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Facilitating Women's Choice in Maternity Care

Marianne Nieuwenhuijze and Lisa Kane Low

ABSTRACT

Maternity careproviders often have strong views concerning a woman's choice of where to give birth. These views may be based on the ethical principle of autonomy, or on the principle of beneficence. The authors propose that an approach utilizing shared decision making allows careproviders and women to move beyond disagreements regarding which evidence on risk should "count," instead adopting a process of increased knowledge and support for women and their partner while they make choices regarding place of birth.

INTRODUCTION

The idea that women have a choice regarding where they give birth, at home or in the hospital, has provoked a variety of strong reactions from maternity careproviders in many parts of the world. Some careproviders view women as autonomous and able to make informed choices about place of birth, using autonomy as the guiding ethical principle. Others hold that beneficence must be the prevailing principle, and some see a woman who makes a choice to birth outside a hospital as an irresponsible mother who takes unnecessary risks with her newborn's life.[1] In this article we will reflect on these responses and explore whether the model of shared decision making can help address this complex situation in everyday encounters between careproviders and pregnant women.[2]

Supporters and opponents of home birth passionately debate the risks that are involved with either choice. Discussions about the place of birth often proceed as if there is one universally applicable right answer to the question of where a healthy woman with an uncomplicated pregnancy and obstetric history should give birth. In presenting an argument for or against one place of birth over another, careproviders often frame their preference as a dispassionate argument that is informed only by scientific evidence.[3] But methodological criticism of scientific evidence can lead to different interpretations of study results—which, in turn, can reignite arguments.[4] The passion of these arguments affirms the complexity of attempts to integrate the available scientific evidence with the values and beliefs of women and maternity careproviders regarding decision making and place of birth.

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Healthcare's gold standard to determine the "right" or best approach is the randomized clinical trial (RCT) which, despite different attempts, has not been successfully conducted in this area.[5] It is unlikely that a successful RCT will be conducted in the near future, because researchers find that women are not willing to participate in a trial that randomly assigns them to one group in the clinical trial or another (in this case, to be randomly assigned to give birth in a hospital or randomly assigned to give birth at home), because women strongly value their autonomy to choose.[6] Position statements issued by maternity careprovider organizations and editorial commentaries in medical journals[7] focus on the use of objective data to determine the "right" place of birth for all women, but often ignore the role that values and beliefs play in informing the decisions individuals make regarding childbirth. Birth is more than a medical procedure; it involves the whole life of those intimately involved.[8] It is a major life event that affects women and their families in physical, emotional, social, and cultural ways. In the context in which a family makes decisions about childbirth, so much is at stake that is difficult to fully articulate. It is not possible to sum up the full picture of harms and benefits that affect all aspects of life in a way that completely illuminates an individual family's decision regarding how and where the mother will give birth.

In determining the best place for birth, many kinds of information are considered and filtered through a woman's personal lens of values and experiences, including her previous healthcare experiences. This intimate decision cannot be reduced to ranking the value of autonomy against the value of beneficence. These two aspects of decision making must be integrated into a single final response. Arguments for the primacy of the principle of beneficence begin with the collection of evidence that identifies one choice as more risky than another, but, in the case of place of birth, the evidence is not yet conclusive for healthy pregnant women. On the other hand, arguments based on the principle of autonomy to defend women's freedom to choose omit, in certain circumstances, the complicated question of the autonomy of the future child. The intersection of these two principles is the ethical space in which a decision about place of birth is made. For example, a healthy pregnant woman may feel she does not want to give birth at her local hospital because it is the same location where her mother, who had cancer, was cared for until her death. The woman associates the location with painful memories of the loss of her mother. As a result, she may exercise her autonomy in selecting a home birth to avoid the complex emotions that could have an impact on her labor and birth process. However, should her membranes rupture (her waters break) and she does not go into labor after a day, there can be an increased risk for infection for the newborn. Should the woman's desire to avoid the hospital, where a careprovider can promote the labor process using medical interventions, persist, then the question of beneficence is raised. Her autonomous decision to not use the hospital may present a health risk to her newborn. In such circumstances, the intersection of the principles of autonomy and beneficence requires expanded decision making and understanding between the maternity careprovider and the woman regarding her choice of location for giving birth.

Scientific evidence regarding the safety of various places of birth has been used to change the focus from choice of location of birth to that of the moral responsibility of women and careproviders to select a place of birth. Scientific evidence may be tailored to coerce, belittle, or frighten a woman into making a particular decision. In some countries, for example, in the United States, discussions of place of birth are grounded in the varied philosophical approaches used by the professional organizations that represent maternity careproviders (obstetricians, physicians, nurses, and midwives). Physician organizations make an argument against the home as a site for birth, and midwifery organizations present scientific evidence that supports the home as a safe site for birth, particularly for low-risk women.[9]

For many women, the choice of where to give birth begins in their philosophical approach to life as a whole. They think about giving birth in the context of their personal lived experience, not based on the results of an RCT. Birth decisions are personal, informed by values and beliefs (paradigms or world views) and are contextual; they are not merely fact-based, objective, or simply calculated. How one individual interprets her personal risk, and what is an acceptable risk compared to benefit, is highly variable when the information that is available is not comprehensive or does not include the contextual aspects involved in the decision, including values and beliefs. Building on the prior example we used regarding the woman who did not want to give birth in the same location as her mother's death, another factor may be the age of the woman making the decision. If the woman has experienced a prior healthy pregnancy and birth and is again having a healthy pregnancy and anticipates a normal course of labor and birth, some maternity careproviders would con-

sider her an appropriate candidate for home birth. However, if a woman is 40 years old, in some instances, her age may be used to argue that she is not low risk, and therefore not an appropriate candidate for home birth. Because the literature supporting age as a risk factor is variable, this woman's emotional reasons for avoiding the hospital may arguably trump her age as a single risk factor in the context of a healthy pregnancy and otherwise low risk status.

In dealing with ethical dilemmas, ethicists like Parker and Verkerk offer a perspective that suggests these dilemmas must be considered in the encounter between patient and health professional, and not on the professional organization level.[10] Parker suggests that the careprovider-patient relationship should be characterized by a genuine engagement in a collaborative attempt to achieve shared understanding. Verkerk advocates a perspective of care ethics that addresses ethical dilemmas first by knowing the person involved: understanding her identity, relationships, and context. The model underlying this relationship and understanding should be oriented towards the patient making an informed decision through a process of conversation with an engaged and respectful careprovider. Rather than debating whether to place a woman's right to autonomy above the presumption of beneficence, it seems that—in line with Parker's and Verkerk's perspectives—an alternative direction would be shared decision making. Rather than creating a hierarchy of ethical principles with either beneficence or autonomy "winning," or according healthcare professionals an authoritative position that reigns over women's wishes, shared decision making allows a new approach that puts the encounter and conversation between patient and health professional at center. Shared decision making allows both the perspectives of autonomy and beneficence to be considered, and includes careproviders' perspectives and women's values and beliefs in the process of making a final decision regarding place of birth.

THE CONCEPT OF SHARED DECISION MAKING

Shared decision making (SDM) is generally defined as "an approach where clinician and patient share the best available evidence when faced with the task of making decisions, and where the patient is supported to consider options, to achieve informed preferences."[11] SDM emphasizes the relationship between careprovider and patient, the background of preference, and a process approach to making decisions. Both parties can bring their preferences, wishes, and values, and explore beneficial solutions. In the process of SDM, maternity careproviders enable, support, and advise pregnant women on the goals and decisions they face during pregnancy, birth, and postpartum. There is an interactive exchange of professional information (options, benefits, harms, uncertainties, and experiences) and personal information (circumstances and issues important to quality of life). Deliberation is based on the disclosure of values and preferences regarding the particular situation by both parties, building towards a consensus-based decision based on joint responsibility.

When a shared decision cannot be reached, women can seek another careprovider. A challenge in maternity care is that alternative providers may not be available or accessible, particularly when geographic location or a woman's insurance status or method of payment may preclude the use of another careprovider. In ideal circumstances, a woman would explore the question of place of birth at initial contact with a careprovider. Using a process of active engagement and openly presenting each other's perspectives using a dialectic process, a conclusion that a resolution cannot be reached would occur early enough in the woman's pregnancy to allow her to seek an alternative careprovider. When a process of SDM is used, the opportunity to resolve differences is enhanced because there is open, active discussion between the careprovider and woman, allowing the woman to be heard and met in her concerns and to build a relationship, rather than engagement at the level of rhetorical argument of a woman's autonomy to make a decision considered against concern for her infant's safety.

Elwyn and colleagues[12] developed a model that outlines a step-wise process for SDM. The model includes three key steps for clinical practice: choice talk, option talk, and decision talk, in which a clinician supports deliberation throughout the process (see table 1). Choice talk refers to making sure that patients know that a choice needs to be made and that reasonable options are available. Option talk refers to exploring patients' knowledge and considerations and providing more detailed information about the options. Decision talk refers to supporting deliberation, considering preferences, and deciding on the best option.

SDM offers women and maternity careproviders an improved way to address decisions about place of birth and other challenging care decisions, allowing a move from polarized debate on home versus hospital birth to an individualized interaction between the woman and her careprovider. In

this context, emphasis is placed on process and dialogue, rather than on the presentation of a morally superior approach that privileges medical authority and dispassionate "evidence." The use of SDM allows an individualized, contextualized approach that enables the parties involved to determine which motives and values inform the discussion and eventual decision or choices to be made by the woman and her partner.

SHARED DECISION MAKING IN MATERNITY CARE

There is a growing awareness that SDM can play an important role in maternity care,[13] as it offers opportunities for greater mutual understanding through a process of exchange and dialogue. SDM recognizes that a woman's values and preferences and a careprovider's values, expertise, and understanding from research are essential in decision making. Careproviders and women are able to openly discuss the benefits, harms, and uncertainties of different options. Consistent with Entwistle and Watt,[14] SDM allows a broad conceptualization of patients' involvement in decision making, recognizing the importance of the relationship between careprovider and patient. Patients are enabled to consider their "best" option; because their individual circumstances from outside the clinical context are taken into consideration, patients can develop a positive sense of involvement in a holistic process.

TABLE 1. Summary of SDM model

Choice talk
- Step back
- Offer choice
- Justify choice—preferences matter
- Check reaction
- Defer closure

Option talk
- Check knowledge
- List options
- Describe options—explore preferences
- Harms and benefits
- Provide patient decision support
- Summarize

Decision talk
- Focus on preferences
- Elicit preferences
- Move to a decision
- Offer review

Source: G. Elwyn et al., "Shared decision-making: a model for clinical practice," *Journal of General Internal Medicine* 27, no. 10 (2012): 1361-7.

Women's Views

In maternity care, most women want to participate in making decisions regarding their care.[15] In a survey of 1,573 American women who had given birth in the hospital at least once, most (73 percent) said they should make decisions after consulting their careprovider, and 23 percent supported shared mother-careprovider decision making as a way to reach a final decision.[16] However, not all women are willing or prepared to participate in the decision-making process. Some women who are not literate regarding health or who have difficulty understanding data or the concept of risk may have difficulty with shared decision making, and some may come from a cultural background that lacks a tradition of individuals making autonomous decisions.[17] There is evidence that the degree of involvement in making decisions about birth, and how these decisions are made, vary among women.[18] For some women, involvement in making shared decisions increased with the feeling that they were informed and could challenge a decision if the need arose.[19] Making healthcare decisions while giving birth is not without concerns for women, and taking full responsibility for decisions can be a burden for women and their partners. In one study, Parratt and Fahy found that women who felt supported during childbirth by people they trusted and felt free "to let go" and not try to exert control while they were giving birth, which had a positive effect.[20] Leaving the responsibility of making decisions with a woman, without first exploring her wishes for involvement in making decisions, may evoke feelings of abandonment.[21]

Some careproviders report that SDM lifts the burden of responsibility for certain choices from their shoulders.[22] The rationale for this perception of reduced responsibility or shared responsibility is that women actively participate in making decisions, and thus they carry a greater level of responsibility than if their careprovider alone is directing their care, including choice of the site of birth. However, participation in decision making can be a great burden for women, especially when the outcome is disappointing. Women and their partner should be made aware that not everything is "knowable" and "controllable"—unexpected things might happen during birth. Additionally, even when a decision is shared and a spirit of joint responsibility for the outcome is present, it does not mean that carepro-

viders are absolved of their professional obligations and responsibilities. Discourses on equality can hide the fact that health professionals have legal obligations in the event of a poor outcome.[23] The overlay of legal responsibility and potential for liability can challenge the process of SDM if concern for liability becomes the prevailing feature of the interaction between the careprovider and the pregnant woman.

Challenges and Opportunities

SDM in maternity care offers both challenges and opportunities. Many decisions made in maternity care take place outside the consultation room. During birth, the decision-making process may be influenced by limited time, the pain of contractions, and the need of the woman to stay focused on the birthing process, which interferes with interaction and elaboration of the options and decisions that need to be made. Through discussions of options and preferences during pregnancy, prior to birth, women should be prepared for the possibility that they may be asked to make urgent decisions during childbirth.[24] Regular checkups during pregnancy offer ample opportunity to establish a trusting relationship, anticipate various situations that may arise, revisit complex issues, and let time do its work. There is also time for careproviders to understand the values and expectations a woman and her partner have for the upcoming birth, so that discussions during labor and birth are facilitated by the trust and understanding that have been fostered previously.

Shared Decision Making in Action

What takes place in the day-to-day reality of practice? In a recent study[25] about women's childbearing experience in the U.S., a significant number of women said they felt pressure from a careprovider to agree to having an intervention during birth. For example, 19 percent of the women who did not have epidural analgesia felt pressure to have it, and 28 percent of the women who had a vaginal birth after a cesarean felt pressure during their pregnancy to choose a repeat cesarean. This study also explored how much women felt involved in the decision-making process around certain interventions, for example, the decision for either a repeat cesarean or a vaginal birth after cesarean in a previous birth. In 40 percent of the cases, women reported that they felt it was mainly their decision, and in another 39 percent, it was a decision made together by the woman and the careprovider. One in five women stated it was mainly the careprovider's decision. When asked, "How much did you and your maternity careprovider talk about the reasons you might not want to have a repeat caesarean?" 40 percent of the women indicated there was no talk about not scheduling a repeat cesarean, and only 20 percent said there was "a lot" of talk about it. In contrast, when talking about "reasons you might want to have a repeat caesarean," the women indicated that only 3 percent "did not talk about having a repeat caesarean," and 40 percent talked "a lot" about having a repeat caesarean. When careproviders expressed their opinion about a preferred option (73 percent), it was mostly in favor of an intervention (88 percent). This reported variance in presenting options highlights the influence of values and beliefs and a potential fear of liability by the careproviders in the study, since the evidence base available suggests there are benefits to not having a repeat cesarean except in unique circumstances, including considerations of the woman's desire for more children.[26]

Decisions in maternity care vary; not all are polarized like vaginal birth after caesarean section, place of birth, or elective caesarean without a medical indication. Less-polarized examples can be used to gain deeper insight into the use of SDM in the interaction between careproviders and women, for example, women's preferences and needs in the second of stage labor regarding birthing positions. Enabling women to choose and change birthing positions in birth is beneficial for women's positive experience of the birth[27] and for promoting a normal physiological birth.[28] In a study focused on the interaction between maternity careproviders and women in labor, maternity careproviders enabled women's selection of various birthing positions by using a dynamic process in which they moved back and forth from open, informative approaches to more closed, directive approaches, depending on the woman's needs and clinical assessments of the circumstances.[29] The authors report that once a careprovider started working with a woman, the woman often began actively working with the careprovider, suggesting positions she was first reluctant to use. This give-and-take or dialectic process combined the preferences of the woman with the ongoing assessments being made by the careprovider. The careprovider used her expertise to flexibly adjust her approach to match the unique features of the clinical situation in concert with the woman's desires.

CONCLUSION

The promotion of shared decision making in maternity care is justifiable and may be valuable in promoting optimal health outcomes for a woman and

the newborn. Through the use of shared decision making as a relational process between women and their maternity careproviders, the discussion remains focused on the wide range of elements that are brought to bear in the final choice women make regarding the place of birth. In many cases, shared decision making allows a balance between autonomy and beneficence, as framed by the women. Through the use of SDM as a process, there is an opportunity to enter into discussion that maintains the integrity of all of the individuals involved. The careprovider and the woman participate in the process with the goal of "opening up" the space at the intersection of beneficence and autonomy, that can then be contextualized for the individual woman, rather than starting with the stands of professional organizations or with ethical arguments that might create a "forced" choice.

Given the impossibility of resolving the beneficence versus autonomy debate over place of birth, SDM provides a relational process, a shared approach, that leads to a choice that contributes to optimal physical and psychosocial outcomes for mothers and babies.

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