Midwifery 29 (2013) e42–e48

Contents lists available at SciVerse ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

# Towards a relational model of decision-making in midwifery care

D. Ann Noseworthy, BN, RM, MA (PhD candidate, Nursing instructor)[a,*], Suzanne R. Phibbs, MA, PhD (Lecturer)[b], Cheryl A. Benn, RM, MCur, DCur, IBLCE (Associate Professor)[b]

[a] Memorial University of Newfoundland, School of Nursing St. John's, NL, Canada
[b] School of Health and Social Services, Massey University, Private Bag 11 222, Palmerston North 4442, New Zealand

ARTICLE INFO

*Article history:*
Received 8 September 2011
Received in revised form
22 June 2012
Accepted 29 June 2012

*Keywords:*
Decision-making
Midwifery
Relational
Autonomy

ABSTRACT

*Objective:* current individualistic ideas of autonomy and decision making do not fit within the context of decision-making in the midwife–woman relationship. This article critically explores current issues around decision-making and proposes a relational decision-making model for midwifery care.
*Design:* qualitative prenatal and postnatal interviews around decision-making within childbirth in general, and the third stage of labour in particular.
*Participants:* eight midwife–woman pairs in urban settings in New Zealand.
*Findings:* a range of relational, social and political factors that are not present within existing decision-making models were highlighted. The themes included ontological and philosophical influences on decision-making; uncertainty, vulnerability and relational trust; and socio-political and cultural influences. Inconsistencies in knowledge arising from social, cultural and familial considerations as well as identities, beliefs, values, conversations, and practices were found to produce uncertainties around potential courses of action, expected consequences and outcomes. 'Unplanned' birth experiences decreased client autonomy and increased vulnerability thereby intensifying relational trust within decision-making. The political context may also open up or close down possibilities for decision-making at both national and local levels.
*Conclusion:* decision-making for women and midwives is influenced by complex human, contextual and political factors. This study supports a relational model of decision-making that is embedded in understandings of choice as 'entangled'. A relational model enables consideration of how factors such as identity projects, individual practices, the organisation of maternity care, local hospital cultures, medicalised childbirth, workforce shortages, funding cuts and poverty shape the way in which care decisions are made.

© 2012 Elsevier Ltd. All rights reserved.

## Introduction

Decision-making and its outcome, informed choice, is considered to be an important indicator of the strength of the working relationship between a woman and her midwife (Guilliland and Pairman, 1995). Informed choice in health care is upheld in law in many Western countries including Canada and New Zealand. It is a reasoning process which leads to the selection of a course of action among alternatives, a process in which those making the decision use various types of evidence to make a choice (Sullivan, 2006). How practitioners and clients approach decision-making differs from encounter to encounter. How much participation clients have and want in the process depends on a number of factors which include beliefs, attitudes and preferences of the client and the practitioner, the criticalness of the situation (Sherwin, 1998; Cooke, 2005; Sullivan, 2006; Douché, 2007) and, most significantly, social, political, economic and cultural environments (Sherwin, 1998; McGregor, 2001; Ruthjersen, 2007).

It is accepted in contemporary Western cultures that consumers of health care are, for the most part, autonomous individuals, who desire and are capable of participating in and taking responsibility for their health and health care decisions (Ruhl, 2002; Davis, 2005). In neoliberal philosophy where the market and competition are regarded as the basis of a healthy economy, the individual is constructed as a consumer of services who has the power to make informed choices that maximise their self-interest (Granovetter, 1985). A health care decision is viewed as a rational calculation of benefit and risk (Granovetter, 1985; Gadow, 1999) without social influences, rather than one where the patient may be vulnerable and uncertain (Ruthjersen, 2007). Decontextualised, market focused decision-making, on which efficient consumer choice is based, influences managerial models within health care settings in which cost effective and efficient

* Corresponding author.
*E-mail addresses:* ann.noseworthy@gmail.com (D.A. Noseworthy), s.r.phibbs@massey.ac.nz (S.R. Phibbs), c.a.benn@massey.ac.nz (C.A. Benn).

0266-6138/$ - see front matter © 2012 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.midw.2012.06.022

patient–practitioner interactions are emphasised (Baum, 2008). In order for a transaction, such as a treatment decision to occur, a list of all possible courses of action needs to be established and ranked according to the preferences of those involved. Outcomes are predictable and clearly understood with conflicts of interest being resolved either through pricing (Callon, 1999) or, in the case of health care, cost–benefit analyses (Mechanic, 1995). In countries like Canada and New Zealand, with an ethos of collectivism and social support in their public health systems, there is an obvious tension in neoliberal philosophy between the self-interested consumer and fiscal constraints on social spending (Segall, 2000; Audrey, 2009). This tension suggests that the basic tenet of supporting the vulnerable individual and respecting autonomy in decision-making is inconsistent with meeting the needs of the entire population in a fiscally responsible way. Health reforms have impacted on the health care system as budgets are strained and calls for efficiencies are made (Segall, 2000; Audrey, 2009), which can result in limitations on choice. Compounding this is the increasing concern about risk (Tulloch and Lupton, 2003; Davis, 2003; Symon, 2006) and an entrenched medical dominance of the health system with its techno-rational approach to women's health issues (Sherwin, 1998; Davis, 2003). Davis (2003) contends that the medicalisation of childbirth and the increased use of technology have been promoted as the norm. She suggests that, with the culture of risk in the health system today, choices outside the medical technological discourses are considered risky. Although choice is encouraged, when that choice is outside the accepted practice, the midwife and woman may be marginalised. It is in this environment that women and midwives make decisions about care during the childbearing experience. It is within this environment that decision-making must be understood and explained.

### *Theoretical models of decision-making within health care*

The process of decision-making in health care has evolved over time from its paternalistic roots to the more informed decision-making that came about after legislation in various countries made it a requirement (Health and Disability Commissioner, 1996; Timko, 2001). A contemporary view of the paternalistic model of decision-making acknowledges that it does not elicit the patient's preferences and may limit the patient's involvement to that of consent only (Woods, 2007). In this regard the paternalistic model violates the patient's right to be fully informed and have treatment decisions respected (Health and Disability Commissioner, 1996). It disempowers the patient, minimises their autonomy and historically did not serve women well (Sherwin, 1998). The paternalistic model is now deemed inappropriate in most situations especially as clients become more informed and medical technology and treatments become more sophisticated.

Informed choice is the favoured model in Western health care where information about the treatment/intervention options with their various risks, benefits and costs is given. The client then makes the treatment decision from these various options (Charles et al., 1997).

The informed choice model most closely approximates the decontextualised, market based decision-making model described earlier as it assumes that both the health professional and the client have access to perfect information on which to base their treatment decisions. However, this model is problematic as for some courses of action there are large amounts of evidence which can be daunting while for other treatments there is conflicting or little supporting evidence available. Although clients want to be informed about their care and treatments (Green et al., 1998) in some situations the client may be stressed or frightened which will interfere with their ability to assimilate and/or process the information (Douché, 2007) and lessen their desire to participate in decision-making (Charles et al., 1997; Harrison et al., 2003). In both the informed choice and paternalistic models informed consent is supposedly upheld. In the paternalistic version the client consents to the health professional making the best choice while in the informed choice model the client makes a choice based on unbiased, clear and full disclosure of available information with their preference in mind. With paternalism the preference of the health professional takes precedence over that of the client while with the informed choice model the preference of the client takes precedence over that of the health professional (Charles et al., 1997). There are also concerns within the informed choice model associated with the expectation that the health professional is the objective agent who provides information and that the client is left to make the decision with little further input thus removing any hint of influence or accountability on the part of the practitioner (Spoel, 2004; Cooke, 2005). The objective provision of information is at odds with the caring professions (Gardner and Wheeler, 1981; Spoel, 2004), is not woman centred and does not take into account individuality (Gadow, 1999).

Research by Harding (2000) with midwives in western Canada and Edwards (2003) with women talking about choice in Scotland has found that decision-making is perceived as ideally being care oriented based on information gathering and discussion in an environment of mutuality which would more closely reflect a shared model of decision-making (Freeman et al., 2004; Murray et al., 2006). In the ideal shared decision-making model evidence is interpreted and discussed between all parties involved; clients' decisions are supported to the degree that the clients want to exercise that choice (Davies et al., 2009) and the choice is arrived at mutually. This model has been encouraged and is suggested as a fitting model of decision making for medicine and midwifery (Charles et al., 1997; Murray et al., 2006; New Zealand College of Midwives, 2008; Canadian Association of Midwives (2010a, b). The health professional brings knowledge and skills and the client their preferences, self-knowledge and experience to the decision-making encounter. The model has a foundation principle of choice and negotiation. It recognises the autonomy of the participants and the client's right to challenge the authority of the health professional (Charles et al., 1997). Shared decision-making requires all parties to be clear about the expectations and responsibilities and should take place in an atmosphere conducive to discussion, negotiation and commitment to mutual decision-making. Continuity of care allows for a longer time frame for the development of an open and trusting relationship which may enhance discussion, negotiation and decision-making (Harding, 2000; Edwards et al., 2001) and adds an additional dimension not previously seen in this model (Murray et al., 2006). The model of shared decision making is not unproblematic; it requires that midwives and women possess some common knowledge on which to base their decisions. However, the nature of this knowledge may be highly variable.

### *Feminist criticism of the informed choice and shared decision-making models*

In the informed choice or shared decision-making models the health professional is expected to ensure that the information is complete, unbiased or, at the very least, transparent and that the content is understood. Decision-making is seen as the unemotional, rational weighing up of readily available, easily understood evidence based information. The decision-maker is an articulate, well informed individual who has a range of options available from which to choose and is used to making life decisions (Sherwin, 1998), conditions which are very rarely met and concepts which mean that the individual takes responsibility for

Download English Version:

https://daneshyari.com/en/article/10515847

Download Persian Version:

https://daneshyari.com/article/10515847

Daneshyari.com