Jackie Short, Gwen Adshead

The report suggests that managerially, it was apparently "wrong" for the nurse to deceive the patient (which justified the final warning) but not "wrong" for the doctor to have ordered the deception. This suggests that the ethical duties of doctors and nurses are perceived as different. However, it seems hard to argue that nurses should be more honest than doctors in their clinical practice unless it is important to protect a tradition of strong medical paternalism.

The author also raises concerns about a style of nursing management. Some of these concerns are not peculiar to nursing: the comparative inexperience of managers, younger managers managing older staff, the possible influences of sexual and ethnic prejudice. In nursing, there may be particular concerns about how nursing autonomy is protected or promoted within multidisciplinary teams. For example, in the first and third paragraphs, the author refers to the nurse "obeying" the consultant, as if the nurse were a slave of the medical hierarchy. But the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting guidelines state clearly that nursing staff can conscientiously object to actions with which they disagree.¹

Trials of war criminals have made it clear that obedience to an order is not a complete excuse for illegal or immoral behaviour. Nurses do not "have" to "obey" any instruction given, even by consultants. Why didn't the consultant give the patient his tea?

The reality is that the nurse and the doctor agreed on a course of clinical action, which others seem to have deemed ethically "unacceptable." What seems clear is

that the disciplinary process was (and is) a bad way to resolve ethical disputes. This could have been an opportunity for the whole team (and others) to learn and develop their skills in analysing ethical problems. Instead, the message seems to be that if you do something that someone else thinks is ethically "wrong" you could get suspended, unless you are a doctor.

The disciplinary process described seems bizarre. Two professionals ethically do the same thing (deception); one gets suspended, warned, and required to "retrain" (in what?—assertiveness skills with doctors?) while the other is "invited" to talk to the unit general manager, disciplined, and exonerated. It might be said that this simply reflects the different status of the two professional groups; but a difference in status does not imply a moral difference. In an ideal world, princes and paupers get the same justice.

If decisions are going to be taken by multidisciplinary teams, it seems appropriate that disciplinary procedures are themselves multidisciplinary. The doctor and the nurse could have been seen together by a team comprising a nurse, a doctor, and one other professional. This would improve cohesion of teams, foster trust, and reduce the risk of people being used as scapegoats. However, in the present paranoid climate use of scapegoats is so convenient that it is unlikely that any organisation will try to eliminate it.

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Wallingford Clinic,
Fairmile Hospital,
Oxfordshire
Jackie Short, senior registrar in
forensic psychiatry

Institute of Psychiatry,
London SE5 8AF
Gwen Adshead, lecturer in
forensic psychiatry

Informed choice for users of health services: views on ultrasonography leaflets of women in early pregnancy, midwives, and ultrasonographers

S Oliver, L Rajan, H Turner, A Oakley, V Entwistle, I Watt, T A Sheldon, J Rosser

With the aim of promoting the informed choice of pregnant women, staff and pregnant women at two urban hospitals were offered leaflets summarising the best available evidence about the effectiveness of routine ultrasonography in early pregnancy. Ultrasonographers doubted the credibility of the evidence and were concerned that the leaflets would raise women's anxiety, reduce uptake of scans, disrupt hospital organisation, and reinforce media messages about the poor safety record of ultrasonography. Midwives thought that the leaflets would inform women, help them to talk about their care with health professionals, and help them to get better care. Women were shocked at some of the contents but thought that it was appropriate to include both advantages and disadvantages of routine scanning in the leaflet. This case study highlights the resistance of some health professionals to evidence based health care; underlying conflicts with the principle of professional autonomy; concern that informed choice may create anxiety; and professional and organisational barriers to allowing informed choice.

Two important themes in current health policy are the value of informed choice for users of health services and the move towards evidence based health care. Greater

participation of users in health care is often seen as desirable and may be beneficial.¹⁻⁵ Evidence based health care is a method of basing clinical decisions on the best available scientific evidence.^{6,7}

Information leaflets for users and health professionals

Parallel leaflets to promote the informed choice of pregnant women on the basis of published evidence have been developed for pregnant women and health professionals by the Midwives' Information and Resource Service and the NHS Centre for Reviews and Dissemination as part of the "Informed Choice" initiative. The women's leaflets are designed to be given to them by health professionals, and they encourage women to participate in decisions about their maternity care. They summarise the best available evidence about the effectiveness of specific interventions drawing on systematic reviews, particularly those in the Cochrane pregnancy and childbirth database.⁸

The leaflets on ultrasonography review the value of routine scanning in detecting fetal malformations and multiple pregnancy and in estimating gestational age, and they discuss the evidence about safety. Midwives were asked to offer the leaflet over a period of two weeks to all women attending for a booking visit at 12-14 weeks of pregnancy.

Social Science Research
Unit, University of
London Institute of
Education, London
WC1H 0NS
S Oliver, research officer
L Rajan, research officer
H Turner, research officer
A Oakley, professor

NHS Centre for Reviews
and Dissemination,
University of York, York
YO1 5DD
V Entwistle, research fellow
I Watt, senior research fellow
T A Sheldon, professor

Midwives' Information
and Resource Service,
Bristol BS8 1SL
J Rosser, head of midwifery

Correspondence to:
Dr Oliver.

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Box 1—Ultrasonographers on accuracy and content of leaflets

Credibility of authorship

"Who's it written by—just midwives?"

Selective interpretation

"Just looking at the references...I think maybe...what's happening with this leaflet the authors have chosen to take what they want, their view on it, and it's not necessarily the correct interpretation of the trials"

Biased presentation of information

"I think my first impression is that it is quite a negative start to the leaflet; should you have one? And is it useful?"

"If I wasn't in this profession and reading this leaflet and knowing not much about scans I could still see that this was a biased leaflet. It leads you towards thinking that you don't want scans, but maybe if this leaflet was produced with less bias, less negative, you would be getting more of an informed choice, whereas I don't think this is informed choice"

"The whole thrust of the leaflet is extremely negative"

"Why do you have to say that you miss so many? Why can't you say ultrasound picks up 80%?"

Accuracy of the evidence

"They also quote there no known health advantages to the babies or their mothers in knowing about twins and I would dispute this as this allows us to give higher doses of folic acid for better placental development and also increases surveillance and monitoring for the rest of the pregnancy"

The leaflet for professionals concludes that "ultrasound scanning should not be presented as routine but rather as one possible course of action" and recommends offering women an informed choice about whether to have a scan. This is in line with the conclusion of Enkin *et al* that "the place, if any, for routine ultrasound has not been demonstrated yet. In view of the fact that its safety has not been convincingly established, such routine use should be considered experimental for the present."

The leaflet for women suggests three questions to help women decide whether to have a scan: Do I particularly want to see my baby before she or he is born? Am I unsure about my dates? Would I choose to have an abortion if the scan showed there was something seriously wrong with my baby?

We report a case study based on the observations from our pilot study of the leaflets on routine scanning in two hospitals (termed A and C) serving urban populations.¹⁰ It illustrates some of the problems that may arise during the implementation of evidence based informed choice.

Withdrawal of hospital C

The pilot study was originally supported by the director of midwifery at hospital C. However, ultrasonographers withdrew their support, although the messages about the effects of routine ultrasonography were all supported by the findings of randomised controlled trials and the radiographers' professional code of conduct specifies the need to support both informed choice and research.¹¹ Their objections focused on the credibility of the evidence reported in the leaflet (box 1); the likely effects on women's anxiety; reduced uptake of scans and disruption to the hospital's organisation; and reinforcement of ultrasonography's poor safety record as reported by some media (box 2).

The women's views

Twenty six women attending hospital A for their booking appointment took part in the pilot study by answering a questionnaire. They were given a second questionnaire when they attended again for a scan at 18-20 weeks of pregnancy.

The women's first reactions to the leaflets included shock at its contents, specifically that one in 200 fetuses had been aborted on the basis of abnormalities in a scan which were in fact normal or had only minor things wrong:

"Oh what a terrible statistic—1 in 200 who were aborted."

"It's got stuff that I haven't read anywhere else before, like the 1 in 200 babies and the risk factors."

Some women did not know that scanning was optional, but they recognised the benefits of being offered all the information in the leaflet:

"It tells you the good and bad things."

"It's giving you the information, the good bits and bad bits in black and white. It's what you need to know."

Ten of the 26 women said that they needed more information about ultrasonography. Eight said the leaflet had dealt with all or some of their questions.

Twenty one women were given the second questionnaire; all 13 who completed it had a scan.

The midwives' views

All 14 midwives participating in the pilot study thought that the women's leaflet would be helpful, give women information, help them talk about their care to midwives or doctors, and help them get better care. None thought that the leaflets were too negative about scanning. One said: "It's about time ultrasound was questioned. It [the leaflet] gives the scope to make up their own mind and decide what is important for them."

None of the midwives who took part in the study reported hearing of any women having a problem with the leaflet.

The views of the ultrasonographers in hospital A

Like their colleagues at hospital C, ultrasonographers at hospital A were also concerned about some of the wording in the women's leaflet and the anxiety it might cause. However, they decided to allow the pilot study to continue on the understanding that only 30-40 women would participate, and extra support for those women would be available if necessary.

They were surprised at the small amount of feedback from women when they were given the leaflet. One said:

Box 2—Ultrasonographers on likely impact of leaflets

Making women anxious

"It will make them more anxious, first of all about missing something, and secondly...if they were anxious before, 'My God, I might have done my baby some harm by having a scan as well'"

"Oh God, I'm not telling them that [1 in 200 babies who were aborted as a result of a scan were in fact normal]"

Impact on hospital organisation

"Finally, on the back page they ask for patients' feedback on whether, if they decided not to have a scan, there would be any reason why they could not change their minds later on. This would cause organisational chaos and should not be encouraged"

Lack of reassurance about safety

"I think...definitely there has to be a safety element in the leaflet, because there is so much bad press in the media"

Seeing the fetus on the ultrasound screen has become a socially accepted aspect of pregnancy for many women

"I haven't had any midwives coming round and saying 'Oh, this woman has asked me a lot about safety of ultrasound, can you come and help me?' I haven't had anyone come round at all, which is very surprising after the issues we raised. In fact I think it raised more anxiety in me than it appeared to have done with the women."

The ultrasonographers were generally reluctant to raise the subject of the leaflet with women directly:

"If they didn't bring it up, I assumed they didn't really want to talk about it."

"It just raises their anxiety levels if you start talking about it before they do—their anxiety levels go sky high."

Issues in implementing evidence informed choice

This case study highlights several key issues about implementing evidence informed choice for users of health services. These are the resistance of some health professionals to evidence based health care; professional ownership of knowledge; conflicts with professional autonomy; concern that informed choice may create anxiety; and professional and organisational barriers to allowing informed choice.

As other research has shown,¹² the social organisation of hospital work may militate against the introduction of policies that seem to call for a restructuring of health professionals' time. The call for more choice for users has not been accompanied by corresponding investment in training professionals how to promote informed choice and in organising the healthcare process to make time for and provide facilities for promoting more active participation by health service users. The same difficulties were not found in our pilot study of the leaflets discussing position in labour,¹⁰ suggesting that implementing evidence about effective health care and promoting evidence informed choice for users may be different for different interventions and may be seen as more appropriate in some healthcare disciplines than in others.

The ability to implement research that may challenge the value of a health technology may also depend on the age of the technology.¹³ Evaluating well established technologies may be particularly problematic. In addition, informed decision making may be frustrated by fast developing technologies that outpace evaluative research. The use of routine ultrasonography in pregnancy is also influenced by the technique's social role, which may prompt users to choose to have it for reasons other than established effectiveness. Whereas some women are critical of routine ultrasonography,¹⁴ for many it is socially desirable to view the fetus on the screen and receive reassurances that the baby is all right.^{15 16}

Much of the information produced for users of health services describes healthcare processes without providing information about options and outcomes.¹⁷ A recent survey of information materials for patients found that few outlined treatment options and even fewer were evidence based.¹⁸

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Commentary: Evidence based information for women is important

Mary Newburn, Meg Gready

National Childbirth Trust,
Alexandra House, London
W3 6NH
Mary Newburn, head of
policy research
Meg Gready, social researcher

The "Informed Choice" leaflets produced by the Midwives' Information and Resource Service and the NHS Centre for Reviews and Dissemination are of fundamental importance. They set out to provide users of the health service—in this case pregnant women—with the best evidence available on the effectiveness of different aspects of maternity care, in an accessible format and language. Significantly, the leaflets encourage

women to ask questions about what procedures are for and why they are needed.

The case study by S Oliver and colleagues is important because it examines how the leaflet on ultrasound screening was received and responded to by women, ultrasonographers, and midwives. We need to know how research evidence is greeted and how it is used, blocked, ignored, denied, and forgotten. It is not