A mixed-methods study of interactional practices of decision-making during childbirth in maternity units: VIP (Video-informed practice/Voices in partnership)

Ellen Annandale,[1*] Helen Baston,[2] Siân Beynon-Jones,[1] Lyn Brierley-Jones,[1] Alison Brodrick,[2] Paul Chappell,[1] Josephine Green,[3] Clare Jackson,[1] Victoria Land,[1] Tomasina Stacey[4,5]

[1] Department of Sociology, University of York, Heslington, York, YO10 5DD, UK
[2] Jessop Wing, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, S10 2SF, UK
[3] Department of Health Sciences, University of York, Heslington, York, YO10 5DD, UK
[4] Department of Nursing and Midwifery, University of Huddersfield, Huddersfield, HD1 3DH, UK
[5] and Huddersfield NHS Foundation Trust, Halifax, HX3 0PW, UK

[*]Corresponding Author: Email ellen.annandale@york.ac.uk Department of Sociology, University of York, Heslington, York, YO10 5DD, UK Telephone: [redacted]

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Scientific Summary

Background

The Department of Health and Social Care and the National Health Service are clear that service-users benefit from engagement in decision-making about their care. Indeed, the importance of informed consent, control and choice relating to decisions about labour and birth has been recognised for decades and particularly endorsed throughout the last fifteen years. Evidence exists concerning the relationship between labouring persons' feelings of control (a key component of which is involvement in decision-making) and greater satisfaction, emotional well-being, and decreased anxiety, as well as suggested better perinatal outcomes. Yet women's postnatal accounts show considerable variation in involvement in decision-making during labour. Indeed, the most recent Care Quality Commission (CQC) report shows that 22% of women surveyed in 2019 said they were only sometimes (18%) or never (4%) involved in decisions. Other studies report highly variable optionality around different types of clinically routine decisions, especially where this concerns personally sensitive/invasive procedures such as vaginal examinations and fetal monitoring.

Good communication is key to creating opportunities for women to participate in decisions about what happens to them; as noted in Better Births [Section 4.6 p. 43], women should ideally make decisions 'through an ongoing dialogue with professionals that empowers them.' However, despite an emphasis on dialogue, existing knowledge about communication during labour tends to be captured retrospectively. Hence, little is known about how decisions are actually made through situated talk-in-interaction between labouring persons, their birth partners, and healthcare professionals (HCPs). So, the real-time accomplishment of decision-making in this context is under-researched and this study addresses this significant knowledge gap.

The broad aim of the study was to use conversation analysis (CA; the leading method for analysing talk) to identify and describe key situated interactional practices of decision-

making that take place during labour in midwife-led units (MLUs). Midwife-led care refers to the autonomous care by midwives of pregnant persons who present to maternity services as low-risk for complications. During the intrapartum period, midwife-led care takes place in units staffed and managed by midwives, though referrals to obstetric-led care occur should complications arise. Notions of normality and risk, then, underpin the distinction between midwife- and obstetric-led care. Midwife-led care is associated with facilitating, where appropriate, the normality of birth as a spontaneous physiological process and, hence, less intervention. Emphasis is placed on midwives' professional expertise and women's embodied and agentic capacities to manage labour. This does not mean, however, that risk-surveillance is absent from midwife-led care, nor that pregnant people and midwives are not engaged in decision-making. Those with low-risk pregnancies have many options for their care during labour and birth, including (but not limited to) choices around pain relief, vaginal examinations, and management of the third stage. These are routine – likely not medically urgent - decisions of the kind that might be of relevance for any labouring person in any context. The routine and widespread nature of these decisions during labour and birth makes it particularly important to understand how they are managed in practice. Accordingly, decision-making in MLUs forms the focus of our research.

Objectives

The study had four objectives:

1. To create a rich dataset based on recordings of giving birth in MLUs. We collected data at three points: antenatal questionnaires surveying women's expectations and preferences for birth; intrapartum video/audio recording of labour and births; postnatal questionnaires about their experiences of, and satisfaction with, decision-making during labour.
2. To contribute to the evidence base for shared decision-making through our fine-grained analysis of the verbal and non-verbal detail of interactions that take place in real-time during birth, specifically: how decisions are initiated; who initiates them, and; how different ways of initiating decisions are responded to. Using CA, the analytic focus is on how talk is used (by all parties) to encourage or discourage involvement in decision making over the course and events of a birth.

3. To assess whether women's actual experiences reflect their antenatal expectations and whether there is an association between interactional strategies used (by all parties) during labour (particularly the extent to which decisions are shared) and women's later reported level of satisfaction. In this way, we could assess whether satisfaction is related to definable aspects of care in MLUs.
4. To disseminate findings to healthcare providers and service-users to contribute to translating existing Department of Health and NHS policy directives on sharing decision-making into clinical practice.

Design

The study utilised a mixed-method design including video/audio recording of labour and births, antenatal and postnatal questionnaires and interviews with midwives and obstetricians. A pilot phase was included to establish feasibility of obtaining high-quality video/audio recordings of birth.

The primary dataset was the video/audio recording of labour and births and the main analytic method was CA, which was used to explore the fine detail of interaction during decision-making. CA is predicated on the understanding that talk is used to perform social actions; to 'do' things. Relevant actions in the context of decision-making include offering ('*Do you want x'*), requesting ('*Can I have x'*) and pronouncing ('*I am going to x'). We examined the precise ways that decisions were initiated, who initiated them and how they were responded to.* Derived from the CA, a coding frame was developed to quantify the interactions that took place in each recording.

Structured antenatal and postnatal questionnaires surveyed women's antenatal expectations and preferences, experiences of, and postnatal satisfaction with, decision-making. Questionnaire data were combined with the quantitative coding of interactions in recordings, permitting analysis of associations between the interactional formats used (by midwives and by women in labour) and postnatally expressed satisfaction.

Semi-structured interviews with healthcare professionals (HCPs) explored perceptions of factors shaping decision-making. These interviews provided background context to the study and were explored only in order to reflect on issues raised by the CA of the recordings.

Setting and participants.

The study took place in two MLUs, located at two different English NHS Trusts. 154 women (aged 16+ with low-risk pregnancies), 158 birth partners and 121 HCPs consented to take part in recordings of labour and birth. Of these, 37 women, 43 birth partners and 74 HCPs were recorded. We aimed to recruit as diverse as possible a sample of women by socioeconomic status (SES) and ethnicity. Socio-economic status (measured by deprivation deciles) is widely distributed for the recorded (and non-recorded) sample though somewhat skewed towards residence in relatively less deprived areas. The sample of recorded women fell in all deprivation deciles, indicating some level of diversity, but there was a larger number of participants from less deprived areas. The majority were White (97%) which means that the experiences of Black, Asian and minority ethnic women were under-represented.

Key findings

Antenatally, the majority of women intending to labour and birth in the MLUs wanted to be involved in decision-making during labour and birth. However, CA of the recordings reveals that midwives initiate the majority of decisions in formats that do not invite women's participation (beyond establishing consent). The extent of optionality that midwives provide to women, however, does vary with the decision being made; women have more involvement in decisions pertaining to vaginal examinations in *early* labour (but not in active labour), pain relief and the third stage. Nonetheless, even in these contexts, optionality is contingent on clinical parameters and expertise. For example, where requests for pharmacological pain relief are in tension with normative decisional outcomes (e.g., that opiates should not be given too close to birth), midwives use various strategies to deter or defer their use. Birth partners are not treated as decision-makers by midwives. The exception to this is the decision about who will cut the cord, which is oriented to by midwives as belonging to birth partners.

Postnatally, the majority of women reported having wanted decision-making either to be led by staff or to be advised by staff and to take that advice. High levels of satisfaction were reported. There is no statistically significant relationship between midwives' use of different formats of decision-making and any of the measures of postnatal satisfaction. But women who initiated decision-making through the decision-implicative format were statistically more likely to have lower satisfaction for being 'listened to', for 'decisions made', and for overall satisfaction. Additionally, women's use of requests was associated with lower satisfaction in 'views being taken into account'. The similarity between pain relief-specific findings and all decisions suggests that it is pain relief decisions that are driving these associations: women who take the lead in pain relief decisions report lower satisfaction.

Discussion

In keeping with other CA research concerning decision-making in healthcare, our study demonstrates the difficulties involved in translating policies of patient involvement and choice into practice. In CA terms, option-listing might be considered the most participatory or 'shared' form of decision-making in clinical interaction (though this is not without nuance). However, in our data concerning decision making in MLUs, women are only explicitly presented with option-lists during decision making in quite specific circumstances. A key challenge is that midwives' interactions are oriented to a particular set of guidelines/clinical norms. Where guidelines/clinical knowledge indicates a normative outcome, midwives appear routinely to use interactional formats that constrain women's choice. This finding resonates with previous CA work that suggests that patient choice tends to be reserved for decisions where clinical outcomes may be less contingent on patient preference.

Although the majority of women intending to labour in MLUs antenatally described wanting to be involved in decision-making during labour, postnatally many described wanting decision-making to be led by staff, and reported that this is broadly what happened (which also corresponds to the interactions observed in the recordings). It is possible that the 'routine' nature of many of the decisions that take place in MLUs mean that their midwife-led nature, and the lack of optionality afforded to women, is uncontroversial. It is notable that

when surveyed antenatally, women generally either wanted or did not mind the interventions that midwives sought to pursue in HCP-led ways as part of routine care such as fetal monitoring at intervals and VEs. In this sense, there may have been no tension between many outcomes sought by midwives and those desired by women, perhaps reflected in the high levels of satisfaction reported postnatally.

However, one area where the goals of midwives and women in labour did sometimes observably diverge in the interactional data, was during decision-making about pain relief. CA demonstrates that women-initiated decision-making occurs in the context of midwives' clinical preference to avoid the use of pharmacological methods of pain relief at particular stages of labour. In other words, pain relief decision-making is sometimes *necessarily* women-initiated due to midwives deterring or deferring of pain relief decisions, particularly relating to the use of opiates. So, although interactions appear to be 'led' by women, the interactional responses being employed by midwives are still shaping decision-making in this context. The negative association between this form of decision-making and women's satisfaction suggest that it can – in some cases - leave women feeling unheard by staff. This demonstrates the consequential nature of the decision-making that takes place during even low-risk birth.

Conclusions

The tensions between adherence to clinical guidelines concerning risk management and the promotion of woman-centred care during labour are well documented in the existing research literature concerning midwifery practice. This study makes a significant contribution to this literature by providing the first UK and, to our knowledge, the only conversation analytic study of interactional practices of decision-making in midwife-led care. Our analysis suggests that to require midwives to share decision-making with people in labour by giving optionality in decision-making in all circumstances may be interactionally difficult. This is because the provision of optionality can be in conflict with clinical imperatives concerning the management of risk, as well as midwifery expertise concerning the management of pain and progress during labour. Put another way, offering choice to people in labour risks failing to achieve normative decisional outcomes. It is for this reason, we suggest, that the majority of

decision-making observed was initiated by midwives in formats that did not invite women's participation. We argue that the significance of this interactional challenge for midwives needs to be at the centre of any policy initiatives regarding decision-making during labour.

Future work

On the basis of this study, we suggest the following six directions of research. Recommendations 3, 4 and 5 could be conducted with our existing dataset. The first recommendation should underpin all new research.

1. Research is needed to explore more effective ways of including Black, Asian and minority ethnic people at all stages from initial approach to recording and what barriers exist to this inclusion (e.g., whether this population of women are more likely than White women to enter obstetric units rather than midwife-led units).
2. The extension of our methodology to studying decision making in obstetric-led care. We have demonstrated the willingness of participants to consent to recording and the practicalities of collecting data of this nature. Given that, by definition, obstetric care involves high-risk labours and our finding that optionality is contingent on clinical factors, it is important to systematically analyse decision-making in this context. The very different, and potentially more consequential (in terms of women's experiences) nature of decision-making in obstetric-care was strongly emphasised by our Service User Group.
3. Further analytic understanding of how pain relief is pursued/resolved, given that this is the area where we found some significant associations between decision-making practice and satisfaction.
4. Broadening the study of interactional practices of participatory decision-making to include practices that occur outside of the (necessarily) narrow confines of initiation, pursuit and response adopted in this study. These might include, for example, information provision and the opportunity to ask questions. Other factors such as continuity of midwife and numbers of midwives involved in the intrapartum period might also be consequential for decision-making.
5. Relatedly, there is a need to understand the interactional markers of the emotional labour enacted by both midwives and birth partners. Further analysis of the role

played, for example, by ‘coaching’ women through contractions, words of encouragement and use of touch might provide broader context for understanding the ways decision-making occurs in practice.

6. Although ambitious, it would be helpful to be able to follow pregnant persons across their antenatal encounters into the intrapartum period. This would allow us to examine not just women’s perceptions of their antenatal wants and expectations but their actual decision-relevant interactions with HCPs throughout pregnancy (including childbirth), hence facilitating further empirically grounded analysis of the relationship between future-oriented decision-making and the decisions that are made during labour.

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