The rhetoric of informed choice: perspectives from midwives on intrapartum fetal heart rate monitoring

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Abstract

Objective To investigate midwives' attitudes, values and beliefs on the use of intrapartum fetal monitoring.

Design Qualitative, semi-structured interviews

Subjects and setting Fifty-eight registered midwives in two hospitals in the North of England.

Results In this paper two main themes are discussed, these are: informed choice, and the power of the midwife. Midwives favoured the application of informed choice and shared a unanimous consensus on the definition. However, the idealistic perception of informed choice, which included contemporary notions of empowerment and autonomy for women expressing an informed choice, was not reportedly translated into practice. Midwives had to implement informed choice on intrapartum fetal monitoring within a competing set of health service agendas, i.e. medically driven protocols and a political climate of actively managed childbearing. This resulted in the manipulation of information during the midwives' interactions with women. This ultimately meant that the women often got the choice the midwives wanted them to have.

Conclusions The information that a midwife imparts may consciously or subconsciously affect the woman's uptake and understanding of information. Therefore, the midwife has a powerful role to play in balancing the benefits and risk ratios applicable to fetal heart rate monitoring. However, a deeply ingrained pre-occupation with technological methods of intrapartum fetal monitoring over many years has made it difficult for midwives to offer alternative forms of monitoring. This has placed limits on the facilitation of informed choice and autonomous decision making for women.

Introduction

The notion of partnership for women and the facilitation of informed choice in maternity care are fundamental principles of good

working practice within the National Health Service (NHS).¹ In this paper, informed choice is defined as: having had enough information and detailed discussion from a midwife for the woman and the midwife to make a choice

together.² Intrapartum (in labour) fetal monitoring involves the use of an instrument to record or listen to the fetal heartbeat during labour, intermittent auscultation (IA) or continuous methods may be used according to risk status. The majority of pregnancies are perfectly straight-forward, however, some midwives in hospital environments may underestimate normality and over-use methods of electronic fetal monitoring (EFM).³ Hence, the ritualistic implementation of EFM has helped to promote a model of care that may be contradictory to prioritizing women's inclusion in decision making.⁴ In this paper, an understanding of informed choice will be advanced through investigating the realities of midwifery practice. Fetal monitoring is justified as an example of practice when investigating informed choice, as there is good evidence that pregnant women are not always provided with all the relevant information to make an informed choice on the type of fetal monitoring method chosen.^{2, 4}

Subjects and methods

Fifty-eight midwives were interviewed from two hospitals in the north of England. The hospitals were chosen according to criteria published elsewhere by the researchers.⁵ These were anonymized as centre A and centre B; both served an urban population with a variable socio-economic and ethnic mix. At the time of the study there were 4000 births at centre A, and 2200 births at centre B. The midwives were a purposive sample⁶ as experience in the use of intrapartum fetal heart rate (FHR) monitoring was required. Midwives were recruited by researchers CH and SH and interviewed by them, each researcher in one hospital. CH and SH were introduced as researchers and not as midwives and explained that they wanted to investigate midwives' views on fetal monitoring. Hence, intrapartum fetal monitoring was discussed in the broad context of midwifery practice according to the midwives' own perspectives. Ethics committee approval was granted.

Recruitment

Midwifery and community managers were asked to make the written information about project recruitment available in order that those midwives who wished to take part in the study could do so. The range of the midwives' clinical experience varied between 2 and 30 years. There was an equal mix of registered midwives (nurse prepared) and 3 year pre-registration (non-nurse prepared) midwives. Midwives recruited at centre A knew that CH was a registered midwife with a background in education but that her role was as a researcher. Similarly, midwives recruited at centre B knew SH as a researcher. As reported elsewhere,⁷ the researchers were aware of the possible influences of their role on the research process i.e. on the selection and interviewing of the midwives. Initially, there was an intention to recruit 60 midwives, due to allowances for the hospital shift system and the availability of suitable volunteers, 58 midwives were recruited, (28 centre A, 30 centre B).

Interviewing

The researchers obtained written consent from the participants prior to conduction of the interviews and all were given pseudonyms. Qualitative interviews were conducted using a semi-structured tool derived from a literature review on intrapartum FHR monitoring for women at low obstetric risk.⁸ Following the interviews each researcher confirmed a strict order for using the schedule and consistency in timing, this helped to maintain rigour of the research. The interviews were transcribed verbatim and reflexivity was maintained by use of a research diary. Specific points addressed by the interview schedule included:

- advantages/disadvantages of intrapartum FHR monitoring methods
- decisions influencing practice
- definition of low-risk status
- influence of research on practice
- implementation of guidelines

- affects of technology on midwifery practice and the process of birth
- influence of information given by midwives on women's choices
- concept and application of informed choice

Data collection and analysis

Silverman⁹ discussed that a qualitative approach to data analysis attempts to understand the participants' categories and how these are used in concrete activities such as describing a particular culture. A general, thematic analysis as described by Aronson¹⁰ was undertaken. During data analysis, it was necessary to establish categories of speech that recurred simultaneously within and across transcripts, in other words 'patterns'. This can arise from direct quotes or when paraphrasing common opinions. For example, the process of listening in to the FHR and the differing experiences from the various participants created one pattern whilst the attitude that each individual midwife had towards the process created a further dimension. All of the vocabulary that matched a particular pattern was identified and placed with the corresponding pattern; this was indexed within Microsoft Word computer software. Grouping the specific patterns of responses in this way explored the participants' views rather than those of the researchers. For instance, when speaking about listening in to the FHR some midwives stated they were 'anti-technology', some found the technology 'protective' and some felt guilty about using 'defensive practice'. These patterns were then combined into subthemes, e.g. conversation topics, specific vocabulary, recurring activities, meanings, or feelings. Once these were identified, the researchers looked for similarities across the categories, i.e. whether one category preceded another or whether one or more occurred at the same time in the same statement. Overlaps were also observed for, and finally, whether statements that might, based on the patterns, offer explanations/relationships between the themes generated.

Validation

Data verification was required in order to establish that the themes were relevant to the chosen research question, that the themes identified from the full scripts were appropriate, and that a degree of researcher bias had not been introduced by interpreting rather than representing. In accordance with this process a fellow researcher (AT) examined at least 20, randomly selected, transcribed interviews. There was concordance with the identified themes; hence, the method used was relevant and consistent. This was important as, due to time constraints, the researchers were unable to use a purely grounded theory approach¹¹ i.e. transcribing, coding and interpreting the data after each interview before conducting the next interview. Similarly, it was therefore not feasible to forward the typed transcripts back to the participants for verification within a reasonable time scale. However, for clarification, the tapes were played back to the participants at the end of the interviews, no changes were made.

Results

The two themes addressed in this paper are:

- A consensus on informed choice
- The power of the midwife

Consensus on informed choice

There is often a presupposition that there is a collective understanding of the term 'informed choice' and that this should necessarily include all the available information.¹² The midwives in our study shared a consensus on imparting information, i.e. that the positive and negative aspects of intrapartum fetal monitoring should be communicated. Their views jointly represented a professional viewpoint that informed choice should not be contrary to the woman's best interest (Box 1).

However, it has been suggested that this typifies the health professional model of

Box 1 Midwives understanding of the term 'informed choice'

Communication scenarios with researchers from interviews with midwives

'Women should be informed about everything, why should we be the gatekeepers of information about women and their bodies?' (Belinda, centre B)

'I would say it means giving the woman as much information as possible on a topic and letting her make the decision about whether she wants something' (Natalie, centre B)

'You tell them the options, the benefits and the pros and cons of each option, and then it's entirely up to them and every thing, whatever road they want to go down' (Alice, centre A)

'Well, if I ever document that I've provided informed choice, I would inform them about both sides of the story. The advantages and disadvantages of whatever it might be and then allow them to choose what they want'. (Cathy, centre A).

promoting informed choice and merely emphasizes the knowledge of the health professional.¹³ This is important as, the information is executed in isolation to the clients' own attitudes and preferences. Our findings show that this is particularly the case where the use of technology is implicated and is in concordance with Stapleton *et al.*¹⁴ who demonstrated that midwives significantly over-estimated the effects of technology even if its use did not facilitate the informed choice of the woman. Knowledge and attitudes are both important determinants of facilitating an informed choice and hence decision-making on intrapartum fetal monitoring, but it must be remembered that knowledge and attitudes are also independent of each other.^{12, 13} Therefore, merely improving a woman's knowledge about fetal monitoring options is not the only or the most important feature when attempting to offer an informed choice.¹⁵ This is crucial, as midwives may consciously or unconsciously exert control over women's choices because their knowledge is often viewed as legitimate by women.¹² For example, Lewis and Salo¹⁶ commented on the scientific basis of technology and that this is often perceived as superior to human detection:

Syndromes of deference and awe towards technological and scientific knowledge lead to a belief that medical information is beyond reproach or question. (:60)

Therefore, the framing of information is a key factor when midwives disseminate information on fetal monitoring.

Power of the midwife

It has been suggested that both professional power and knowledge operate on a range of differing levels whereby the health care practitioner uses strategic tactics by which to sustain their position of authority over the consumer.¹⁷ This is in direct contrast to the professional obligations of midwives who, by statute, are instructed to be advocates for women and to place the interests of mothers and babies above all else.¹⁸ Despite the midwives' responsibility for promoting advocacy and informed choice, having a midwife in attendance at the birth does not necessarily rule out the traditional, patriarchal approach associated with medicine.^{19–21} For example Stapleton *et al.*²² demonstrated exchanges of information by midwives to women in the antenatal period; this sometimes entailed the delivery of detailed and specific medical information. Stapleton *et al.*²² reported that midwives ensured their professional agendas were maintained by adopting communication strategies that did not allow women to fully participate in the decision making process. This was also evident in our study, where the midwives' well-meaning approach was often tempered by their power in influencing women's ultimate decisions. For instance, despite the midwives support of autonomy for and partnerships with women, some midwives controlled their professional discourses with women. Stapleton *et al.*²² referred to this as 'professional dominance' (p. 198), whereas in our study the manipulation of information is referred to as 'strategic communication' (Box 2).

Throughout the data, the emergent dialogue was congruent with the principles of ethical decision-making and informed choice; whereby midwives consistently discussed the importance

Box 2 The midwives' influence on the facilitation of informed choice

Communication scenarios with researchers from interviews with midwives

'Most of the time information is biased to be honest, I mean to be honest most of the time in my experience women will go with what you say, and low risk women like you just listening in, I've not had anybody who's said, oh, no, I'd rather you didn't' (Eleanor, centre B)

'Sometimes it's just biased information isn't it? You give them the information you want to give them that you want them to have'. (Paula, centre A)

'I think sometimes if you knew as much as I did... and I've been a midwife for 5 years, I know it's not the right way but you know I think we should have some impact on choice' (Faye, centre A).

'I don't have a definition as such because I do find it very difficult really; I do find it very difficult. I think it's how you speak to the women sometimes, that the choice isn't always really that well informed, because you can.....you'll notice it with the doctors more so. I think if a doctor's leaning towards one particular decision he can actually make that woman choose that decision in what he says and the way he says it. I like to think that like as midwives we do give all the information available so that the woman can make that decision, but again sometimes depending on what is going on within the labour.....you know a woman's choice... especially when she's in labour, a woman's choice is not alwayswhat's the word I'm looking for? I think she can be influenced and I don't always think that she is fully informed' (Christine, centre B)

'It's very hard now because I think in some respects it's gone from one extreme to another. At one time we were more or less dictating choice and saying this is what we're doing I am going to put you on this monitor and there was no choice for the woman. Now, if we've got somebody who falls into the high risk category and want to be considered low risk you're saying that monitoring is the best thing for you. But women have very high expectations these days and you have obviously got some concerns from a midwifery perspective but you try to see it from her perspective and offering an informed choice is trying to get that balance. Have we gone too far in this direction though? I think it's up to us as individuals, as midwives to say 'well this is what I think professionally and you have got a choice but at the end of the day you try and steer them towards your direction'. (Vivian, centre A)

of liberating women from a system which promoted a technological model of birth. For example, midwives viewed disempowerment as 'the norm' for pregnant women and that mid-

Box 2 (Continued)

When women arrive in labour, they're obviously concerned about themselves and concerned about the baby so it's difficult to find the right words to make something like intermittent monitoring sound better than continuous monitoring. I think if they could see it in retrospect, they'd say oh God, that continuous monitoring is no good, but to say we'll listen in to your baby all the time, and often women want to listen to the baby all through pregnancy, you know, they'd say 'oh I wish I could have a Sonic aid all the time'. So I, I do talk about it, I just say 'I'm just going to listen to your baby, I'm not going to listen to your baby for a long period of time, I'm just going to listen through the contraction'. I'll listen throughout and hopefully there'll be no problems and that's all I need to do. But I don't think that's real informed choice. I know it isn't. (Angela, centre A)

wives had a crusading role in rescuing women from the active management (routine interventions) of labour and birth. Yet, there were obvious contradictions, as the decisions fostered around intrapartum monitoring techniques appeared to predominantly emanate from the midwife rather the woman. Others have also demonstrated similar findings where midwives have attempted to influence the decision making process rather than allowing women to make their own choices.²³ This is at distinct odds with a midwifery philosophy that has traditionally promoted the woman as the focus of care.^{17, 19–21} Our study continues to suggest that this remains a culturally defined norm in midwifery, yet, paradoxically, midwives have practiced predominantly within a medical paradigm of care. Hence, the consequences are that medically defining factors of childbearing have also imposed medically orientated parameters of normal birth in the practice of midwifery. Therefore, some midwives found it difficult to reconcile the informed choice ideal with the pressures of their daily working lives (Box 3).

The midwives were keenly aware of their responsibilities towards facilitating informed choice and encouraging women to play an integral role in making their own decisions. But, the reality of practice and their perceived inability to change things proved intolerable to their professional integrity. Consequently, they used a

Box 3 Pressures affecting midwives' facilitation of informed choice

Communication scenarios with researchers from interviews with midwives

'I have worked in a regional referral unit where it was very difficult to do IA (listening in with a Pinard stethoscope) and that's the reason why I left there to come to a less medical hospital. I felt that the midwives..... I might be in danger of losing sight of what's normal' (Belinda, centre B).

'The only disadvantage I can see for using intermittent listening is from a litigation point of view; it's your word against theirs if there's a problem because you've not got that proof' (Donna, centre B).

'I think with the climate that there is now, and the obsession at the moment of being seen to be doing the right thing to avoid litigation we sometimes over react to a normal heart tracing. I think some midwives especially those who are not as experienced as others ... they see one early deceleration (low FHR that recovers when a contraction of the uterus has ended) and they panic. They have not got the confidence with interpreting it. This has really got a knock on effect for the woman.' (Winnie, centre A)

'I think that a lot of midwives are under pressure from outside the delivery room door, you know that you might walk out, and somebody will say 'have you put her on a trace?' you know..... and I feel sorry particularly for the newly qualified midwives who might not feel they can stand up for themselves and say 'No she doesn't warrant it, there is no need to', it's hard for them, really they need a lot of support of someone saying 'you've made the right decision, she doesn't need it, well done' (Mary, centre B)

'I'm sure we do EFM because they are always on about litigation, and you know if you don't get it (the paper recording of the FHR) or don't document it, then if something did go wrong.....but I mean, that's a very defensive kind of practice isn't it? Thinking everything's only normal with hindsight, that's no good either' (Wanda, centre B).

'I mean the benefits are that it (EFM) may provide reassurance to midwives or women but again.....

I think it's a tool that prevents midwives from gaining confidence and competence because you know we do know that it doesn't prove anything except that it's recording. I mean if we leave it on long enough we can all find something that worries us. We've just got some statistics from November you know.... our stats are like a month in advance? And I was only looking at them last night and saying'

'70% of our deliveries for November were normal deliveries and yet 50% were continuously monitored!'

Now, it doesn't say that they're low risk, it just says normal deliveries but something doesn't add up there?

For what reason are women being continuously monitored by CTG? Does it make the midwives feel safer?

They are consciously looking for a reason and then they'll say 'well that's the reason and I'll keep it on' (Miranda, centre A)

coping strategy that allowed them to reinforce an idealistic notion of informed choice to themselves where each of them recited in 'cook book' fashion, a shared concept of informed choice and woman-centred care. It was only on deeper probing during the interviews that the manipulation of choice by imparting limited information on fetal monitoring became evident. Gould,²⁴ discussed how the knowledge, values, attitudes and beliefs of the medical profession have become entrenched within midwifery practice over time in order to increase the credibility of midwives. This is an important assertion because the language of medicine and the technological interventions used in childbirth have been the dominant force hence; woman-centred care has not primarily been the main focus in the delivery of care.²⁵⁻²⁷ However, there was also recognition by some midwives that the

lack of choice made available to women over recent years in respect of the routine application of EFM could not be unilaterally blamed on obstetricians. For example, the attitude of the attendant midwife to evidence-based practice, the facilitation of informed choice, and the fear of litigation were reported as barriers to the implementation of informed choice and fetal monitoring (Box 4).

Midwives are the lead professionals for pregnant women in the UK, when those women are deemed to be at low obstetric risk.¹⁸ Hence, midwives invest more time supporting and caring for women during the birthing process than do doctors. Despite the diametrically opposed philosophies around the management of birth to which midwives and obstetricians subscribe, midwives have promoted the use of medically focused policies such as, EFM,

Box 4 Resistance to the promotion of informed choice

Communication scenarios with researchers from interviews with midwives

'You see, some midwives don't like change, they rely on old routines. I can't tell you how many times I get phone calls from upstairs, 'there's a woman coming down, she's having dips (drops in the FHR) and you look at the tracing (paper record of the FHR) and there's no more a dip on there than the man on the moon! But because this midwife has said it, it's very difficult to ignore it. The doctor gets called.....you know the rest!' (Angela, centre A).

'It's often the older midwives who find it hard to adapt. I mean we've got a few here, I could take you to them now and if you watched them you'd be horrified, they trained in the 80's when machines were used all the time' (Polly, centre B).

'Some of the midwives use EFM because it's easier for them really.... So it's got nothing to do with research or anything. I mean, it shouldn't ever get to the point where you're leaving a woman. Just because they're on a monitor doesn't mean you have a license to go out the room and have cups of coffee'. (Alice, centre A).

'I don't feel its withholding information.... If I didn't feel she needed EFM then it's really not something she needs to know about. I would never offer somebody the choice to go an electronic fetal monitor. Because, if I didn't feel it was necessary, then that's my decision' (Amanda, centre B)

'I wouldn't get across the risks of being monitored, I would have just said 'Is it alright if we monitor you and just check the baby for 20 minutes? and not say anything to her about the risks of it' (Linda, centre A)

'So, you know I would say "We're not just doing it (EFM) to make you uncomfortable and to keep you on the bed, it's in your own best interests", so they usually accept that' (Alexandria, centre B)

'You're only as informed as the person that's giving you the choice. Certainly, you can influence choice by the way you ask questions. I think if women don't want to be monitored; people will try to persuade them to be monitored. Because the midwife tries to make the labour..... I think sometimes we try to make it our labour rather than theirs' (Hannah, centre A).

'You see it time and time again, particularly in midwives who have an attitude and you know that the women they look after continually have problems. Continually are distressed and yet someone else with a completely different attitude..... the woman's totally different. So, I do think the way women are given information, you know the way it's portrayed makes a difference (Carina, centre B)

regardless of the woman's risk status.²⁸⁻³⁰ Sandelowski³¹ has reported why midwives have adopted the medical paradigm for delivering care in normal birth whilst rejecting a more low-tech approach, as non-technological practices have accorded the midwifery profession less status. The promotion of informed choice for women and the non-use of EFM was limited for women by those midwives who perceived that the use of technology increased their professional status and by default relegated their intuitive knowledge and skills to a lower level. In contrast, Kardong-Edgren³² discussed the paradox of other midwives rejecting the use of technological practices because these interventions de-emphasized the ritual and tradition of clinical skills that for most midwives have been the focus and basis of their practice over time. The woman-centred focus of care so diligently promoted by the midwifery profession has prided itself on the continued presence of a midwife giving one-to-one support, using the finely honed skills of intuitive knowledge rather relying on technology to predict and assess progress.^{33, 34} Integral to this notion of woman-

centred care has been the facilitation of choice in and control over women's own birthing processes.³⁵ In our study, the midwives often referred to the poor practice of 'other midwives' and that there was a lack of consistency in the dissemination and implementation of informed choice on the use of intrapartum monitoring techniques. The midwives in our study also reported that because of the busy working environment of the labour ward it was sometimes difficult to enter into discussions with women about fetal monitoring techniques as the routine nature of labour ward care was deemed as paramount when trying to rationalize time. Stapleton *et al.*³⁶ also reported a similar phenomenon where the busyness and body language of midwives meant that women did not feel able to engage in the decision making process. This was because women were overly concerned on taking up the valuable time of the midwives. Consequently, the women's needs were relegated in preference to those of the professionals. The women's fear of unnecessarily burdening the midwives could be compounded further by the assumptions and attitudes of some midwives. For example, in our

study the midwives made assumptions that the women would not want information on fetal monitoring because of pain, fear and the effects of drugs. This ultimately meant that a lack of informed choice for the woman led to a greater degree of acceptance for the midwives actions.

Conclusion

The literature has shown that health professionals' integration of attitudes, values and beliefs around the implementation of evidence is a very complex process and is inextricably linked to role modelling, self-efficacy, personal belief systems. Our study shows that there are irrefutable imbalances of power that exist in defining the professional relations between midwives and the women they care for. Changes are required in the relationships between women and midwives whereby giving women the choice they want them to have and that they as professionals feel secure with, has to be more balanced towards an equitable partnership. When offering an informed choice, midwives communicating the risk of intrapartum fetal monitoring techniques to women, had to be negotiated within a complex system of competing priorities. This influenced midwives' perceptions and attitudes towards how information on intrapartum FHR monitoring should be divulged. The midwives used divergent strategies to deliver information in such a way as to influence the outcome towards their own ends. Although midwives did not tell deliberate untruths about monitoring, they distorted the information by attempting to control what they told women. This was often due to the fear of litigation as midwives reported their concerns about non-use of the electronic fetal monitor should there be a poor outcome for the fetus. This occurred regardless of women's awareness of the consequences of monitoring method chosen for themselves and their babies. Despite the advent of nationally approved guidelines on intrapartum monitoring which signify that midwives' practice cannot be deemed negligent if they do not use electronic methods of fetal surveillance for women at low obstetric risk; midwives in our study still said

they felt limited in the face of political power in obstetrics. There were only a few that challenged the system directly and others have shown how difficult it is for midwives to promote woman-centred care. In the UK, a whole generation of midwives has cared for women in predominantly high-tech environments where the use of electronic forms of technology in monitoring the FHR was normal practice. Consequently, there has been a pre-occupation with scrutinizing a paper record of the FHR. This professional, but deeply ingrained cultural expectation has made it difficult for midwives to consider offering alternative forms of monitoring to women and has served to limit informed choice for women. The midwives in our study found that it was not easy for them to negotiate informed choice in a maternity system immersed in a blame culture. Finally, despite midwives' abstract perceptions of informed choice it is clearly difficult for them to apply it in an ideological void. In our study the midwives genuinely affirmed their desire to offer high quality care to childbearing women, which involved them ascribing to modern notions of choice. In reality, informed choice for women is a slogan that often does not apply to practice.

Contributors

CH is the principal researcher. She was responsible for the overall study aims, data gathering, analysing the interviews and writing the paper. CH was involved in gathering the data. AT was involved in supervising the project and the data analysis.

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