public hospitals in Urmia, Iran. Data were collected through 24 in-depth semi-structured interviews with 24 midwives. Sampling was done purposively and continued up to data saturation. Data were analyzed through Graneheim and Lundman's qualitative content analysis.

Results: Midwives' expectations from pregnant women regarding their participation in safe delivery were grouped into the two main themes of effective communication (with two main categories) and empowerment of pregnant women (with three categories). The five main categories of these two themes were client's interaction with midwife, confidence in midwife, readiness for delivery, health literacy improvement, and participation in safe behaviors, respectively.

Conclusions: Understanding midwives' expectations regarding pregnant women participation in safe delivery is important to the development of policies for care quality and safety improvement in perinatal care.

Keywords: Patient participation, Safe delivery, Qualitative study

Background

Concerns over patient safety in maternity settings have increased due to the increase in the number of perinatal interventions in recent years [1]. Studies show that in developed countries, one tenth of patients experience injury while receiving healthcare services. This rate in developing countries is almost twenty times greater [2]. Each year, around 200000 Asian women die due to the complications of pregnancy and delivery and five million neonates die due to inadequate perinatal care [3]. Statistics show that one woman dies among each 20–30 pregnant women who experience acute or chronic morbidity due to the complications of pregnancy and delivery [4]. These complications can negatively affect women's physical, mental, and sexual health, cognitive, mobility, and social abilities, body image, and socioeconomic status [5]. The costs related to the injuries caused during healthcare delivery are 6–21 billion dollars in some countries [2].

Safe midwifery-led care is one of the strategies to ensure safety among pregnant women. It uses confident methods and processes to fulfill women's needs and protect them against preventable errors and injuries [6]. Safe delivery (SD) is a component of safe midwifery-led care and refers to a delivery assisted by trained and skillful professionals in a safe and appropriate environment, in a short time, and with an acceptable cost. SD is performed at the highest level of standard and guarantees maternal and neonatal health [7].

One of the components of SD is women's active participation in the process of delivery. The World Health Organization defines patient participation as involvement of patients and family members in care through providing them with educations about the advantages and the risks of treatments and empowering them for informed decision-making and collaboration with healthcare providers [8]. Patient participation in healthcare services is considered as a critical component of healthcare delivery [9, 10] and evidence-based medicine [11], an ethical requirement, and an effective method for care quality improvement [12]. According to the International Confederation of Midwives, one of the basic rights of pregnant women is to become aware of the advantages and the disadvantages of different treatment options and participate in the process of decision-making for cure and care [13].

Patient participation has many different outcomes. It is associated with greater patient safety, higher patient satisfaction, greater patient confidence, lower level of anxiety, better understanding of individual needs, closer relationship with healthcare providers, and positive long-term effects on health [14]. The informed participation of pregnant women in the process of treatment and care not only enhances their satisfaction with delivery, but also reduces the rates of cesarean section and pregnancy complications [13]. Moreover, it reduces the rates of medical errors, attendance at healthcare settings, and unnecessary hospitalizations, and thereby, reduces healthcare-related costs [13].

Midwives have some expectations from pregnant women in the process of safe midwifery-led care with the participation of pregnant women. Relevant studies in this area only addressed some aspects of safe midwifery-led care. For instance, a study reported that physicians' motivation for involving patients in care services is one of the factors affecting patients' participation in safe care [15]. Similarly, a study showed that midwives' interaction with their clients significantly affected pregnant women's participation in SD [16]. Another study found that patient safety was among pregnant women's expectations in labor and delivery [17]. However, no study had yet evaluated these expectations among Iranian midwives who engage in safe midwifery-led care with the participation of pregnant women. Therefore, the present study was conducted to narrow this gap. The aim of the study was to explore midwives' expectations from pregnant women regarding their participation in SD.

Methods

This qualitative study was conducted from January to August 2019 through conventional content analysis [18]. Participants were 24 midwives purposively selected from the maternity units of three public hospitals in Urmia, Iran. Inclusion criteria were a work experience of three consecutive years in maternity settings and agreement for participation, while unilateral withdrawal from the study was the exclusion criterion. Sampling was done with maximum

variation in terms of age, work experience, and employment and marital status. The first and the second participants were senior in-charge midwives with long clinical experience.

Data were collected through semi-structured interviews started with broad questions. The first and the second interviews were almost unstructured and interviewees were just asked to talk about their experiences of care delivery. Pointed questions were also avoided and participants were allowed to freely talk about their experiences. This technique helped us collect more in-depth data. From the third interview on, interviews were semi-structured and were guided using questions developed based on the findings of the first and the second interviews. Examples of these questions were, “May you please explain about your experiences of care delivery to pregnant women in your unit?” “What behaviors did you prefer your patients show?” Based on participants’ responses to these questions, probing questions were used to delve into their experiences. Examples of these questions were “Can you provide explanations about this?” “What do you mean by this?” “How do you describe your perception of this topic?” “In your opinion, what is the meaning of this experience?” During interviews, participants’ facial expressions and non-verbal signals were documented. At the end of each interview, interviewee was asked whether she wanted to add anything more. Finally, her participation was acknowledged and she was informed about the possibility of a follow-up interview. The duration of the interviews ranged from twenty to sixty minutes. All interviews were held in a quiet room in participants’ workplace, were recorded using a recorder, and were immediately transcribed.

Graneheim and Lundman’s conventional content analysis approach [19] was used to analyze the data concurrently with data collection. Initially, each whole interview was considered as the unit of analysis and its transcript was read for several times in order to obtain a general understanding about its main ideas. Words, sentences, and paragraphs which were related to the study aim were considered as meaning units and were condensed, abstracted, and coded. Codes were compared with each other in terms of their conceptual similarities and differences and were categorized into subcategories and categories. Then, subcategories and categories were compared with each other and the latent content of the data was conceptualized as main themes.

Lincoln and Guba’s criteria [18] were used to ensure trustworthiness of the findings. Credibility and dependability were maintained through member checking and peer checking. In member checking, excerpts from interviews together with their codes were provided to some participants to confirm the congruence between their experiences and the generated codes. In peer checking, the generated codes and categories were provided to peers experienced in qualitative studies to check the accuracy of the data analysis. In case of any disagreement, data analysis was repeated and its findings were presented to peers to confirm the accuracy of the data analysis.

This study was approved by the local Ethics Committee of Urmia University of Medical Sciences, Urmia, Iran (IR.UMSU.REC.1397.476). Information about confidential data management and voluntary withdrawal from the study was provided to participants and informed consent was obtained from each of them.

Results

Twenty four midwives participated in the study. They ranged in age from 26 to 49 years and in work experience from 36 months to 28 years. They held bachelor’s or master’s degree in midwifery. Two participants were senior in-charge midwives and others were staff midwives. Moreover, two participants had the experience of working in private hospitals (Table 1).

During data analysis, 550 primary codes were generated, which were reduced through combination to 238 codes. These codes were grouped into twelve subcategories, five main categories, and the two main themes of effective communication and empowerment (Table 2).

Effective communication

Most participants considered midwife-client effective communication as a factor encouraging client’s participation in SD. They noted that clients’ interaction with midwives and their confidence in them facilitate effective communication.

Client's interaction with midwife

Most participants noted that question and answer between midwives and their clients result in their interaction.

When a mother receives labor induction, she asks what the administered solution is, why it is administered, and whether there is any ampoule in the solution. Thereby, her midwife explains for her the process of induction and thereby, the client is involved in care (P7).

Most participants highlighted that the provision of incomplete history data by clients may endanger their safety and interfere with diagnosis and treatment.

Not all data can be collected through clinical examination [and hence, history taking is necessary]. For instance, if a patient with epilepsy who takes antiepileptic medications avoids giving a complete history and hides her disease, how her physician or midwife can notice her disease? An incomplete history may have adverse consequences for both mothers and neonates (P11).

Clients' expression of their individual and health-related needs and midwives' attempt to fulfill those needs can ensure client safety.

Many times, we had mothers who got out of bed in the recovery ward without informing their healthcare providers. The results of such unsafe practice were hypotension or fall. If a mother expresses her needs (for example for water or toilet), we can help her and thereby, protect her against negative events (P5).

Participants considered pregnant women's disrespectful behaviors, such as shouting aloud, verbal aggression, and angry outburst as barriers to midwife-client interaction.

Most of the times, the parturient in the delivery room is in bad humor, gets angry, and uses abusive words, creating a barrier to midwife-client interaction(P14).

Confidence in midwife

According to the participants, pregnant women's confidence in midwives is one of the bases of effective communication and has significant effects on their obedience to healthcare providers. Most participants believed that women's confidence in midwives' knowledge and abilities strengthens their relationships, while their lack of confidence in midwives damages their relationships and breaks the chain of care.

After delivery, you suddenly see that the parturient has three business cards of different physicians, denoting that she has no confidence in midwives (P8). Despite my explanations about their conditions, some of my patients have no confidence in me and ask questions from my colleagues. Such behaviors upset me (a young midwife with a work experience of four years) (P8).

Some participants noted that clients' confidence in midwives results in satisfaction for both clients and midwives.

Clients' confidence in midwives' knowledge and practice has mutual benefits. On the one hand, client is sure that she has received appropriate care and on the other hand, midwife feels great satisfaction (P21).

According to most participants, clients' confidence in midwives also promotes their obedience to midwives and requires them to follow midwives' recommendations and educations both in hospital and after hospital discharge.

Sometimes, patients shout, complain that they cannot undergo normal vaginal delivery, and ask for cesarean section. When I talk with them, inform them of their labor progression, and encourage them for normal vaginal delivery, they feel calm and collaborate with me (P19).

After delivery, mothers should continue to care for themselves and their babies. They should adhere to dietary recommendations, breastfeed their babies, and care for episiotomy site based on our education (P6).

Empowerment of women

The second main theme of the study was empowerment of women. Participants expected pregnant women to participate in prenatal classes, receive education and counseling, improve their knowledge and abilities, and actively participate in SD.

Readiness for delivery

Almost all participants noted that participation in physiologic delivery classes and adequate physical and mental readiness are necessary for pregnant women's participation in SD. They expected women to get physically ready for SD through attending physiologic delivery classes. According to the most of them, educations about neuromuscular exercises, effective breathing, relaxation, concentration, and appropriate positioning during delivery help women have a less complicated pregnancy and delivery.

Women who have already participated in physiologic delivery classes have unique behaviors. Care delivery to these women is easier for us.

Women who have learned pelvic tilt and breathing techniques have shorter labor and easier delivery (P6).

According to our participants, mental readiness for delivery reduces pregnant women's fear and anxiety and helps them have a safe and less complicated delivery.

Most women have fear over delivery. Fear has adverse effects on both mother and fetus and increases the need for medical interventions (P11).

Some participants believed that physical and mental readiness are related to each other so that physical readiness results in mental readiness and promotes pregnant women's participation in health-related behaviors.

Our experience shows that women who use breathing techniques experience lower anxiety and stress, show greater readiness for normal delivery, and are more interested in postnatal breastfeeding (P4).

Health literacy improvement

Given the accessibility of midwifery counselors, our participants expected pregnant women to receive prenatal counseling and acquire reliable information about pregnancy and delivery from midwifery counselors. In fact, they believed that pregnant women should plan for participation in SD through participation in prenatal counseling classes.

Pre-pregnancy health is associated with a healthy and low-risk pregnancy and delivery (P17).

Moreover, our participants expected that in case of any problem, pregnant women should receive counseling from midwifery counselors.

A woman with a history of preterm delivery who comes to receive education and counseling will have better pregnancy outcome (P22).

Participation in safe behaviors

According to the study participants, pregnant women's participation in infection control behaviors and their safety-related feedback to healthcare providers about their problems are among the methods for participation in SD. Participants expected women to participate in infection control behaviors such as hand washing during the course of their hospital stay.

During their stay in maternity unit, women can prevent infection transmission through washing their hands and adhering to hygiene regulation (P1).

Our participants also expected pregnant women to report medication side effects or any other warning symptoms during their hospital stay.

*It is very important for women to report any abnormal bleeding to midwives.
Moreover, women need to report medication side effect (P12).*

Discussion

This study aimed to explore midwives' expectations from pregnant women regarding their participation in SD. Findings revealed effective communication and empowerment of women as the two main themes of the study. Similarly, a former study showed that patient participation is effective in establishing effective nurse-patient communication [20]. Another study showed that effective communication between midwives and pregnant women can enhance satisfaction, give senses of security and mutual confidence, facilitate informed decision making, improve control over delivery, reduce blood pressure, fear over normal vaginal delivery, pain, and anxiety, and most importantly, improve health status [21].

Study findings showed question and answer between midwives and clients about health status, labor progression, and fetal health as an example of effective communication. This is in line with the findings of a former study [14]. Midwives answering clients' questions and providing them with information enable both of them to actively participate in clinical decision making, provide mutual support to each other, and prevent patient safety hazards [22]. A study showed that patients who actively ask questions from their healthcare providers more actively participate in clinical decision making, feel greater control over their health, and show closer adherence to treatment regimens [23].

Midwives in the present study expected their clients to provide detailed history about their health status because they believed that a complete history helps physicians and midwives make right decisions. A complete history helps physicians reach accurate diagnosis and prescribe effective treatments even in the absence of physical examination data and laboratory findings [24]. However, a study in Iran found that cultural barriers may prevent patients from providing detailed data to their physicians, particularly about issues which contradict their beliefs [25]. Of course, care services in Iran are currently provided without careful attention to patients' participation in clinical decision making, adequately informing them about treatment options, and their active participation in clinical decision making [26]. Similarly, a study reported that despite the significance of communication and participation for quality midwifery care delivery, they are neither adequately valued nor considered as important aspects of the process of childbirth [27].

Findings showed that in midwife-client interactions, repeated disrespectful behaviors may result in discomfort for midwives and negatively affect care quality. A study reported that 21% of healthcare providers confirmed the relationship of disruptive behaviors with patient death and more than 50% of them believed that disruptive behaviors are associated with negative clinical outcomes such as impaired patient safety, medical errors, negative events, low care quality, and low patient satisfaction [28]. Disrespectful behaviors at workplace, particularly verbal violence, are a significant problem in midwifery settings [29]. A study in Iran showed that 57.7% of midwives in hospitals, healthcare centers, and private offices had experienced verbal violence committed in 60% of cases by patients' companions [30]. Workplace violence has inverse relationship with mental health [31], quality of work life [32], job satisfaction [33], and professional performance [34] and has direct relationship with stress and job burnout [35]. Therefore, researchers, managers, policy makers, midwives, and other authorities need to develop and take creative measures in order to prevent disrespectful behaviors towards midwives and protect and support them against these behaviors.

Our findings also indicated that clients' confidence in midwives is necessary for their participation in SD. Confidence is the cornerstone of effective midwife-client communication which can encourage clients to obey midwives' orders. Similarly, a study reported that besides technical skills, healthcare providers need their clients' confidence for the delivery of quality services [36]. Confidence affects attitudes and behaviors and is considered as a prerequisite for participation in health-seeking behaviors, information provision to healthcare

providers, and treatment adherence [37]. Of course, confidence in healthcare providers may result in clients' blind obedience to them even if the services recommended by healthcare providers are unnecessary or produce insignificant effects [38].

Another expectation of midwives from pregnant women regarding their participation in SD was to get adequately ready for delivery through attending physiologic delivery classes. A study reported that participation in prenatal classes was effective in significantly reducing pregnant women's delivery-related stress and increasing the rate of normal vaginal delivery among primiparous women [39]. A systematic review also showed that participation in prenatal classes empowers pregnant women for delivery [40]. Moreover, participation in these classes enhances women's self-efficacy for delivery and reduces midwives' occupational stress [41]. Therefore, pregnant women should be encouraged to attend these classes to develop their abilities and readiness for delivery.

Our participants also expected pregnant women to develop their health literacy. A former study in Iran reported that most pregnant women had limited health literacy [42]. Our participants believed that seeking and receiving counseling from physicians or midwives during the pre-pregnancy and prenatal periods can develop women's health literacy. In line with this finding, a study in Iran reported the significant positive effects of counseling on anxiety during pregnancy [43]. Apparently, pregnant women are constantly concerned with fetal health and delivery [44]. Such concerns are associated with the increased risk of cesarean section, postpartum depression, and neonatal complications such as low birth weight [45]. Therefore, pregnant women can be recommended to receive professional counseling and education from physicians or midwives, though a study reported that counseling had no significant effects on anxiety [46]. Such contradictory results may be due to the differences in the context and the counseling interventions used in different studies.

We also found that midwives expected pregnant women to participate in safe behaviors such as hand washing. A study reported that perinatal self-care promotion programs (on self-care activities such as healthy nutrition and regular physical activity) are effective in empowering pregnant women for self-care, reducing pregnancy complications, and promoting safe pregnancy [47]. Our participants expected women to provide them with feedback about medication side effects and high-risk conditions during labor and delivery. In line with this finding, a former study reported that patients can participate in healthcare delivery through participating in clinical decision making and infection control interventions, detecting and reporting medication side effects, and performing self-care activities [48].

To the best of our knowledge, this was the first study into the expectations of midwives from pregnant women regarding their participation in SD. Among the study limitations was the reluctance of some participants to share their experiences and feelings. Of course, we attempted to gain their confidence through providing them with adequate explanations about the study and the use of its findings for quality improvement.

Conclusions

Midwives have different expectations from pregnant women regarding their participation in SD. Most of these expectations aim at ensuring safety and improving pregnancy and delivery outcomes. Expectations identified in the present study can be used in healthcare policy making in order to improve the quality of healthcare services, enhance client satisfaction, and ensure client satisfaction in perinatal care. Prenatal and perinatal care should include interventions for developing pregnant women's health literacy, promoting their participation in prenatal classes, and improving midwives' communication skills.

Availability of data and materials

The data analysed during the current study are available from the first author on reasonable request.

Acknowledgements

We greatly appreciate the financial support of Urmia University of Medical Sciences. We also offer our sincere thanks to the women who participated in our study.

Funding

This study was funded by the Vice-Chancellor for Research and Technology of Urmia University of Medical Sciences, Iran. The grant number was 2512

Ethics approval and consent to participate

This research work was approved by the Ethics Committee of Urmia University of Medical Sciences, Iran (No. IR.UMSU.REC.1397.476).

Consent for publication

An informed consent was obtained from the volunteers.

Competing interests

The authors declare no conflict of interest, financial or otherwise.

Authors' contributions

Conceived the study: R.Bayrami.(50%) and R.Baghaei. (50%); collected article data: R.Bayrami. (100%); analyzed data: R.Bayrami. (100%) , wrote the paper: R.Bayrami.(70%) and R.Baghaei. (30%).

References

1. Hodnett ED, Downe S, Walsh D: **Alternative versus conventional institutional settings for birth.** *Cochrane database of systematic reviews* 2012(8).
2. IZADI AR, DRIKVAND J, EBRAZEH A: **The patient safety culture in Fatemeh Zahra hospital of Najafabad, Iran.** 2013.
3. Reichenheim ME, Zylbersztajn F, Moraes CL, Lobato G: **Severe acute obstetric morbidity (near-miss): a review of the relative use of its diagnostic indicators.** *Archives of gynecology and obstetrics* 2009, **280**(3):337-343.
4. Pacagnella RC, Cecatti JG, Camargo RP, Silveira C, Zanardi DT, Souza JP, Parpinelli MA, Haddad SM: **Rationale for a long-term evaluation of the consequences of potentially life-threatening maternal conditions and maternal “near-miss” incidents using a multidimensional approach.** *Journal of Obstetrics and Gynaecology Canada* 2010, **32**(8):730-738.
5. Storeng KT, Murray SF, Akoum MS, Ouattara F, Filippi V: **Beyond body counts: a qualitative study of lives and loss in Burkina Faso after ‘near-miss’ obstetric complications.** *Social Science & Medicine* 2010, **71**(10):1749-1756.
6. Obstetricians RCo, Gynaecologists, Whittle MJ: **Safer Childbirth: Minimum standards for the organisation and delivery of care in labour:** RCOG; 2007.
7. Wallerstein N: **What is the evidence on effectiveness of empowerment to improve health.** *Copenhagen: WHO Regional Office for Europe* 2006, **37**.
8. Coulter A, Ellins J: **Patient-focused interventions: a review of the evidence,** vol. 1: Health Foundation London; 2006.
9. Berwick DM, Nolan TW, Whittington J: **The triple aim: care, health, and cost.** *Health affairs* 2008, **27**(3):759-769.
10. Chen J, Mullins CD, Novak P, Thomas SB: **Personalized strategies to activate and empower patients in health care and reduce health disparities.** *Health Education & Behavior* 2016, **43**(1):25-34.
11. Sackett DL, Rosenberg WM, Gray JM, Haynes RB, Richardson WS: **Evidence based medicine: what it is and what it isn't.** In: British Medical Journal Publishing Group; 1996.

12. Nilsen ES, Myrhaug HT, Johansen M, Oliver S, Oxman AD: **Methods of consumer involvement in developing healthcare policy and research, clinical practice guidelines and patient information material.** *Cochrane database of systematic reviews* 2006(3).
13. Santema T, Stubenrouch F, Koelemay M, Vahl A, Vermeulen C, Visser M, Ubbink D: **Shared decision making in vascular surgery: an exploratory study.** *European Journal of Vascular and Endovascular Surgery* 2016, **51**(4):587-593.
14. Zali M: **New basic relationship between patient and physician.** *Tehran: Hoghoghi publication* 2009.
15. Schildmeijer K, Nilsen P, Ericsson C, Broström A, Skagerström J: **Determinants of patient participation for safer care: a qualitative study of physicians' experiences and perceptions.** *Health science reports* 2018, **1**(10):e87.
16. Olfati F, Asefzadeh S, Changizi N, Keramat A, Yunesian M: **Patient Involvement in Safe Delivery: A Qualitative Study.** *Global journal of health science* 2016, **8**(6):33.
17. Iravani M, Zarean E, Janghorbani M, Bahrami M: **Women's needs and expectations during normal labor and delivery.** *Journal of education and health promotion* 2015, **4**.
18. Burns N, Grove SK: **Understanding nursing research-eBook: Building an evidence-based practice:** Elsevier Health Sciences; 2010.
19. Graneheim UH, Lundman B: **Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness.** *Nurse education today* 2004, **24**(2):105-112.
20. Loghmani L, Borhani F: **Determination of the content of communication between the care team and family members of patients in the intensive care unit: The experience of nurses and patients' families.** *Journal of Qualitative Research in Health Sciences* 2014, **3**(3):257-268.
21. Takács L, Seidlerová JM, Šulová L, Hoskovcová SH: **Social psychological predictors of satisfaction with intrapartum and postpartum care—what matters to women in Czech maternity hospitals?** *Open Medicine* 2015, **10**(1).
22. Sheikh Beiklou M, Hemmati Maslak Pak M: **Patient-Nurse relationship and Patient Safety in Intensive Care Unit.** *Journal of Health Picture* 2012.
23. Wolff LS, Massett HA, Weber D, Mockenhaupt RE, Hassmiller S, Maibach EW: **Opportunities and barriers to disease prevention counseling in the primary care setting: a multisite qualitative study with US health consumers.** *Health Promotion International* 2010, **25**(3):265-276.
24. Jose JA: **History taking.** *Work* 2012, **41**(Supplement 1):5369-5370.
25. poorgharehkhani A, Hekmatpu D, Mahdavian N, zarie M, karimi O: **Exploration of Emergency Physician's Experiences on Barriers of Precise Patient History Taking And Physical Examination: A Qualitative Study.** 2016.
26. Arab M, Hosseini M: **Inpatient Perceptions of Participating in cure decision making and safety among public hospitals of Tehran medical sciences university.** *Journal of Hospital* 2012, **11**(1):29-38.
27. Nilsson C, Lundgren I: **Women's lived experience of fear of childbirth.** *Midwifery* 2009, **25**(2):e1-e9.
28. Rosenstein AH, O'Daniel M: **Disruptive Behavior & Clinical Outcomes: Perceptions of Nurses & Physicians: Nurses, physicians, and administrators say that clinicians' disruptive behavior has negative effects on clinical outcomes.** *Nursing Management* 2005, **36**(1):18-28.
29. Zahra AN, Feng J-Y: **Workplace violence against nurses in Indonesian emergency departments.** *Enfermeria clinica* 2018, **28**:184-190.
30. Najar S, Alipour M, Afshary P, Hagigie E: **Review the amount of verbal violence against midwives and its related factors in midwife of Khuzestan province.** *Int J Bioassays* 2015, **4**(7):4134-4138.

31. Beattie J, Innes K, Griffiths D, Morphet J: **Healthcare providers' neurobiological response to workplace violence perpetrated by consumers: Informing directions for staff well-being.** *Applied nursing research* 2018, **43**:42-48.
32. Eslamian J, Akbarpoor AA, Hoseini SA: **Quality of work life and its association with workplace violence of the nurses in emergency departments.** *Iranian journal of nursing and midwifery research* 2015, **20**(1):56.
33. Liu W, Zhao S, Shi L, Zhang Z, Liu X, Li L, Duan X, Li G, Lou F, Jia X: **Workplace violence, job satisfaction, burnout, perceived organisational support and their effects on turnover intention among Chinese nurses in tertiary hospitals: a cross-sectional study.** *BMJ open* 2018, **8**(6):e019525.
34. Lin W-Q, Wu J, Yuan L-X, Zhang S-C, Jing M-J, Zhang H-S, Luo J-L, Lei Y-X, Wang P-X: **Workplace violence and job performance among community healthcare Workers in China: the mediator role of quality of life.** *International journal of environmental research and public health* 2015, **12**(11):14872-14886.
35. Sun T, Gao L, Li F, Shi Y, Xie F, Wang J, Wang S, Zhang S, Liu W, Duan X: **Workplace violence, psychological stress, sleep quality and subjective health in Chinese doctors: a large cross-sectional study.** *BMJ open* 2017, **7**(12):e017182.
36. Irurita V: **Factors affecting the quality of nursing care: the patient's perspective.** *International journal of nursing practice* 1999, **5**(2):86-94.
37. Hall MA: **Do patients trust their doctors? Does it matter?** *North Carolina medical journal* 2001, **62**(4):188-191.
38. Dranove D, Wehner P: **Physician-induced demand for childbirths.** *Journal of health economics* 1994, **13**(1):61-73.
39. Najafi F, Abouzari-Gazafroodi K, Jafarzadeh-Kenarsari F, Rahnama P, Gholami Chaboki B: **Relationship between attendance at childbirth preparation classes and fear of childbirth and type of delivery.** *Journal of hayat* 2016, **21**(4):30-40.
40. Rajabi Naeeni M, Simbar M: **Effect of child birth preparation classes on empowering Iranian pregnant women: a systematic review.** *J Educ Community Health* 2018, **5**(1):61-71.
41. Howarth AM, Scott KM, Swain NR: **Skills-based childbirth preparation reduces stress for midwives.** *Midwifery* 2017, **50**:235-238.
42. Hoseinpour N, Sajadi H, Mahmoudi Z, SHARIFIAN SM: **Health Literacy And Nutrition Status In Rural Pregnant Women Of Izeh, Iran.** 2014.
43. Andaroon N, Kordi M, Kimiaee SA, Esmaily H: **Effect of Individual Counseling Program by a Midwife on Anxiety during Pregnancy in Nulliparous Women.** *The Iranian Journal of Obstetrics, Gynecology and Infertility* 2018, **20**(12):86-95.
44. Biehle SN, Mickelson KD: **Worries in expectant parents: Its relation with perinatal well-being and relationship satisfaction.** *Personal Relationships* 2011, **18**(4):697-713.
45. Alderdice F, Lynn F, Lobel M: **A review and psychometric evaluation of pregnancy-specific stress measures.** *Journal of Psychosomatic Obstetrics & Gynecology* 2012, **33**(2):62-77.
46. Khodakarami B, Gotalizadeh Bibalan F, Soltani F, Soltanian A, Mohagheghi H: **Impact of a counseling program on depression, anxiety, stress, and spiritual intelligence in pregnant women.** *Journal of Midwifery and Reproductive Health* 2017, **5**(2):858-866.
47. Shakouri N, Noroozi H, Tafazoli M, Mazlom S: **Effect of the "Orem Self Care Model"-based Educational-Supportive Intervention on the Anxiety of Primigravidae.** *The Horizon of Medical Sciences* 2018, **24**(1):41-46.
48. Coulter A: **Engaging patients in healthcare:** McGraw-Hill Education (UK); 2011.

Table 1. Participants' demographic characteristics

Characteristics	Mean±SD or N (%)
Age (Years)	36.33±6.72
Work experience (Years)	12.16±6.93
Educational degree	
Bachelor's	22 (91.66)
Master's	2 (8.33)
Marital status	
Single	10 (41.66)
Married	14 (58.33)

Table 2. The subcategories, main categories, and main themes of the study

Subcategories	Categories	Themes
Information exchange between midwife and client	Client's interaction with midwife	Effective communication
Complete history provision		
Need expression		
Respectful behaviors		
Confidence in midwife's knowledge and skills	Confidence in midwife	
Obedience to midwife		
Physical readiness	Readiness for delivery	Empowerment of women
Mental readiness		
Prenatal counseling	Health literacy improvement	
Perinatal counseling		
Participation in infection control behaviors	Participation in safe behaviors	
Providing feedback about safety-related issues		