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A participatory action research study exploring women's understandings of the concept of informed choice during pregnancy and childbirth in Ireland

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ABSTRACT

Objective: to explore women's understandings and definitions of the concept of informed choice during pregnancy and childbirth.
Methods: a three-phase action research approach. In the first phase of the study (reported in this paper), fifteen women were interviewed to establish their understandings and experiences of informed choice.
Setting: Dublin, Ireland in a large maternity hospital.
Participants: fifteen postnatal women who gave birth to a live healthy infant, women attended obstetric or midwifery-led care.
Findings: we found that multiple factors influence how women define informed choice including; their expectations of exercising choice, their sense of responsibility towards their infant, their sense of self and the quality of their relationships with maternity care professionals. The interdependence of the mother-baby relationship deems that in the context of pregnancy and childbirth, women's definitions, perceptions and experiences of informed choice should be considered to be relational. Women consider that informed choice means more than just the provision of information; rather it requires an in-depth discussion with a professional who is known to them. Women's understandings reveal that informed choice, is not only defined by but contingent on the quality of women's relationships with their caregiver and their ability to engage in a process of shared decision-making with them.
Key conclusion: Informed choice is defined and experienced as a relational construct, the support provided by maternity care professionals to women in contemporary maternity care must reflect this.

Introduction and background

Internationally, maternity policy makers and service providers recognise the importance of two issues: firstly, the long-term benefits to society from the delivery of quality maternity services and, secondly, the need to ensure that women are central to, or are the focus of, the services provided (Department of Health, 2016; Ministry of Health New Zealand, 2012; Society of Obstetricians and Gynaecologists of Canada, 2012). In the E.U, researchers involved in the COST Action IS0907 project, argue that optimal maternal and infant health is critical to societal well-being (COST, 2016). The World Health Organisation, published their vision for quality maternity care (2015) suggesting it requires a service that is safe, effective, timely, efficient, equitable, and people-centred. Indeed, over the past two decades' maternity health policy and legislation has increasingly emphasised the importance of patient participation in decision-making alongside comprehensive information provision (Thompson and Miller, 2014). However, as suggested by Nieuwenhuijze et al. (2014) shared decision-making is a complex phenomenon and requires that women are provided with the opportunities, time and space to discuss their preferred choices and desires for childbirth. In the Irish context, national strategies and frameworks informing women about the choices they can expect are lacking. Successive governments have been accused of failing to take on their responsibilities with regard to supporting women's choices for maternity care services (Devane et al., 2007; Kennedy, 2012; Cullen and Holland, 2013). Further, women's ability to contribute to the

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development of maternity services in Ireland is considered to be much more limited than in other European countries (Kennedy, 2012).

Maternity services in Ireland are delivered in medicalised environments and midwives have limited autonomy (Higgins, 2007; Keating and Fleming, 2009; O'Connell, 2011). The majority of women in Ireland (77.3%) attend combined care between an obstetrician and their general practitioner (GP) for antenatal care (Economic Social Research Institute, ESRI, 2013). Women do have the choice of attending for private, semi-private, or public obstetric care in each of the 19 units offering maternity services. In fact, public and private healthcare have coexisted within Irish maternity hospitals for decades. Critics claim this has led to significant divisions and results in a two-tier system in which public care is considered to be second best to private maternity care (O'Connor, 2006; Kennedy, 2012; Mander and Murphy-Lawless, 2013). A consistent criticism is that women attending this overstretched system of care have limited opportunities to engage in meaningful discussions with a care-giver that is known to them (Begley et al., 2009; Larkin et al., 2012). Women therefore, have few opportunities to engage in the dynamic processes required for shared decision-making as defined by Nieuwenhuijze et al. (2013). In fact, little is known about women's perceptions or experiences of the choices offered to them by their caregivers during childbirth in Ireland. The limited evidence that is available reveals women's requests for improvements in the provision of information to improve, their overall birth experiences (O'Hare and Fallon, 2011; Larkin et al., 2012; Murtagh and Folan, 2014; Butler et al., 2015). The concerns raised by parents, in highly publicised reviews of maternity care in Ireland, about the communication difficulties they experienced with their care givers highlights considerable improvements are necessary to embed shared decision-making, as a cultural norm in maternity care in Ireland (Cullen and Holland, 2013; Cullen, 2013, Health Information and Quality Authority HIQA, 2013). Informed choice is an output of shared-decision-making, the available evidence suggests that to embed shared decision-making into maternity care requires exploring the contextual and relational issues that define the process of informed choice for women in the Irish Context.

Aim

This research study had three aims: firstly, to generate greater awareness of how women define informed choice during childbirth; secondly, to explore the supports women consider necessary to exercise informed choices; thirdly, to develop an information package that potentially could assist women to make informed choices during pregnancy and childbirth. This paper focuses on the first aim: the exploration of women's understandings of informed choice.

Defining Informed Choice

Although informed choice as a concept is discussed and published extensively in the midwifery literature, the volume of good quality research in the area is slight (Jomeen, 2010). The debate about supporting informed choice is therefore challenging, particularly in the absence of a clear understanding of what it means for women. That said, there is also a lack of conceptual clarity within midwifery and obstetric literature about informed choice (Goldberg, 2009; Oberman, 2000). As described by Marteau et al. (2009, 2001), many different terms are used, often interchangeably, to encompass informed choice. An extensive review of the literature revealed multiple definitions utilised in midwifery and obstetric practice derived mainly from ethical and medical contexts, with little contribution from women and with the exclusion of women's voices from the debate surrounding choice (Jomeen's, 2006, 2010). This is inexplicable and suggests there is a lack of recognition of the need to explore the concept from women's perceptions. The manner in which maternity care professionals conceptualise the concept of informed choice will influence women's experiences, adding to the argument for a clear and universal definition and understanding of the concept.

Methods

An Action research (AR) design was selected because of its emphasis on collaboration and inclusiveness. Reason (2004) argues that 'sometimes in action research what is most important is how we can help articulate voices that have been silenced' (p. 16). 15 women were approached and all were willing to participate. The interviews were undertaken by DOB during 2010–2011 over a six month period. Fathers were not involved in this phase of the study as the aim was to establish women's understandings of informed choice, however they were invited to contribute to phase three.

Setting

This setting for this study is a national referral hospital which has approximately nine thousand deliveries per year (9187 in 2015, 9106 in 2014). It has a normal birth rate of 57% as defined by the Royal College of Midwives (RCM 2014) and the caesarean section rate of 23% is significantly lower than the national rate of 28% (ESRI, 2013). Women attending the hospital can avail of obstetric-led care, midwife-led care and Domino midwifery, ('Domino' means 'IN' and 'OUT', and refers to the service led by a team of midwives who provide community antenatal and postnatal care and the choice of homebirth, or hospital based birth).

Sample

All healthy women over the age of 18 who had gave birth to a live healthy infant in the previous year were eligible to participate. Participants under the age of 18 years of age and women whose spoken English prevented them from achieving written informed consent were excluded. Following University research ethics approval and with the assistance of midwives, women were recruited from postnatal wards, the postnatal baby-clinic, the community midwives postnatal support group and the breastfeeding support clinics. Women meeting the eligibility criteria were approached and asked if they would like to participate in the study. Women interested in participating were given oral and written information about the aims of the study as well as the terms of confidentiality. They subsequently signed a written consent form.

Data collection

The interviews were conducted by one of the researchers (DOB), who has extensive knowledge of maternity care in Ireland and previous experience in qualitative interviewing. The interview guide was derived from the literature review on the topic and from professional knowledge and experience. The interview guide consisted of 12 open questions focusing on women's understandings and experiences of the processes of informed choice, with associated prompts. Two interviews were undertaken to pilot test the interview guide, following which no changes were recommended. Because of the sensitive nature of the topic, a support mechanism for debriefing was included into the study design. The bereavement midwife specialist in the research site agreed that the team could refer participants to them should the need arise. However, there were no requests for additional supports services throughout the course of the study. Women were offered three venues for the interview to take place. The majority opted to have the interview in their own home; two choose a dedicated interview room at the University, and two choose a room at the hospital. The interviews were conducted three to six months into the postnatal period, and ranged from 33 minutes' duration to 120 minutes in duration. A member check was conducted after each interview and a copy of the transcript was provided to each of the participants, who affirmed the transcript for accuracy and completeness.