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Decision-making in Swiss home-like childbirth: A grounded theory study

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ABSTRACT

Background: Decision-making in midwifery, including a claim for shared decision-making between midwives and women, is of major significance for the health of mother and child. Midwives have little information about how to share decision-making responsibilities with women, especially when complications arise during birth.
Aim: To increase understanding of decision-making in complex home-like birth settings by exploring midwives' and women's perspectives and to develop a dynamic model integrating participatory processes for making shared decisions.
Methods: The study, based on grounded theory methodology, analysed 20 interviews of midwives and 20 women who had experienced complications in home-like births.
Findings: The central phenomenon that arose from the data was "defining/redefining decision as a joint commitment to healthy childbirth". The sub-indicators that make up this phenomenon were safety, responsibility, mutual and personal commitments. These sub-indicators were also identified to influence temporal conditions of decision-making and to apply different strategies for shared decision-making. Women adopted strategies such as delegating a decision, making the midwife's decision her own, challenging a decision or taking a decision driven by the dynamics of childbirth. Midwives employed strategies such as remaining indecisive, approving a woman's decision, making an informed decision or taking the necessary decision.
Discussion and conclusion: To respond to recommendations for shared responsibility for care, midwives need to strengthen their shared decision-making skills. The visual model of decision-making in childbirth derived from the data provides a framework for transferring clinical reasoning into practice.

Statement of significance

Problem or issue

Shared decision-making when complications arise during childbirth in home-like settings has not been studied yet.

What is already known

Shared decision-making is an ethical ideal that was outlined in a position statement from the International Confederation of Midwives. Shared decision-making offers opportunities for mutual understanding through a dialogue between client and care provider.

What this paper adds

This paper describes a dynamic model of decision-making in childbirth. The model provides a framework, which enables defining/redefining decision as a joint commitment to healthy childbirth. A diagram shows all steps of the model.

1. Introduction

In Switzerland, women supported by midwives can choose to give birth at home or in a birthing centre. In 2014 a total of

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2122 births, amounting to 2.48% of births registered in the country took place in such settings.[1] As the organisational models of care delivery vary in such settings, Hodnett et al.'s expression "home-like settings" was adopted in this article to describe them.[2] This model includes the naturalness of birth, no routine input by medical practitioners and variable staffing models. Therefore, midwives working in home-like settings have at least two years' professional experience and are registered with the *canton* (administrative area) in which they practise. Costs for non-hospital births are covered by the woman's medical insurance. Generally, women contact their midwife during pregnancy to arrange their maternity care. Should unexpected complications develop during labour, women and midwives jointly can decide whether or not to transfer to hospital. According to the European Charter on Patient Rights,[3] some cantonal health laws (Switzerland is a federal state with cantonal laws) include the right to free and informed consent[4] stipulating that an individual of sound mind cannot be forced to have medical treatment they do not want. Thus, professionals always have to act based on informed consent given by the patients. Guidelines or other formal agreements between hospitals and midwives concerning medical reasons for transfers do not exist at a national level in Switzerland. A recent report by the Swiss Academy of Medical Sciences[5] concluded that recommendations fail to encourage patient engagement and involvement. Substantial progress could be made by looking more closely at women-centred care and one of its fundamental principles: women's participation in decision-making. For example, in the United States, the Home Birth Summit, with representatives of all stakeholders, developed best practice guidelines for transfer from planned home birth to hospital to address the shared responsibility for care of women who plan home births.[6]

1.1. Background

The process of decision-making involves choosing between at least two alternative actions.[7] Based on this assumption the term "clinical reasoning" has been used to conceptualise the process of decision-making in midwifery practice. Clinical reasoning is the prevalent model of decision-making in the medical context. It is a form of logical, hypothetical-deductive decision-making relying mainly on biological and medical facts. The steps used provide a systematic approach for deciding the best alternative based upon rationality and clinical features. Jefford et al.[8] reviewed the literature on the cognitive process of midwives' clinical decision-making in context of birth and reached the following conclusions: a. Clinical decision-making encompasses clinical reasoning as essential but is not sufficient for midwives to make a decision; b. Women's roles in shared decision-making during birth has not been explored by midwifery research. In another study, Jefford et al.[9] analysed the existing decision-making theories and their usefulness to the midwifery profession. One of the theories presented is the five-step framework of the International Confederation of Midwives adapted from the medical clinical reasoning process, with the involvement of women for care planning and evaluation. While the model of clinical reasoning undeniably contributes to decision-making in midwifery, the authors conclude that it is not sufficient to guide best midwifery practice, as it does not address the autonomous decisions of healthy women. Additionally, midwifery decision-making should incorporate contextual and emotional factors and the midwife has to consider both the woman and the baby as an indivisible whole. Furthermore, Jefford and Fahy[10] have indicated, in a study during second stage labour, that only 13 of 20 midwives demonstrated clinical reasoning as their way of making a decision.

Decision-making in midwifery, including the claim for shared decision-making, has been embedded in a philosophy of partnership with women defined in the midwifery model.[11] Partnership between women and midwives, where a woman's informed choice is used to conceptualise the process of decision-making in midwifery, is now included in a position statement of the International Confederation of Midwives.[12] Shared decision-making offers opportunities for mutual understanding through a dialogue between client and care provider. The emphasis is on the process of coming to a decision with shared power and acceptance of responsibility for the decision.[13] Ideally, the decision is made consensually, with the woman at its centre. The woman takes on the role of decision-maker if she has been informed comprehensively and can make a well-reasoned choice. Partnership in decision-making has been shown to range over a continuum from unilateral to joint, with little emphasis placed on the need for equality.[13,14] A joint decision may be achievable when the woman and the midwife both have enough information to participate actively in decision-making. In the event of different interpretations of the information, the joint decision may not be equal.

The process in which a woman makes choices and controls her care and her relationship with her midwife is considered the essence of the concept of woman-centred care.[15] Other studies supporting choice for women and involvement in the birth process are associated with positive birth experience being favourable to women's satisfaction.[16–18] In addition, the home-like setting has a special impact on the processes used in clinical decision making. Indeed, the collaborative relationships between the midwife, the woman and the medical system guarantee regulating processes, which allow safe and effective midwifery practice.[19] Furthermore, bringing information and sensitivity around decision-making in cases of transfer from a birth centre to hospital is essential to help women adjust to changing circumstances.[20]

Other research has focused on decision-making processes related to a concrete question. These studies analysed shared decision-making regarding birth position during the second stage of labour,[21] augmentation of labour,[16] transfers for prolonged labour,[22] and birth of the placenta.[23] Results highlighted that decision-making in midwifery is a dynamic process integrating understandings of choices in the context of care.

Despite the significance of competent decision-making, the concept of shared decision-making when complications arise during labour does not seem to be well established in Switzerland or elsewhere.

1.2. Aim

The purpose of this study was to increase understanding of decision-making in complex home-like birth settings by exploring midwives' and women's perspectives and to develop a dynamic model integrating participation processes for making shared decisions.

2. Method

Because the focus was on understanding of processes, a grounded theory approach was used to allow a deeper understanding of participants' decision-making through rich descriptions in their own words. Accordingly, data were collected and analysed using theoretical sampling and constant comparative analysis. Development of the central phenomenon and subsequent categories was based on the coding paradigm described by Strauss & Corbin.[24]

2.1. Sampling and study population

The sample was composed of 20 midwives and 20 women from the French and German-speaking parts of Switzerland. Midwives

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