Informed Consent During Labour: Patient and Physician Perspectives

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INTRODUCTION

In contemporary medicine, shared decision-making is the gold standard. It is no longer acceptable for providers to make unilateral decisions on behalf of their patients. Informed consent is closely related to shared decision making as it provides a structured process for providers to explain the risks, benefits, and alternatives of a treatment option before the patient makes her choice. Several factors that are unique to the setting of labour and delivery can compromise patient-centred care and can make obtaining informed consent more challenging.

Qualitative studies have indicated that important components of patient-centred medicine include: finding common ground, understanding the whole person, and exploring the patient's experience with their condition.[1] Not only do patients' outcomes benefit from this approach, but physicians find greater satisfaction in their work and the efficiency of medical care improves.[2,3] The purpose of this commentary is to summarize the existing evidence on informed consent during labour and to highlight considerations for clinicians to make the process more patient centred.

THE CHALLENGES OF INFORMED CONSENT DURING LABOUR

The components of adequate informed consent include disclosure, capacity, and voluntariness.[4] Consent for a procedure in labour involves several factors that can compromise these elements. First, emergencies in obstetrics occur rapidly and unpredictably. When emergencies arise, time may be limited for a full discussion of a procedure's risks and benefits. Pain, fatigue, and medication side effects may additionally impair knowledge retention and capacity. In the United Kingdom, a study assessed whether women met all aspects of capacity as defined by the Mental Capacity Act during labour. Although most women felt they received adequate information to make a decision, they did not necessarily satisfy all the criteria of capacity.[5] During labour, it can be difficult to disentangle a woman's autonomy from her concern for the fetus.[6] It may also be difficult to separate the woman's decisions from those of a partner or other family member.[7,8] Combined, these factors that are unique to labour and delivery make obtaining consent in this setting significantly more challenging. In many situations, the fluctuating course of labour may mean that not all criteria of informed consent are met throughout. However, whenever possible, the patient's expressed decisions should guide clinical management.

RISK DISCLOSURE FOR PROCEDURES IN LABOUR

Providers have a responsibility to disclose the risks and benefits of all management options when obtaining consent. Several studies have been done on the consent process prior to epidural or CS. Despite the frequency with which these procedures are performed during intrapartum care, there is considerable variation in the content of these discussions.

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In studies examining risk disclosure for epidural placement during labour, there was significant variation between anaesthesiologists in the number of risks discussed, which risks were discussed, and the quoted frequencies of adverse events.[9–12] Fewer studies have looked at the consent process for CS. When comparing patient chart documentation to the Royal College of Obstetrics and Gynaecology guidelines for informed consent prior to CS, a particular area of strength was disclosure of serious risks including bladder damage, ureteric injury, and fetal laceration. The most significant area of deficiency identified was the risk of CS to future pregnancies, which was rarely documented as discussed, even among those undergoing elective CS.[13] Given that this important consideration is mentioned infrequently, patients may benefit from standardization of risk disclosure.

There is a paucity of data on the informed consent process in patients undergoing operative vaginal delivery (OVD), including the use of vacuum or forceps. In a study that reviewed charts following OVD, one third had no documentation of consent for the procedure. Any maternal and/or neonatal risks of instrumental vaginal delivery were documented in only 3% and 0% of charts reviewed, respectively.[14] To create a standard approach, one study developed expert consensus on the steps for rotational forceps delivery, including discussion points when obtaining consent. These points included the reason for forceps delivery, likelihood of success, options if forceps delivery is unsuccessful, and possible complications including laceration and episiotomy.[15] To date, no studies have assessed patient satisfaction or perceptions of the informed consent process for OVD.

WOMEN'S PERCEPTIONS OF THE INFORMED CONSENT PROCESS

In obstetrics, urgency has been demonstrated to impact the quality of informed consent discussions, as well as women's perceptions of the process. Studies have indicated higher satisfaction and higher perceived levels of involvement in the decision to have an elective CS compared with emergency situations.[16,17] In elective cases, when there was adequate time for discussion, many more maternal and fetal risks were documented as discussed compared with emergency cases.[18] Conversely, women who had no recall of the risks of CS were four times more likely to have undergone an emergency CS compared with those who had substantial recall of risks.[19] When emergency arises, it may be particularly beneficial for the patient to have had prenatal discussions with her provider about preferences for management during labour.

Further, women's views of their involvement in decision-making vary at different points during pregnancy and labour. The percentage of women feeling that they had exercised informed choice ranged from 73% for screening for Down syndrome to 31% for fetal heart monitoring during labour.[20] This may indicate that it is more difficult for health care providers to promote informed choice during labour than it is prenatally. Patient factors including language, educational status, and multiparity can also impact perceptions of the informed consent process.[19–22] Providers should tailor communication around informed consent to the patient's level of health literacy, taking care to foster understanding of management options.

STRATEGIES FOR OPTIMIZING INFORMED CONSENT DURING LABOUR

A common outcome measure in studies of the quality of informed consent is patients' retention of knowledge about the procedure. In one study, 91% of women had prior knowledge of epidural analgesia through friends, family, or antenatal classes. However, 72 hours following vaginal delivery, 26% of these women could not recall any potential complications of epidural anaesthesia.[23] Although women who attended antenatal classes had better recall of the risks of epidural, retention was generally poor.[24] During prenatal care, early discussion of intrapartum procedures has been demonstrated to improve patients' retention. Up to 96% of women believed that consent should be obtained prior to the onset of labour when there was more time for processing the information.[25] Identifying interventions that can be implemented during labour, especially those found to be effective in other health care settings, is an important area for further work to enhance patients' knowledge retention and empowerment.

To make discussions about options for anaesthesia and delivery method more consistent and informative, two main strategies have been studied. The first is the use of decision aids. These aids take the form of pamphlets, information cards, or decision boards that are intended to supplement, rather than replace, counselling by a health care provider. These tools were found to increase knowledge retention and decrease decisional uncertainty among women in labour.[26–29] Another strategy for improving this process is standardizing the discussion with patients before obtaining consent. Currently, there is significant variation in the risks discussed by providers and no consensus on the process of obtaining consent. When UK and US anaesthesiologists were asked about their practices for consent during labour, not all obtained written consent.[30] Another study in the United Kingdom found that 35% of hospitals surveyed used pretyped stickers or consent documents, whereas 65% relied on the memory of doctors, resulting in heterogeneity of the