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"It can be challenging, it can be scary, it can be gratifying": Obstetricians' narratives of negotiating patient choice, clinical experience, and standards of care in decision-making

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ABSTRACT

This paper examines obstetricians' perceptions of standards of care and patient-centered care in clinical decision-making in childbirth. Patient-centered care and standardization of medicine are two social movements that seek to change how physicians make clinical decisions. Sociologists question if these limit physician discretion and weaken their social power; the degree to which this occurs in everyday practice is up for debate. Of additional concern is how physicians deal with observed tensions between these ideals. These questions are answered through in-depth interviews with 50 self-selected obstetricians from Massachusetts, Louisiana, and Vermont collected between 2013 and 2015. Interview data was analyzed using a grounded theory and template approach. The author problematizes obstetricians' attitudes about standards of care and shared decision-making, mechanisms that encourage or discourage these approaches to decision-making, and how obstetricians negotiate tensions between patient choice, clinical experience, and standards. The key findings are that most obstetricians feel they have the authority to interpret the appropriateness of standards and patient choice on a case-by-case basis. They feel empowered and/or constrained by pressures to practice patient-centered care and standards depending upon their style of practice and the organizational context. Following standards of care is encouraged through organizational mechanisms such as pressure from colleagues, malpractice threat, hospital policy, and payer restrictions. Practicing shared decision-making is challenged when the patient wants something that violates the physician's clinical experience and/or standards of care. When obstetricians prioritize patient choice over experience and/or standards this is done for moral reasons, less so because of organizational pressures. These findings have implications for theorizing the social status of medical professionals, understanding how physicians deal with tensions between standardized and individualized ideals in medicine, and illuminating the way obstetricians interpret power in the physician-patient relationship.

1. Introduction

This paper examines obstetricians' perceptions of standards of care and patient-centered care in their clinical decisions in childbirth. Patient-centered care and standardization of medicine are two social movements that seek to change how physicians make clinical decisions. Patient-centered care refers to the rising expectation that patients participate in the decision-making process, and that those decisions are based on patient's values and individual circumstances (Berwick, 2009; Epstein et al., 2010; Haug and Lavin, 1983; Vinson, 2016). Standardization of medical practice refers to the expectation that physicians make decisions on standardized forms of knowledge such as based on evidence-based research, professional guidelines, and protocols (Berg, 1997; Lambert et al., 2006; Lambert, 2006; Mykhalovskiy and Weir, 2004; Timmermans and Angell, 2001; Pope, 2003). Each of these proposed changes to medical practice may reduce physician power by replacing their discretion over the content and/or control of clinical decisions; the degree to which this occurs in everyday practice is up for debate (Haug, 1988; Light, 1991; Timmermans and Oh, 2010). This is theoretically relevant to medical sociology because autonomy over work is one of the defining characteristics of physicians as professionals, and understood as a signifier of their social power (Abbott, 1988; Freidson, 1970; Light, 1991). Additionally, scholars have observed tensions between the standardized nature of practice protocols and guidelines, and the individualized nature of patient-centered care as competing ideals in medical decision-making (Bensing, 2000; Reiger and Morton, 2012). Yet we lack an understanding of how these tensions are experienced by physicians and negotiated in everyday practice.

This article examines obstetricians' attitudes about standards of care and shared decision-making, a central component of patient-centered

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care. This paper analyzes obstetricians' perceptions of the appropriate use of shared decision-making and standards, the contextual mechanisms that encourage or discourage these approaches, and how obstetricians negotiate tensions between patient choice, clinical experience, and standards. These findings are empirically important for improving maternity care in the US. Between 1990 and 2013, maternal mortality more than doubled in the United States, and the US has the highest maternal mortality rate of any high resource country in the world (MacDorman et al. 2016). Shared decision-making and standardizing medical practice are two solutions experts propose will improve maternity care outcomes (Sakala and Corry, 2008; Wagner, 2006). How obstetricians perceive these approaches in their practice informs our understanding about the efficacy of these reform efforts and the complexities of their integration.

Decision-making in birth is a complex process that occurs over time with a large number of medical professionals involved. Nurses play a central role in decision-making with obstetricians and patients, in addition to others such as anesthesiologists, maternal-fetal medicine specialists, and pediatricians. Shared decision-making and standardization reform efforts are aimed at maternity practitioners as a whole. Although obstetricians are one actor among many in the decisional context in birth, they are a central actor that both reform movements have focused on. Understanding their perception of the decision-making process is important for scholarship, advocacy, and quality improvement efforts.

1.1. Standardized practice and shared decision-making as challenges to physician authority

Physicians exercise power in a number of ways, but autonomy over clinical decisions is a central issue in sociological theory about the social status of medical professionals. Freidson (1970) and other scholars studying physicians as ideal types of professionals argued that autonomy was the distinguishing characteristic of medical professionals, and that it was secured by their exclusive relationship to specialized knowledge (Abbott, 1988). However, changes in the relationship between the state, corporations, the public, and the profession of medicine in the last sixty years have led scholars to question if physicians were losing social authority and professional autonomy, including a loss of control over their clinical decisions (Hafferty and Light, 1995; Light, 1991; Light and Levine, 1988; Mckinlay and Marceau, 2002; Mechanic, 1991; Timmermans and Oh, 2010; Quadagno, 2004). Standardized medical practice and shared decision-making are two changes to medicine that have been theorized in terms of reducing physicians' clinical discretion and social power.

Although the standardization of health care can be traced to early 20th century efforts to improve public health through the industrialization of medicine, the evidence-based medicine movement was an unprecedented attempt to control physicians' clinical decisions (Timmermans and Berg, 2003). The evidence-based medicine movement began in the 1990s and sought to replace professional clinical judgment with the systematic application of research evidence, especially randomized controlled trials. Evidence is organized by medical elites in professional organizations and institutionalized into guidelines and protocols in clinical settings (Berg, 1997; Lambert et al., 2006; Lambert, 2006; Mykhalovskiy and Weir, 2004). Evidence-based medicine became a dominant measure of quality in wealthy western countries as reflected in medical education, health care policy, and insurance rules. For these reasons it can be understood as a challenge to professional discretion (Hafferty and Light, 1995; Timmermans and Oh, 2010).

However, research on evidence-based medicine in practice shows that some physicians resist evidence-based decision-making and that it remains in tension with clinical judgment (Armstrong, 2002; Timmermans and Angell, 2001). Timmermans and Oh (2010) argue in their review of evidence-based medicine as a threat to professional power that it has not eroded clinical autonomy. In *The C-Section Epidemic* (2013), Morris examines standardization of medical practice in the form of hospital policy and protocols for maternity care. She explains how hospitals are under legal and economic pressure to reduce risks associated with malpractice litigation, and in response they set protocols for decision-making in labor and delivery that constrain providers' decision-making. She presents standardization amidst the backdrop of a "litigation crisis" in obstetrics that places additional pressure on obstetricians to follow the rules. She explains, "Maternity providers feel they must strictly follow protocols to protect themselves from a lawsuit in the case of a bad outcome" (p.55).

Although Morris highlights how medical legal pressure has created protocol-driven maternity care, there is great variability in obstetric practice in birth regionally, across hospitals in the same city, and among physicians in the same hospital (Kozhimannil et al., 2013; Main et al., 2012; Metz et al., 2016). The American Congress of Obstetricians and Gynecologists (ACOG) regularly publishes guidelines for a number of clinical decisions, but there have been no consistent enforcement mechanisms for these. This is beginning to change. Since the early 2000s there have been efforts to measure and control specific clinical practices in birth as part of a multiple-stakeholder effort to improve maternal and infant health in the US.

For example, there have been major policy efforts in the last 10 years to reduce the rate of early elective delivery (EED) (Buckles and Guldi, 2017). An EED occurs when a woman who is less than 39 completed weeks gestation is induced or gives birth via cesarean in the absence of medical indication. ACOG has recommended against inducing labor before 39 weeks since 1979, however, the rate of early term births rose through the 1990s into the mid 2000s (Buckles and Guldi, 2017). Since 2007 ACOG has produced multiple reports to emphasize the reduction of EEDs, but these reports were not enforced until third party actors got involved. In 2008 the National Quality Forum adopted perinatal core metrics that included no EED before 39 weeks, and some hospitals created "hard stop" policies that forbade scheduling EEDs. Additionally, payers such as Blue Cross Blue Shield and Medicaid changed reimbursement policy to refuse to pay for EED births. This enforcement of EED guidelines is one example of a general shift in maternity care towards more measurement and regulation of obstetric practice. This is a timely moment to assess obstetricians' attitudes about standardization of clinical practice and experiences of decision-making within this changing quality control landscape.

Like evidence-based medicine, patient-centered care has become a measure of quality care and has been institutionalized in policy and medical education (Institute of Medicine, 2001; Andreassen and Trondsen, 2010). A central component of patient-centered care is shared decision-making, which seeks to change the power dynamic between the physician and patient from a paternalistic model where the physician maintained all power and told the patient what to do, to a model of decision-making where the patient participates in his or her health care decisions (Berwick, 2009; Charles et al., 1997, 1999; Epstein et al., 2005; Ishikawa et al., 2013). Research suggests practitioners vary in their willingness to share decision-making with patients (Dubbin et al., 2013; Mead and Bower, 2000).

Collins and colleagues (2005) found that practitioners tend to use either a paternalistic "unilateral" or shared "bilateral" approach, but observe some variation in approach according to individual patient preferences (p. 2025). Karnieli-Miller and Eisikovits (2009), and Vinson (2016) suggest physicians resist shared decision-making, and illustrate how they strategically manipulate conversations to make it appear like power is shared when it remains in the hands of the physician. In seeking to explore why physicians engage some patients in decision-making and withhold this opportunity from others, Dubbin et al. (2013) explain that providers do not see all patients as worthy of participating in decision-making. They show through an interactive model of cultural health capital how physicians' perceptions of patients and good patienthood shape whether or not they practice shared decision-making.