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ORIGINAL RESEARCH – QUANTITATIVE

Maternity Care Plans: A retrospective review of a process aiming to support women who decline standard care

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ABSTRACT

Background: All competent adults have the right to refuse medical treatment. When pregnant women do so, ethical and medico-legal concerns arise and women may face difficulties accessing care. Policies guiding the provision of maternity care in these circumstances are rare and unstudied. One tertiary hospital in Australia has a process for clinicians to plan non-standard maternity care via a Maternity Care Plan (MCP).

Aim: To review processes and outcomes associated with MCPs from the first three and a half years of the policy's implementation.

Methods: Retrospective cohort study comprising chart audit, review of demographic data and clinical outcomes, and content analysis of MCPs.

Findings: MCPs ($n = 52$) were most commonly created when women declined recommended caesareans, preferring vaginal birth after two caesareans (VBAC2, $n = 23$; 44.2%) or vaginal breech birth ($n = 7$, 13.5%) or when women declined continuous intrapartum monitoring for vaginal birth after one caesarean ($n = 8$, 15.4%). Intrapartum care deviated from MCPs in 50% of cases, due to new or worsening clinical indications or changed maternal preferences. Clinical outcomes were reassuring. Most VBAC2 or VBAC>2 (69%) and vaginal breech births (96.3%) were attempted without MCPs, but women with MCPs appeared more likely to birth vaginally (VBAC2 success rate 66.7% with MCP, 17.5% without; vaginal breech birth success rate, 50% with MCP, 32.5% without).

Conclusions: MCPs enabled clinicians to provide care outside of hospital policies but were utilised for a narrow range of situations, with significant variation in their application. Further research is needed to understand the experiences of women and clinicians.

1. Introduction

Pregnant women, like all competent adults, have the right to refuse medical treatment. Autonomy, choice and informed consent underpin health care policy generally, and maternity specifically.[1,2] When pregnant women decline recommended care, concerns about maternal and fetal safety can lead to conflict. Clinicians may also feel their own autonomy is challenged or that the care preferred by the woman is beyond their expertise.[3] Ethical turmoil and medico-legal concerns for clinicians are well documented[4–6] and in some cases women face difficulties accessing the care they prefer.[7]

Women who decline recommended maternity care may have poorer perinatal outcomes[8,9] and debate continues over the nature of a pregnant woman's obligations to her fetus.[10,11] However there are few, if any, circumstances under which any such obligations could override a competent woman's right to refuse medical treatment.[12,13]

Professional guidance for midwives and obstetricians emphasises the importance of informed consent and respect for patient autonomy.[14–17] Although clinicians' rights to withdraw care are protected in all but emergency situations,[14–17] doing so may undermine women's autonomy.[18] Processes to guide clinicians who continue to provide maternity care after women have

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declined recommended care are rare and unstudied. Cuttini and colleagues found that such situations present an unresolved "ethical conflict".[19(p1121)]

Evidence-based clinical guidelines are increasingly used to standardise practice[20] and whilst adherence may reduce medico-legal risk,[21] it may also restrict women's and clinicians' autonomy.[22,23] One study[24] examined how guidelines can be adapted to more directly support shared decision-making, however there is a dearth of literature exploring strategies to support clinicians and women in situations where recommended care is declined. The World Health Organisation have similarly called for research related to respectful maternity care practices.[25]

Most of the published literature concerning women who decline recommended care focusses on the experiences of clinicians[19,26,27] and their attitudes to court intervention[28]; the experiences of women are less commonly described.[29] Three papers[30–32] have described processes for managing a broader range of situations in which women may decline recommended care, although none reports on the efficacy of those processes in clinical practice.

A large tertiary hospital in Brisbane, Australia, developed a process to enable clinicians to provide care for women who declined standard care. The Maternity Care Plan (MCP) policy was implemented in August 2010 to guide "communication and documentation [when] women . . . request maternity care contrary to hospital policy or guidelines,"[33(p1)] that is, women who decline standard care. The policy directs that a consultant obstetrician meet with such women during the antenatal period to discuss and document their intentions in an MCP, ensuring that the woman receives information about the "risks and benefits of all options, including the option to have no treatment [and] a clear, evidence-based and rational response . . . as to why standard care would be advised."[33(p1)] When women decline standard care during labour, the policy indicates that the process of obstetric consultation should be followed and documented in the woman's health record, but without the creation of a discrete MCP. The policy recognises the woman's "absolute right to refuse any procedure" and describes the hospital's "willingness to provide ongoing care", including care which is "outside of hospital policy."[33(pp1–3)] Fig. 1 describes the MCP process.

2. Methods

2.1. Aim and objectives

The study aimed to review the processes and outcomes associated with MCPs created for women who declined standard

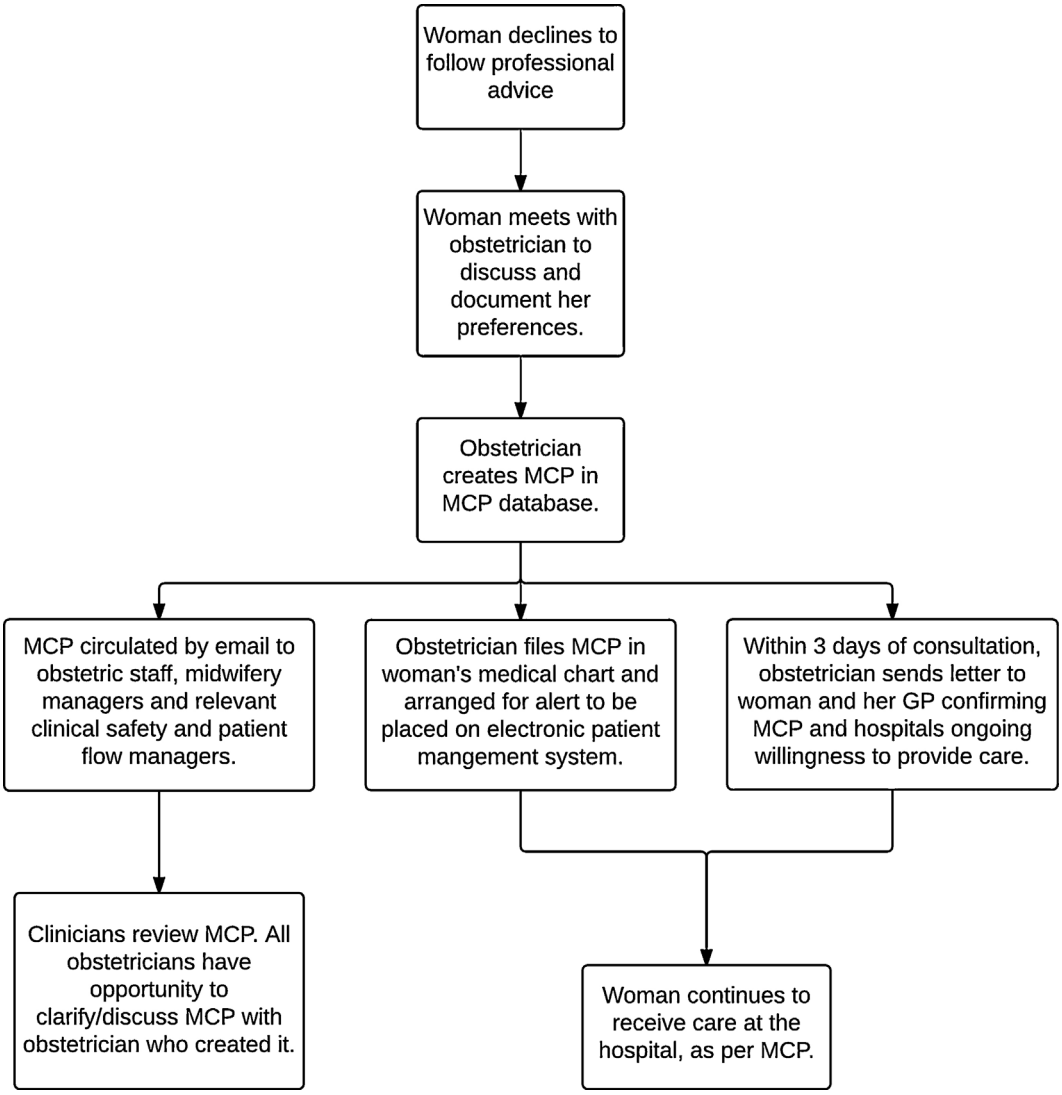

Fig. 1. The MCP process.