

Talking about smoking cessation with pregnant women: Exploring midwives' accounts

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RUNNING HEAD: MIDWIVES' ACCOUNTS OF SMOKING CESSATION ADVICE

Abstract

The aim of the current study was to use interviews to explore midwives' own experiences of talking to pregnant women about smoking cessation. Eight midwives based in the UK took part in face-to-face semi-structured interviews. Thematic analysis revealed that midwives were aware of health risks associated with smoking, saw providing smoking cessation advice as part of their role, would value more support from GPs, and were clear that support and a client-centred approach were key. Failure to refer women for support was related to cumbersome or misunderstood referral procedures rather than reluctance to refer. Implications are discussed.

Keywords: Women, pregnancy, smoking cessation, midwives, interviews

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It is estimated that 11% of women in the UK smoke during pregnancy (Office of National Statistics, 2014). Smoking is recognised as a significant predictor for adverse outcomes in

pregnancy, increased risk of intra-uterine growth restriction, and premature birth (Centers for Disease Control and Prevention, 2014; Royal College of Physicians, 2010).

In the UK, National Institute for Health and Care Excellence guidelines (NICE, 2008; 2010; 2013) recommend that all pregnant women are advised to stop smoking and referred for stop smoking support. However, midwives vary in their level of adherence to clinical guidelines for helping pregnant smokers to quit (Abatemarco et al., 2007) and may be unwilling to address smoking cessation with women in ante-natal visits, possibly believing that their relationship with women could suffer if they did so (Randall, 2009).

The aim of the current study was to use interviews to explore midwives' own experiences of talking to pregnant women about smoking cessation. The key objectives were to gain deeper understanding of whether midwives a) ask, b) advise, and c) subsequently refer pregnant women who smoke to a Stop Smoking Service, and if not then why not.

Methods

Participants

Eight UK-based midwives from one hospital were recruited for the study. Sample size was determined following guidelines from Smith (2008), and data saturation was reached after the seventh interview and no further themes were identified from the eighth interview. Participants' ages ranged from 25 to 56 years, and they had worked as midwives between three and 30 years. All participants were female. Pseudonyms are provided in the Findings and Discussion section below, but other personal information is not provided to protect the identity of participants. Midwives with pseudonyms Hilary, Kim, Lorna, Morag and Norma were interviewed at an ante-natal clinic, Isabella and Janet at a Stop Smoking Service base, and Olivia at a midwifery unit.

The Interviewer

The Interviewer was female and employed as a nurse coordinator in the Stop Smoking Service. At the time of data collection she was a trainee health psychologist, and this research was carried out as part of her doctorate training.

Materials

As attitudes, confidence and beliefs may impact on whether midwives discuss smoking behaviour (Beenstock et al., 2012), questions were formulated using these concepts as a guide, but also focused on asking, advising and referral practices, following UK National Institute for Health and Care Excellence guidelines (NICE, 2006; 2010; 2013). The smoking cessation briefing for midwives from the National Centre for Smoking Cessation and Training (NCSCT; 2013) recommend a three step brief intervention which should be offered to all pregnant women who smoke; Ask, Advise, Act. Questions focused on conducting brief interventions with smokers; asking about smoking status; advising about stopping smoking; and referring women for stop smoking support. The interview schedule included questions such as “what do you believe are the advantages in asking pregnant women about smoking status?” and “what factors inhibit you from advising pregnant smokers to stop smoking?”. The interview schedule was piloted with two midwives who were asked to comment on the questions on the schedule. No changes were required as both midwives found that the questions were clear and easily understood.

Procedure

British Psychological Society ethical guidelines were consulted to ensure the study was adherent (British Psychological Society, 2009). Ethical consent was sought and obtained from the relevant University Ethics Committees. The relevant Head of Midwifery was approached, the purpose of the research explained and permission was granted to contact midwives requesting their participation. An information sheet outlining the purpose of the research was distributed via the electronic mailing lists for midwives.

Potential participants contacted the author by email or telephone and a date and time to meet to conduct the interview was arranged. The author explained that she was undertaking the study as part of her doctorate research in her role as a trainee health psychologist and emphasised that all information collected would remain anonymous. Participants were also asked to sign two copies of a pre-prepared consent form and one copy was kept by the author and the other given to the participant. Participants were encouraged to talk freely. The interview schedule provided a guide for the researcher, and where appropriate, additional questions were asked enabling the author to explore participants' responses in more detail. At the end of the interview, participants were debriefed and were given the opportunity to ask any further questions. The length of the interviews varied from 20 minutes to 45 minutes in length. Each interview was transcribed verbatim from the audio recording.

Data Analysis

Transcripts were submitted to a thematic analysis informed by Braun and Clark (2006), enabling us to identify and analyse patterns emerging from within data. The audio-taped sessions were transcribed and resulting data were initially analysed by the first author who identified key shared themes across interviews, and then discussed these with the second author who validated the themes through reading the original transcripts and ensured that saturation had been reached. The final themes, associated quotes, and theme headings were agreed by both authors through a series of face to face and e-mail discussions.

Findings and Discussion

Four themes were identified from the analysis: health promoting role, supportive approach, awareness, and referral processes. These themes were common to all interviews, but selected quotes are used for illustration. Pseudonyms will be used to identify each participant below in order to maintain anonymity. All quotations are reported verbatim as transcribed from audio recordings.

Health promoting role

Midwives believed that asking about smoking status was a vital part of their role, and it was clear that midwives felt very committed to addressing smoking with all pregnant women, and not only those who asked for help:

LORNA: I think because we do it with everyone it just becomes automatic. You don't have much of an issue asking the questions. You might get the issues afterwards, the attitude, the response might be defensive or whatever, but I don't have a problem asking the questions.

Whilst the midwives were committed to providing advice and information about smoking cessation, they recognised there were limitations in what advice could be given. The first opportunity to address smoking was at the initial appointment when the woman was approximately 12 weeks pregnant. To gain most health benefits for the unborn baby, stopping smoking in early pregnancy is important (West, 2002). Midwives believed that although some general practitioners (GPs) were supportive and some did refer women for stop smoking support, more GPs could intervene to ensure women were offered help to stop smoking earlier in pregnancy:

NORMA: The first trimester is when everything is developing and by the time they hit us, they're twelve weeks, whereas the doctors see them at six or eight weeks they really could be doing that.

Midwives were very aware that early intervention would be helpful, and believed that rather than providing information about health during ante-natal booking, this could be addressed by providing an educational session in early pregnancy as Morag explains:

MORAG: That's when you give them all that spiel, but if you did that as a group session for women who were interested in, in you know early pregnancy...they want to know about healthy lifestyle. I mean you won't reach everybody because some women won't come that smoke. That might reduce the time then that's required at booking.

Supportive approach

Participants believed that to be able to support women effectively it was important to take a non-judgemental approach, even if this differed from their own personal beliefs. Norma talks about her frustration when she knows a woman would benefit from stopping smoking, but continues to smoke despite problems with the developing baby. Participants recognised that even though the best thing for women to do would be to stop smoking, the final decision as to whether they quit remained with the woman herself:

NORMA: I find it frustrating when I get a woman. You know in the past when I've had women who have had a hugely growth restricted baby, just no interest in giving up. All I can do is give them the information, but if they choose not to that's their choice.

There was also recognition of the vulnerability of some pregnant women, and that it might not always be appropriate to advise women to stop smoking at particular time points. For example, Olivia spoke about how it was important not to be too forceful with women who were stressed or depressed:

OLIVIA: I could think of people who are heavily stressed and suffering from depression and who weren't kind of mentally stable. I wouldn't push things, but I would want to refer them, yeah. You've got to tread very carefully, people who are on anti-depressant medication and telling them that they have to stop I think that is a tricky one and they have to be monitored by experts.

Midwives believed that being sensitive and non-judgmental was essential as it affected how women felt about being advised to stop smoking. These midwives were all aware of the importance of empathy, which has been found to increase the likelihood of a pregnant woman taking up the offer of smoking cessation support (NICE, 2010).

Awareness of risks

Participants had a good knowledge of the risks associated with smoking in pregnancy which enabled them to provide accurate information to women, to enable them to make an informed

decision about stopping smoking. For instance Olivia spoke about how she had obtained knowledge and how this had made her aware of how pregnant women found it difficult to stop smoking:

OLIVIA: I've done plenty of smoking cessation reading. I've done courses, I've worked with the smoking cessation team, it must be close to 5 years now. Yeah it's my role I do ante-natal, intra-partum and post-natal care with women..... I feel I've got quite a lot of empathy and quite a lot of knowledge about how hard it is and the phases you can possibly go through when you've stopped.

Although midwives reported that pregnant women were generally aware that smoking was harmful, they were not always fully aware of the specific risks of smoking during pregnancy. The information could also be misinterpreted. For example, women were advised that smoking in pregnancy can lead to babies with lower birth weights, but midwives reported that younger women sometimes used this as a reason for continuing to smoke, believing it might be easier to give birth to a smaller baby:

HILARY: So what you are finding is young mums, teenagers smoking so that they have a small baby so that can be a disadvantage of advising people not to smoke. Cos you can't say don't smoke it's not good for you, you have to give reasons as to why it's not good. So yes, I think because you give information, information can be you know turned around to sort of like what works for them rather than look at baby's health as well.

The birth weight of a baby is often used a health indicator (Bonellie, 2001), but it may be useful to consider ways in which this information is communicated to ensure that low weight is not interpreted as being positive, for instance describing the baby as weaker rather than smaller.

Referral processes

To obtain stop smoking support for pregnant women, midwives made referrals to the Stop Smoking Service, but having to complete referral forms was perceived as a barrier

particularly during busy clinics. Norma spoke of re-referring a pregnant woman who had started smoking again to the Stop Smoking Service and having to fill in another form:

NORMA: I have referred women back that I've seen at the beginning that have stopped seeing you guys and started smoking again and then I've done a re-referral back in. I did find once I tried to do re-referral back in on the phone and they wouldn't have it. They said I had to fill in a form and everything which then, you know in those situations in a busy clinic. I did re-fill in a form, but you might find that there are some people in that situation that would just be "oh I just haven't got time to be doing that".

This suggests that staff in the Stop Smoking Service need to make it easier for health care professionals to refer individuals for stop smoking support. Making referral easier was also suggested by other midwives who spoke of time pressure, that physically filling in a form was additional paperwork, and that being able to refer online might make this easier:

MORAG: I don't think it's a difficult thing to do....there's just so much paperwork, it's just more paperwork, whether an online referral might be better.

The UK Department of Health (DoH) has suggested that referral routes which are simple and easy to use may increase referrals to Stop Smoking Services (DoH, 2011). More recently, it has been proposed that electronic referral systems may be preferable (NICE, 2013) and referrals may be delivered directly to the "Quit Manager" database if the Stop Smoking Service uses this software (NCSCT, 2013). Responses obtained from midwives interviewed in this study would support this.

Conclusions, reflections, and future research

Analysis of transcripts suggested that midwives were very much aware of health risks associated with smoking, and saw providing smoking cessation advice as an important part of their role. They would value more support from GPs in relation to initiation of earlier referral, and had a high regard for a client-centred approach, and failure to refer women for additional support was primarily related to awkward and time-consuming referral procedures.

Obviously these results need to be treated with caution due to the relatively small data set, and future research is needed to investigate whether results generalise beyond this group of midwives. However, themes were evidenced in all interviews and suggested that training in providing brief smoking cessation advice should be mandatory to ensure all midwives are able to offer this advice. Midwives believed that GPs should intervene earlier, before around 12 weeks gestation which was when women saw the midwives, to ensure that women were offered help to stop smoking earlier in pregnancy. Given that stopping smoking in the first three months of pregnancy can improve health outcomes for the baby (Prabhu et al., 2010; West, 2002), this is potentially very important. This additional support would also take some of the load from midwives, and could increase the number of women who receive effective stop smoking support during pregnancy.

Methodological limitations included the fact that the length of some of the interviews were relatively short, with the shortest being 20 minutes in length. However, despite this similar themes were found in the shorter interviews as were evidenced in the longer interviews. The first author has previous experience at conducting semi-structured interviews and as a nurse is experienced in gaining a large amount of information in a relatively short period. We had some concerns prior to the study about the fact that midwives might be reluctant to be open and honest with the first author because of her stop smoking role. Having looked at the wide range of views expressed and the fluency with which these women spoke during the interviews, we do not feel that they were constrained. However, the quotes above should be read within the context that women were speaking to a stop smoking coordinator, even though it was made clear that this was part of her academic research rather than any kind of evaluation of the service.

Future research could involve interviews run by other midwives or someone independent of healthcare and stop smoking services, could possibly use survey methods

such as online questionnaires to assess the views of a wider range of midwives from a range of geographical areas, and might also include interviewing GPs to investigate their experiences of referral of pregnant women for stop smoking support. This further work could explore the generalisability and validity of these exploratory findings, to develop this work further.

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