Ellie Sonmezer

Choice, informed consent and risk- managing women's care choices in the absence of Midwifery supervision: The birth choice clinic.

Abstract

Women with 'low risk' pregnancies are largely encouraged through research and national policy to delivery in midwifery led units or at home, however, it appears that the majority continue to attend consultant led hospital settings. Much research exists to support midwives in facilitating informed choice but it has been identified that midwives are often influenced by internal and external factors when providing this and that time constraints hinder this process. Supervisors of midwives (SoM) provided a complex care planning service to women. However, with Supervision of Midwives removed from statute and the new Advocating for Education and Quality Improvement (A-EQUIP) model not yet operational a 'gap' area has been identified as a potential concern. This 'gap' is complex care planning with women, therefore, an alternative approach to SoM providing complex care planning is The Birth Choice Clinic.

Introduction

The Peel report (Ministry of Health, 1970), advocated 100% of births should take place in hospital. Succeeding governments advocated the same and despite the reports evidence base being challenged, (Rogers et al, 2012) birth became more medicalised. Changing Childbirth (DoH, 1993) advocated individualised choices for women but over a decade later in 2007 women had very little choice about where they gave birth with only 34% of maternity units having had a midwifery led care unit, (Redshaw, 2011). The choice available to women was either an obstetric consultant led unit or a home birth. The Department of Health emphasised and reiterated the importance of women's choice in 2007 and guaranteed choice of birth place by 2009, to include midwifery led care units (DoH, 2007).

Brocklehurst et al (2011) provided health professionals with robust evidence about place of birth and safety in the Birthplace study. The study demonstrated that previous

national policies, indicating it is safer for women to give birth in obstetric units, were discredited (Rogers et al, 2012). As a result, the Intrapartum care guidelines (NICE, 2014) added the need for Commissioners and providers to ensure that all four birth settings are available to every woman. Despite many drivers for change only 10% of women nationally give birth in a midwife led setting (Gardner, 2015). With 60% of women having a spontaneous vaginal delivery (Health and Social Care Information Centre, 2017), there appears to be a disconnect in the choices women make, the evidence available and the outcomes. Place of birth is amongst one of the biggest decisions for women in pregnancy and often one that provides challenges for midwives, despite a national policy of offering women choice on exactly this matter (Coxon et al, 2017).

The majority of women will choose to follow national recommendations. However, some choose differently. This will be dependent on an individual's circumstances and views. Coxon et al's (2017) quality evidence synthesis identified that few women were given a 'real choice' of birth because discussing homebirth or birth on a freestanding midwifery unit was often more contested and complicated. All midwives are trained to provide women with the ability to make their own care choices through informed consent however, many factors influence this. When women have more complicated needs it can become more difficult. SoM, as part of their role, provided additional advice and support to women experiencing difficulty in achieving their care choice (NMC, 2015). SoM were governed by NMC codes and evidence based practice and not by local NHS trusts so could provide impartial, informed choices, to women and their families. As SoM has been removed from statute (DoH, 2017) as a result of national scrutiny and reports (DoH, 2016; Kirkup, 2015; PHSO, 2013; The Kings Fund, 2015) the extra layer of discussion, advice and care planning has been removed.

The NHS England (2017) Advocating for Education and Quality Improvement model (A-EQUIP) does not include an element replacing previous SoM direct contact with women for care planning. The A-EQUIP model provides a Professional Midwifery Advocate (PMA) to support midwives to make safe personalised care for every woman, even if this is complex. It highlights the obligation for all midwives to provide informed choice at

all times and to advocate for women (NHS England, 2017) and has developed a system with the PMA providing support for this. With SoM now obsolete and the PMA role having been confirmed but no widespread training available, complex care planning was identified as an area for development. After local discussion and awareness that current local community midwife appointments were no longer than 20 minutes long and with an understanding that a full informed discussion of care choices is often unachievable in this time, it was decided that a Birth Choice Clinic would be an appropriate alternative. The aim of this Clinic is to provide women with a high quality opportunity to discuss their care choices in an unrushed and thorough manner, thus fulfilling in part the vision from the Better Births (2016) maternity report. A Plan, do, Study, Act (PDSA) cycle (Demming, 1983 cited by Donelly and Kirk, 2015) was used to support the setup of the Birth Choice Clinic (Appendix 1).

Choice, informed consent and risk

Every woman has the right to refuse medical treatment (where a woman has mental capacity to do so) and the right to informed consent (NMC, 2015). Kitzinger (2005) explains the validity of informed refusal as well as informed choice. Nolan (2011) describes that it is therefore unreasonable and offensive to consider any choice as inappropriate or stupid if it is informed. As professionals it is difficult to navigate through a system that expects women to make informed choices and then scrutinises, through the risk process, the care provided if the outcome is affected adversely by the choices that a women and her family have made. It is especially difficult when the decisions made by one woman may not necessarily be shared by others (O'Boyle, 2006). Baroness Julia Cumberlege (Better Births, 2016) identified that the importance of choice and the safety of both mother and baby being paramount, can cause conflict. She also identifies that women want the right to personalized care that fits around and respects their circumstances, and that women are free to choose care after a full discussion of benefits and risks. Depending on whether you are working from a medical or technocratic model of maternity care (birth as a pathology waiting to happen) or a social model (a physiological event) can help or hinder the ability of informed choice and

autonomy. The UK government engenders a medicalised, bureaucratic birth model (Kitzinger, 2005). With practices moulded by risk management strategies resulting from large legal pay-outs (Walsh, 2006), the need to follow national guidelines becomes ever more important in an illusion of choice provided by maternity services to women (Kirkham, 2004).

Midwives are autonomous practitioners. Through shared knowledge and understanding they empower women to make decisions about their care (Nolan, 2011) and then advocating for the women. However, Barber et al (2007) research identifies that Midwives are influenced by their personal experiences when discussing options for place of birth. Being aware of bias and culpability when providing or withholding information is essential when discussing care options with women (Jomeen, 2010). Anderson (2004) suggests that supporting autonomy is threatening to the obstetric ideology. This is supported by Kirkham (2004); she infers women can be steered by authoritative obstetric speech therefore obliterating any autonomy. Professionals are to respect women's autonomy and their right to make decisions and midwives cannot refuse to care for women if the decisions they make are not shared by the care provider. Only in very limited circumstances can there be a conscientious objection to care (NMC, 2015). However, our healthcare model is utilitarian in design and works toward the best possible outcome for the most amount of people possible (Symon, 2006). Whilst this is an ideology shared by most there is dissension regarding the best way of achieving this journey to its end point, that being the safe delivery of the baby and wellness of the mother.

Skinner (2016, p35) describes that "midwifery attributes of skillful practice and conscious alertness seem to have been replaced by the concept of risk with its connotations of control, surveillance and blame". A thriving fear of litigation is a very real result of the current risk approach to maternity care (RCM, 2003). Symon (2006) suggests a woman needs to cooperate with a technocratic approach to maternity care, in order that she maximises her chances of avoiding disaster. He also describes a Risk-Choice paradox. Risk management has given society and professionals a false sense of hope and closes down possibility (RCM, 2014). Uncertainty is seen negatively and has

no acceptance in today's healthcare (Skinner, 2016). The Oxford dictionary (2017) gives 'risk' the definition as 'A situation involving exposure to danger or the possibility that something unpleasant or unwelcome will happen'. Fear of risk influences the information we pass on to women.

Community Midwives are busy and limited with time during appointments. Providing women time for informed choice can be challenging. Despite reforms over the past three decades in the NHS there still remains a contradiction between time (according to the clock) and relationship building time (Deery, 2008). A payment by results (DoH, 2004) rather than a quality system contributes to a time pressured system, (Deery, 2008; Henshall et al, 2016). Achieving continuity of carer, empowerment of women and individualised women chosen care was identified in Changing Childbirth (DoH, 1993). The National Maternity review (NHS England, 2016) reiterates the vision of women and family centred, individualised, fully informed, unbiased care to be delivered in a family friendly way with the need to build relationships over time with continuity of carer. However, it has been demonstrated that the positive development of maternity in line with these reviews has been hindered by an organisation not set up for such a system, under economic pressures and as a result, disillusionment (Kirkham & Stapleton, 2000). Time constraints combined with a culture of powerlessness hinder midwives' ability to empower women (Kirkham & Stapleton, 2004).

It is essential within maternity teams to agree a way to empower women to make personal choices about pregnancy, birth and the postnatal period (RCM, 2014). Henshall et al (2016) conducted a systematic review of the literature relating to option for birthplace. The article identifies limits to credibility due to the lack of studies available for critique, but they do identify that the findings of the review give good insights and that complement the existing body of knowledge. They found that organisational pressure and professional norms, including peer opinion and avoidance of confrontation, influence midwives' information giving. It was identified that despite midwives knowing the research behind place of birth (Brocklehurst et al, 2011), the confidence of midwives to impart these choices on women was very varied and so consequently the information imparted to the women was varied. Coxon et al's (2017)

work confirms that women do not receive balanced and consistent information when it comes to place of birth. Also of note is the influence midwifery colleagues have on each other and is highlighted as a concern in decision making and information provision (Henshall et al, 2016).

Thompson (2013) describes that the increasing social and cultural values of convenience and control in western society correlates with questions about women's ability to birth and professional's clinical skills. Her small qualitative study identifies midwives discomfort when women choose care outside of the guidelines. Despite the fact midwives are fulfilling their professional duty of care obligation when supporting women with evidence based choice (Dimond, 2004), they have concerns about accountability, thus limiting women's choices by not discussing all the available information and fitting in with the organisation rather than the individual. This study could however be criticised on its small sample size and representation from one NHS trust alone.

The Intrapartum care guidelines (NICE, 2014) set out the expected information midwives should discuss with all women when deciding on planned place of birth. Evidence based care and policy can inhibit choice (Edwards and Murphy-Lawless, 2006). Thompson & Millers (2014) research demonstrated a significant lack of informed choice reported by women. However, their research response rate of questionnaires was poor which could signify a bias from those women who had a negative experience. All midwives have the ability to provide informed choice and aid decision making, however, midwives often feel confined by restraints on time (Thompson, 2013). The increasing complex needs of women can also make this a confusing process. In addition to this, women had the option of approaching a SoM independently if they were unhappy or wished for further discussion or assistance. With local midwifery anxiety about the evidence on informed choice provision, the birthing statistics and the cessation of SoM the development of a Birth Choice Clinic commenced following extensive local discussion.

The Birth Choice Clinic

A designated clinic for 'Birth Choice' gives a clear indication that firstly women do have choice; secondly it gives support to the midwives providing clinical care by providing written discussions and decisions. It enables experienced midwives to provide an information and discussion service to women in an unrushed manner. The Birth Choice Clinic offers a separate appointment encouraging women to make decisions with a midwife that may not be their primary care provider. This perhaps fits the organisation more so than the woman, however, it does fulfil the brief of facilitating the opportunity of a women to discuss her care needs with a Midwife in an unrushed and full manner as these discussions can be time consuming (Thompson, 2013).

Planning and having a written plan of care gives the clinical midwife confidence in decision making and makes it easier to discuss care and deviations from the plan with the women (Thompson, 2013). The SoM played a key role in supporting midwives as will the PMA when they are assigned and trained. The difference being that PMA's will support Midwives to write the individualised care plans and the SoM wrote these with the women. Decision aids are interventions that help people make unbiased deliberate decisions based on high quality research evidence (O'Connor et al, 2009). Decision aids are non-directive in the sense that they do not aim to steer the user towards any one option, but rather to support decision making which is informed and consistent with personal values (Roberts et al, 2004). Rogers et al's (2015) work on birth choice also demonstrates the usefulness of the decision aid, as part of a multifaceted approach, in increasing informed choice for women. The use of decision aids helps reduce decisional conflict, improves knowledge and different options (Rogers et al, 2015). The decision aid is a tool to prepare midwives to impart all the information needed regardless of the bias individuals may have. The Birth Choice Clinic will, therefore, have evidence based decision aids to help guide midwives in providing informed choice to women (Example in Appendix 2). Decision aids are available covering a multitude of areas, many of them highlighted by the NICE (2014) Intrapartum care guidelines as individual areas of consideration. The aids utilise latest research and will be updated as necessary. Women and families are currently presented with the lowest mortality rates ever seen

(MBRRACE, 2016). However, risks including increased intervention rates must be disclosed in a way that the individual can understand, avoiding coercion, ensuring all the information has been understood, whilst given sufficient time to consider and document their decision (O'Boyle, 2006). Participants of Thompson's (2013) study found that documentation of the discussion gives evidence that the best care possible is being provided and which is supported by the NMC (2015) with the decision aid providing this evidence.

Page (2015) suggests that we could learn from other successful health care models and implement a transformative fundamental change over a whole system. She provides an exemplar of a philosophy of care that is based on Guilliland and Pairman's (1995) model of partnership at every level: Education, regulation and practice. This model is based in New Zealand and is influenced by a smaller society that has different history and cultures to the United Kingdom so may not be easily replicated. At a local level it may be possible to adhere to these principles within the current system as it is a smaller scale change. The Birth Choice Clinic aims to provide this such change.

A clear process of how to utilize the Birth Choice Clinic has been devised (Appendix 3). At any point during the process the woman may choose to go away and consider the discussion before making a final decision. All the information and the plan of care created with the woman is made available in the notes, to the Consultant Obstetrician, named Midwife and to the woman.

Conclusion and recommendations

With the removal of SoM from statute and the A-EQUIP model yet to be initiated practically, the Birth Choice Clinic presents women and midwives with an option to further discuss plans of care. Ideally all midwives should have the skills, knowledge and time to provide informed choice to all women regardless of the complications presented to them. It is clear that many factors can affect this and the quality of information provided, not least the time available for this in today's time constrained health system. Whilst conforming to the organization rather than the women, the Birth Choice Clinic

does enable a more structured opportunity for further discussion and decision making. The aids used enable thorough documentation of the decisions and provide the women with the reassurance that they have all the knowledge to make their own informed decision.

The completion of the PDSA cycle is necessary to continue to improve the service or adapt it with the A-EQUIP model and the PMA role in future. Evaluation (Study) of the Birth Choice Clinic service is essential from perspectives of both the women and the Midwives to understand the effectiveness and care outcomes.

WORD COUNT: 2984

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Appendix 1- PDSA cycle for Birth Choice Clinic set up

Plan:

Location of Clinic (s)- Antenatal Clinic

Frequency of Clinics- initially monthly with a view to fortnightly once set up. Commencing January 2017.

Referral to clinic- via email

Who will run the clinics- 2 midwives to support each other (from senior management or previous SoM team)

Lead for the Birth Choice Clinic- (Assistant divisional director and previous SoM)

Resources available (folders, computer files) - Birth Choice clinic folder on secured drive and a paper folder for resource and decision aid storage

Complete literature reviews and devise decision aids- different midwives responsible for different subjects. Major subjects covered (PPH, Obesity, Previous manual removal of placenta, Grand Multiparity etc.)

Meetings to discuss issues and progress- many

Devise a Birth Choice Clinic process- completed (Appendix 3)

Do:

Complete first clinics and follow the Birth Choice Clinic process.

Discuss with other Birth Choice Clinic midwives, Lead midwife and senior midwives as appropriate.

Study:

Does the process work?

What are the outcomes for the women clinically and their satisfaction with the service

Act:

Alter service as needed and commence cycle again

Appendix 2- PPH decision aid tool

Discussion outline for women who have had a previous primary postpartum haemorrhage (500ml blood loss or more from the uterus within 24 hours after birth)

Name: MRN Date of discussion: EDD:

Woman's History: ***(Free text)***

A primary PPH is bleeding of more than 500ml within the first 24 hours after birth. Primary postpartum haemorrhage (PPH) is the most common form of major obstetric haemorrhage. The MBRRACE-UK (2015) report found that PPH was the 3rd leading direct cause of maternal death. Women who have had a PPH in a previous birth are at least 3 times more likely to have a PPH in a subsequent birth. (In one study of 538,332 women from the Swedish Medical Birth Register from 1997-2009 found that women with a history of PPH had a 3-fold increased risk of PPH in their second pregnancy compared with unaffected women (15.0% vs 5.0%, respectively). In a third pregnancy, the risk of PPH was 26.6% after 2 previously affected pregnancies, compared with 4.4% in women with no previous PPH, Oberg et al (2014)).

Recommended package of care

NICE (2014) and Gloucestershire Hospitals NHS Foundation Trust recommend that women who have had a Primary postpartum haemorrhage requiring additional treatment or blood transfusion (anything in addition to the 2 prophylactic oxytocin's immediately after birth due to uterine atony) previously should give birth in an Obstetric unit as there is increased risk for the woman after labour, where care in an obstetric unit would be expected to reduce this risk. This care plan is designed to ensure discussion of

the risks and the additional care that can be provided in the obstetric unit so you can make an informed choice about planned place of birth.

"Whilst respecting maternal choice, the Consultant Obstetrician team in Gloucestershire Hospitals NHS Foundation Trust believe in their opinion VBAC outside the CLU is unsafe and would not be advised from a medical perspective."

Recommended care (Based upon NICE guideline CG190 (2014) and RCOG Green top guideline No.52 (2009)	**Rationale**	**Understood**	**Accepted**	**Declined**
Labour care to be provided on the obstetric unit.	An Obstetrician and Anaesthetist are available to provide medical care and any necessary surgical interventions to a woman having a primary PPH. The additional time for transfer may have consequences for you. Some lifesaving equipment and medication are available immediately in the obstetric unit that are not available on the midwifery led units.	☐	☐	☐
Blood sample taken on admission	It is important to have up to date blood results for haemoglobin, blood group and a platelet count in case you should need and blood products.	☐	☐	☐
Active management of third stage	Active management of the third stage of labour lowers maternal blood loss and reduces the risk of PPH	☐	☐	☐
Prophylactic Cannulation	Something to consider Risks of infection to discuss	☐	☐	☐

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Additional information is available at
http://www.healthtalkonline.org/pregnancy_children
www.nice.org.uk/
RCOG/greentopguideline

Signed: ………………………………………… (Pregnant woman) ……………………………………………… (Midwife)

Ref:

NICE CG190 (2014) **Intrapartum care for healthy women and babies**

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Appendix 3- How the Birth Choice Clinic is utilised