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Ensuring the choice agenda is met in the maternity services

Susan Law, Maureen Brown, Carmel McCalmont, Susan Lees, Natalie Mills, Frances McGregor, Colin Thunhurst

Since the publication of *Changing childbirth* (DH 1993), there has been a succession of government and other influential reports that make specific reference to choice, both in the general health care context and that of the maternity services. These illustrate the main forces governing the settings and contexts in which health care workers operate and in which childbearing choices are made. One of the most important government reports related to childbearing is *Maternity matters* (DH 2007), which emphasised that every woman must have flexible, personalised services to meet her individual needs.

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A literature review was commissioned by NHS West Midlands Workforce Deanery to provide information on choice in the maternity services and its implications for the maternity workforce (Law *et al* 2008). A thorough search of literature published during the past ten years was carried out to address specific questions, including which choices are important to childbearing women, the factors influencing women making choices, and the skills and competencies needed by midwives. This paper presents the main points identified in the report and offers the opportunity to look deeper into the concept of informed choice and the role of the health care professional and the maternity services in trying to achieve this.

The report has now been widely disseminated at national, regional and local level. The implementation of some of its recommendations has already begun to address deficits in necessary skills and competencies, with others planned for the future.

What is choice – and what is informed choice?

Choice can be defined as '*1a – the act of choosing, preferential determination between things proposed*' and '*2 – the right, power, or faculty of choosing; an option*' (Simpson & Weiner 1989). In the context of health, and particularly childbirth however, the term is now more frequently qualified as *informed* choice.

Choices made during childbearing are not equal. Some are simple and others are complex; some exist between two options, eg whether or not to accept a proposed course of action; others are to select from a range of options. Some have much more serious implications than others, with possibly life-threatening consequences. When choice is 'informed', it is based on the possession and understanding of information, and reflects the values of the decision-maker (Demilew 2004). It suggests that alternative, equally accessible courses of action must be possible, with reliable and available information about advantages and disadvantages (Wiggins & Newburn 2004). It implies that the individual is free to choose any option, and there is no hint of any judgment or opinion of others. A more cautious interpretation however, is that it is a *reasoned* choice, made by a *reasonable* individual (Bekker *et al* 1999). This definition immediately places an onus on the individual to take an appropriate course of action that can be judged by others. Indeed, in English law, the 'reasonable person' is an objective standard by which an individual's conduct can be measured. Reasoning leaves no room for instinct or feelings but requires an individual to carefully consider evidence and make a decision which is deemed to be right by others. Any expectation by health care providers that recipients of health care must be 'reasonable' in order to be autonomous has huge implications for individual patients and clients. If this definition is correct, many vulnerable women would be disqualified from making choices regarding their care. Those who are unable to read or understand information could not possibly make a 'reasonable' decision on this basis. Simply 'not wanting' a proposed course of action would not do. Health care providers who claim to offer and encourage real choice in childbirth must not object if choices made are, to them, 'unreasonable'.

The meaning of 'choice' is ambiguous: whereas it can be interpreted as '*starting out with a blank slate and a*

creative mind' (Lindsay 2006), for most women, choice is likely to be confined to the options which the maternity services provide (Anderson 2002), which arguably reduces women's autonomy (Leap & Edwards 2006). It has also been suggested that not all women are interested in choice. Indeed, Cooper (2001) argues that it would be wrong to impose the burden of choices on women who do not want to make them. Others believe that women in labour should not only be 'allowed' choice and control, but indeed have a moral obligation to exercise them (Green *et al* 1998).

Choice is inextricably linked with consent, since in making choices, women must give their consent to taking whatever option is being offered. Consent is based on the respect for autonomy and for it to be valid, the woman must be competent to make the decision, be free from coercion and have all the information necessary to make that decision (Beauchamp & Childress 2001). Midwives need to be aware of all the barriers to informed consent if they are to facilitate women in their care to make their own choices (Cooper 2001). There is sometimes a blurring between choice and consent with invasive procedures such as vaginal examinations in labour. It is essential for health care workers both to know and to remember that intentional touching of a person without consent and without lawful justification is a legal wrong, that is, the tort of trespass to the person. Indeed, if it is an unauthorised procedure and it is also invasive, it may constitute a criminal offence (Hewson 2004). A birth plan is the woman's record of her wishes and she is free to change her mind at any time. The capacity to make choices and to give consent is assumed in most adults unless it can be established otherwise; where there is any difficulty, such as with a learning disability, different strategies may be needed to help a person make a decision on their own responsibility or through a legal process of advocacy (Great Britain 2005).

What women want: their experiences and opinions

Midwives must be aware of the choices that are important to women if they are to support them. Choice in maternity care is likely to be different from choice in other health settings because women are usually healthy and make decisions about another person as well as themselves. The sheer number of decisions to be made is also different (O'Cathain 2004).

Women who are articulate and well-read formulate their own questions of what their choices are. Many, especially those pregnant for the first time, do not know what they should be asking. Therefore, if women do not identify them first, occasions for choice are defined by the service (Kirkham 2004). The *Maternity matters* report (DH 2007) made four national choice guarantees for all childbearing women and their partners by the end of 2009. These will enable women to choose how they access maternity care, the type of antenatal care they receive, the place of birth and how and where to access postnatal care.

The MIDIRS *Informed Choice* leaflets were designed to address a series of topics that were felt to be important to childbearing women. Topics were initially identified through focus group discussions with maternity service users and providers including midwives, obstetricians and anaesthetists, with the first set of five paired *Informed Choice* leaflets being published in 1996 (leaflets 1–5), and the next five following in 1997 (leaflets 6–10) (Kirkham & Stapleton 2001). These were updated in 2003 when another five titles were added (Anon 2003). Five more titles followed an update in 2005 (Ockenden 2005) and then a total revision of the existing 20 titles and the addition of five further new titles was completed in 2008. The mother's leaflet was written in a simple and factual style, whereas the professional's version was written in a more academic style with the inclusion of published evidence. Further titles on the subjects of anaemia, infections in pregnancy, maintaining a healthy lifestyle after birth, and sexual health and contraception have also been published and access to this information has now been expanded to the internet services so that women can make direct contact with MIDIRS to obtain this information and other general information related to their pregnancy (see MIDIRS Informed Choice website: http://www.infochoice.org).

The *NHS Choices* (NHS 2008) website has attempted to anticipate which choices might be important to childbearing women. For maternity services users, there is a facility to compare hospitals and find midwife-led units as well as maternity units. A pregnancy care planner is included, with an online birth plan template. This can either be completed and printed off in hard copy, or saved and amended in an online *NHS Choices* account, which can only be created on supply of personal details and an email address. Terms and conditions of this facility require that account holders consent to *NHS Choices* using data in any way the government chooses.

Although the web page does include a section at the end regarding extra help, for example, with translating, signing, diets, special needs and religious customs, it advises the user to prepare for discussions with a midwife, GP or consultant.

The making of some choices is actively encouraged on the template with the use of drop-down menus. These are used to select the place of birth, positions for labour, and infant feeding. However, others are not as simple. Rather than providing the drop-down menu, some topics have the question '*Have you discussed with your midwife or doctor?*'. These include the presence of students, episiotomy and delivery of the placenta, which implies that some negotiation is needed before women are able to make these choices.

In her small qualitative study on the planning of home births, Edwards (2004) found that women did not necessarily want a great deal of choice; in seeking control over the birthplace, they did not necessarily want control over the birth process. Additionally, they felt that fundamental choices were unavailable or constrained, for example, women repeatedly stated

that information on home birth was not provided. The lack of equipment was highlighted – 'horrible' plastic chairs, beds – as was the spatial layout of hospitals, suggesting that a homely atmosphere was important to these women.

Not all choices are met with approval by health care professionals, despite their importance to the women making them. In her description of three women's birth experiences, Anderson (2002) suggested that choice was a 'misleading myth'. One woman who was pregnant with twins, another whose baby was in a breech presentation (both of whom had given birth at home previously), and a third who wanted a vaginal delivery after her previous baby had been born by caesarean section (CS) all wanted to give birth in hospital, but without any interference. They were all told it was not allowed. Midwifery managers, supervisors of midwives and obstetricians said that if they came into hospital they had to follow hospital protocols and rules. The women were left with two unpalatable choices – either to accept the medical approach offered, or to pay for an independent midwife. A third but even more frightening choice was to give birth alone at home without help. These women did in fact all give birth at home, with ease, under the care of independent midwives.

There has been an increase in the number of women who choose to give birth, possibly alone, without midwifery or medical assistance. Women who 'freebirth' may feel so compromised by the system that they cannot conform to it (Nolan 2008) and are ensuring that they have the final word in their birth choices. Beech (2008) reports that the website *unassistedbirth.com* claims to have 40,000 'hits' per month, with a third of these coming from the United Kingdom. She explains that there is an important difference between unattended, where the midwife is not present at all, and unassisted, where the midwife is present but does not touch the mother or her baby without permission. The latter may arguably be the safe compromise in some situations as the midwife can give parents the information to help them make new decisions if problems arise; however should things go wrong, there could be repercussions for the midwife as the attendant health care professional in terms of legal accountability.

A choice of elective CS with no medical indication has undoubtedly emerged as a choice important to some women and has contributed to the rise in the CS rate (Thomas & Paranjothy 2001), resulting in much controversy and debate. Bewley and Cockburn (2004) felt that the General Medical Council was clear on this issue: patients have a right to decide whether or not to undergo any medical intervention, even when a refusal may result in harm or death. This 'negative right' is very different to a 'positive right' where a patient insists on the intervention. Through its Committee for the Ethical Aspects of Human Reproduction and Women's Health, the International Federation of Gynaecologists and Obstetricians (FIGO) made it clear that physicians have an ethical duty to allocate resources wisely and provide treatments only where there is a net benefit to health: where CS is performed without medical indication, hard evidence of a net benefit does not exist (Schenker & Cain 1999). It seems reasonable that where obstetricians are themselves able to demand elective CS, then the same should be offered to patients. There is also the argument that obstetricians may not be so personally objective in that they may be biased by their exposure to pregnancy and labour complications, rather than what is physiologically normal and more common. The scenario could be presented that were there to be a perinatal death following CS, no one would say *'Why didn't she have a normal birth...'* whereas the same situation after a vaginal birth will always pose the question *'Why didn't she have a CS?'*, leaving doctors feeling that they are more likely to be sued for not performing a CS than for performing one (Weaver 2001).

The factors influencing choice

Not all childbearing women are able to make choices during childbirth and midwives should understand that their ability to do so is influenced by a number of factors, both intrinsic and extrinsic. Intrinsic factors are the characteristics and experiences of the women themselves, which cannot be changed but must be acknowledged when supporting women. Extrinsic factors are the external influences on childbearing women, including the influence of others, the knowledge and attitudes of health care professionals and the policies of the institutions in which they operate; these are factors which potentially *could* be changed.

Choice means different things to different women, and varies according to their social and cultural backgrounds, their past experiences and their present expectations (Green *et al* 1998). Personal assertiveness skills are essential for women to be able to formulate their own questions when discussing choices with their midwives (Kirkham 2004) but this may require a command of English and a level of personal assurance which many service users do not possess (Stapleton 2004). Education also appears to be a strong factor influencing women's ability to make choices, in providing them with the skills to find the information they need or that they gain through effective childbirth education. Kitzinger (2006) suggests that professional women with university degrees are often blamed for demanding attention and, in particular, for being stubborn about having birth at home. In contrast, those who cannot access and use written information are likely to remain powerless and helpless, because no resources are invested in them (Stapleton 2004). The Department of Health (2004) acknowledged that in order to access information to make healthy choices, inequalities in literacy and numeracy need to be addressed. Proficiency in these areas is often assumed and different formats are therefore needed when providing information to service users without these resources. Women who are articulate and well-read formulate their own questions as to the choices available to them. Many, especially those pregnant for the first time, do not know what they should be asking.

Therefore, if women do not identify them first, occasions for choice are defined by the service (Kirkham 2004).

Education is likely to be linked to social class, another factor found to influence women making choices in childbirth. It has been argued that informed choice places an onus of control on the individual; it is often forgotten that social inequalities, especially poverty, restrict the ability of women to make changes in their lives, or even engage in making choices (Leap & Edwards 2006). Index of Multiple Deprivation analyses of women's postcodes in one national survey of childbirth experiences found that those from the more deprived (highest quintile) areas were less likely to have choices than those from the less deprived areas. Interestingly, while their access to information was also more limited, they were more likely to have been given a copy of *The Pregnancy Book* than those in the higher socioeconomic groups (Redshaw *et al* 2007).

Choices are also influenced by cultural factors, which will vary according to the cultural profile of a given area. Cross-cultural analyses show that similar women make different choices in different areas. Taking the example in relation to place of birth, in some cultures home birth is an impossible choice whereas in others it is impossible to choose anything other than home birth (Leap & Edwards 2006). Following her home birth study, Edwards (2004) had suggested that childbirth choices were influenced by social norms, such as belief systems and the availability of resources. She found that women felt unable to put some of their decisions into place because of conflicting ideologies, fragile relationships with midwives and a general lack of support for any alternatives to medicalised births and practices.

In her qualitative study of the birth experiences of Scottish women and Chinese women living in Scotland, Cheung (2002) found that Chinese women tended to want normal, trouble-free births, while fitting into the current medical model and accepting what was the most common or safest. In contrast, Scottish women wanted 'natural' births that conveyed a sense of assertion, being in control and being free from medical interventions. Scottish women focused on expecting to have control over what was happening to them, whereas Chinese women tried to fit in with what was normal in the host culture while still retaining elements of their original culture. The author concluded that choice and control were Euro-American socio-cultural concepts which did not appear in either historical or contemporary Chinese birthing culture.

Women from some cultures may not be accustomed to expressing their wishes. A midwife in a qualitative study in Sweden explained her experience of this:

'I have learned that in some cultures the man makes the decision. And you must learn that you must not get angry with that. One needs to accept their culture. When they meet me during childbirth I cannot change that. But instead I have to enter into their culture and establish contact by first addressing the man if that's their wish' (Lundgren & Dahlberg 2002:161).

Culturally determined privileging of male practices and beliefs such as this example may often be witnessed at a personal or family level by health care practitioners. However, this can also be institutionalised when layered under a similar imbalance at the professional and/or managerial level, which can then interfere with the pursuit of institutional objectives. Gendered discourse at the executive level may be inclined towards consideration of institutional performance – currently perceived as the meeting of targets – rather than towards consideration of improving quality of care. If the woman's voice is unheard at the individual level, any such imbalance becomes legitimised.

Previous experiences are likely to be powerful influences on choice (Stapleton 2004). Some women choose elective CS because of a previous instrumental delivery or a long and painful labour; others express a real, perhaps phobic, fear of vaginal delivery (Weaver & Statham 2005), or have the desire or need to schedule delivery in advance (Amu *et al* 1998). Shallow (2004) found that some women requesting CS had histories of previously 'normal' births, yet they could not bear to go through the trauma again. The lack of consensus between professionals on what is meant by 'normal' childbirth is the subject of much debate and its meaning for childbearing women may be entirely different. Women who have already given birth by CS may be offered another because of the *'once a section always a section'* philosophy. Where women lack confidence in their ability to have a straightforward birth, it is more difficult to refuse the offer of another CS (Shallow 2004).

Choice can also be influenced by a wide range of external factors ranging from people to organisations. Some are predictable, known factors, whereas others are contingencies or chance occurrences such as individual staff preferences and the availability of services and equipment (Stapleton 2004). Women may be influenced by the views and actions of other people who may consciously or unwittingly have an impact on their ability to make choices. This has been found to be a factor for those giving birth at home, where women feel they need to have their partners' support in their choice (Madi & Crow 2003). Most indigenous women of childbearing age will have been influenced by the experiences of their mothers, most of whom will themselves have given birth when hospital birth was the well established norm (Kightley 2007). These 'about to be' grandmothers will genuinely believe that hospital provided the best care and the safest option for them and their babies and will do the same for their daughters. A similar trend exists with infant feeding; women are more likely to choose the same method of feeding as their mothers (Bolling *et al* 2007).

Groups such as the National Childbirth Trust, the Association for Improvements in Maternity Services and Maternity Services Liaison Committees may influence women's choices in childbearing through information giving and advocacy for women in making choices.

The organisation of maternity care in the United Kingdom has an effect on women's ability to make choices, with the more women-centred types of care facilitating choices the most. It is often claimed that home births or birth centres are not wanted by women, but in areas where these choices are supported, they are accessed and well used by the women (Leap & Edwards 2006). Churchill and Benbow (2000) found that women giving birth in general practitioner or midwife-led units were more likely to make informed choices than those in consultant units. Bird (2005) found that the positive information conveyed from consumers to other women influenced their choice to give birth in one midwife-led unit.

The existence of larger, more centralised services have been found to restrict choices such as home birth, water birth and the presence of family members. In their Reform think-tank report, Bosanquet *et al* (2005) suggested that few units operate at below capacity. They calculated that a sudden increase in booking numbers of even 5% more women could place severe strain on any unit in terms of staffing, resources and space, let alone the opportunity for these women to exercise choice.

Demilew (2004) found that a shortage of resources affected women's ability to make choices. Following several years in independent midwifery practice where the 'booking' consultation was as long as needed – usually between 1–3 hours – and all antenatal consultations allowed for 30 minutes, she was shocked to find time for only crammed antenatal booking interviews and limited 15 minute antenatal consultations. Books and videos had been available for loan to women in her previous role, whereas she was now finding only poor quality information sheets were available.

Patterns of working have inevitably affected women's choices in childbearing. The European Working Time Directive (EWTD), due to be fully implemented in August 2009, aims to protect the health and safety of workers in the European Union (NHS Employers 2009) and sets minimum requirements with regard to annual leave, rest breaks, working hours and night work. The legislation requires that staff have an 11 hour rest period between shifts and work no more than 48 hours per week. The choice agenda has been traditionally reliant on the establishment of on-call rotas or midwives making themselves available outside of normal working hours, in particular to provide continuity of care to women opting for a home birth. As the number of women choosing home birth increases, this way of working is under review in many maternity units with the role of maternity support worker being reviewed and expanded. Community midwives often work a full day with a fixed workload, then take the on-call responsibility overnight. Some Trusts are exploring the development of a new night practitioner role whereby midwives would work on labour ward on a night shift in a supernumerary capacity and would attend a home birth should it occur, which would enable compliance with the EWTD. Lone working may be necessary to provide choice to women in the community and this can only be supported where employers develop systems for ensuring staff safety.

Among the strongest influences on women making choices in childbirth are policies within health institutions and these are often the decisions of the most powerful, such as obstetricians (Stapleton 2004). Several studies have demonstrated such influences where health professionals in one study felt that leaflets should not be given if they were likely to lead to any increase in demand for services not available locally (Stapleton 2004). Bones (2005) felt that choices were acceptable as long as women chose what the management approved and the choices were not an irritation to the smooth running of the organisation. In another study, the establishment of a new midwife-managed unit led to inequity when risk categories were set to determine women's suitability to give birth there, including limiting the offer to multigravid women. The choice that may have initially appeared to be on offer was, for some women, quickly removed (Watts *et al* 2003). Clift-Matthews (2007) suggests that where a medical intervention may be presented as 'routine', in terms of a regular and proven practice, this may have the effect that the woman opts for this as a 'choice' in following what appears to be the most sensible option. She claims that defensive practice is rife and that clinical decisions about care are not necessarily woman-centred. In a study of midwives' obedience behaviour, Hollins Martin and Bull (2006) found that hospital protocols, hierarchy and fears of challenging senior people impeded the provision of choice. Midwives expressed fear of litigation resulting from some of the decisions they fought to support. In another study, choice was often limited by midwives rigidly sticking to 'routine procedures' (Edwards 2004).

The possession of information is essential for women to be able to make informed, rather than uninformed choices in childbirth. Stapleton (2004) found that the women who wanted the fewest interventions were the ones who had amassed the most information and this was usually obtained through their own efforts. The absence of information can inhibit women from making choices. Accessibility and literacy should not be assumed when offering information; it needs to be made available in a variety of media, which may include podcasts, MP3 and MP4 players, DVDs and websites, as well as in written and pictorial formats and in direct one-to-one communication with appropriate staff. The quality of the information provided may vary, with some information leaflets being of poor quality and repeatedly photocopied (Magill-Cuerden 2006).

Women's views on the information they receive when making informed choices during pregnancy was investigated in a postal survey in Powys (Churchill & Benbow 2000). This demonstrated that midwives were the primary source of information for 78% of the women. Most women felt that they were encouraged to make an informed decision about their antenatal care and felt that they took an active part in decision-making about their care.

Those who attended more than one type of antenatal clinic, but including a midwife-led clinic, were more likely to feel that they had been encouraged to make informed decisions. Of the women who had given birth in midwife/GP units, 77% said that they were encouraged to make informed decisions about labour care, and 83% felt that they had taken an active part in decision-making about the birth. Consultant units rated less favourably (50% and 58%), even though 68% of the women in the sample gave birth in the consultant units. This study showed that midwives play an important role in giving women information to assist their choices during childbirth. Clearly, all health professionals who participate in the care of childbearing women need to provide information early in pregnancy to give women every opportunity to make decisions regarding their care.

Racial prejudice and discrimination can also limit women's choices. Ellis (2004) studied the birthing experiences of ten UK born, second generation, primiparous women from a South Asian Muslim background, using observation, interview and a review of birth plans. The women in her study said they felt that they were treated differently to other women. None was informed of any choices, so they could not make them, and midwives conveyed by their behaviour that they expected women to comply with whatever was done to them, which they did. They had all asked for a female doctor, but they were not always available and sometimes a male doctor would attend them without advance warning from the midwife. The women were also prevented from praying five times per day during labour because they needed to wash beforehand and were not offered the facilities to do so. Through their attitudes, the midwives did not allow the women to give the information as to their needs. The researcher felt that the midwifery care in this study was not observed or experienced as empowering or facilitating informed choice. She felt that not to recognise their individuality was to deny these women choice.

Reviewing the literature has shown that midwives should re-explore the meaning of choice and in particular, *informed choice*. They need to do more to support women in making choices, not just those from a predetermined menu, but from whatever choices women feel are appropriate. However, midwives also need to appreciate that many factors influence women being able to make choices and that women who are least able to select and make these choices will need extra support and help in aiming for and achieving the birth experiences that are individual to them. Any woman who makes a particular childbirth choice that is clearly not achievable deserves to receive the information that would help her to understand why and to reconsider her choice based on new information.

While intrinsic factors cannot change, extrinsic factors which will make a difference to women, can. For example, high quality information must be provided in appropriate formats to ensure that all women are able to make informed choices.

Antenatal education should be commenced early in pregnancy and offered on both a one-to-one basis and in group settings, as appropriate to individual needs and wishes. The place of birth should be discussed with every woman and home birth should be a real option within the realms of safety. Midwives who are not yet confident in offering home birth need to be supported and developed to achieve this. The availability of midwife-led units needs to be reviewed to give women a real choice that is not just a matter of where they live. The concept of normality needs to be explored and understood by midwives and others involved in the care of the childbearing woman and a consensus reached.

The midwife is central to the choice agenda and has a key part in taking forward the transformation of care in relation to choices. It is essential that they not only have the requisite knowledge and skills to facilitate choice and promote normality, but also the inclination to use these to their full capacity.

The report's commissioners have disseminated the report nationally, regionally and locally. On a national level, copies have been sent to relevant leads in the Department of Health and the report is to be promoted at a national conference later in the year. The report has also been sent to the maternity commissioners and maternity leads in the region's Strategic Health Authority area. It has recently also been forwarded to the Local Supervising Authority and thereon to the Nursing and Midwifery Council. Locally, Heads of Midwifery and lead midwives for education have also received copies.

Some of the recommendations made in the report have already been implemented, such as the establishment of champions for normality in each NHS Trust in the region, who are, in turn, developing others using the 'Back to Basics Normality Skills Training Package' which is a three hour session of practical skills training to enhance normal labour and birth. An interactive DVD accompanies the training. Other recommendations are in the planning stage, such as the maternity support worker proposed training, where a specific competence on facilitating choice is to be integrated. As part of the Next Stage Review Maternity and Newborn Care Pathway, work around implementation has started between the local midwifery educationalists and the identified lead Dean. Discussions are taking place regarding incorporating the findings into pre-registration and other educational programmes. Gap analyses are to be undertaken and appropriate recommendations made, for both commissioning purposes and curriculum development.

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