by ALLISON SHORTEN

A 'decision-aid' for making informed choices about birth after caesarean
Results of a Randomised Controlled Trial

My personal philosophy about health care decision-making in pregnancy is that:

Women must have the opportunity to make informed and supported choices about their pregnancy and childbirth, using the best available evidence about the probable outcomes of those choices.

This personal philosophy has driven a five-year journey that began with the production of a decision-aid booklet for women who had experienced previous caesarean birth and who were facing the difficult decision about what type of birth they should have in their new pregnancy. The journey has now culminated in the completion of a multi-site RCT involving 227 women, to evaluate the effectiveness of this decision-aid with the purpose of supporting informed choices for women.

Although the main results of the RCT have been presented at various conferences (including the ACMI in Perth) and will be published in full elsewhere (Shorten, Shorten et al. 2005), I would like to provide an overview of the study and then focus on the key findings, as well as presenting some important issues raised by the women participating in the RCT.

What is a decision-aid?

The decision-aid booklet written and produced for my study was based on the University of Ottawa decision-aids, developed

by Annette O'Connor and colleagues in Canada (O'Connor, Drake et al. 1999). Decision-aids are more than patient education materials. Decision-aids are a strategy to help consumers work through a process of decision-making. There is evidence-based research presented in language that most people can read and understand; risks and benefits are illustrated and presented in a balanced way for each of the options for care; a values clarification exercise is used to help the reader to make a choice that matches their individual needs and values. Through this process consumers are able to increase their knowledge about their options and then take into account their personal judgements and past experiences, and consider how important these factors are for them - so that the choice they make is the one that is best for them.

Birth Choices: What is best for you...Vaginal or Caesarean birth?

The Birth Choices decision-aid was written for women who had already had one caesarean birth, who were currently pregnant and were eligible to choose between trial of vaginal birth or elective caesarean birth. The purpose of the booklet was to assist women, in consultation with their midwife, doctor and family, to choose which method of birth they felt was right for them.

The decision-aid was produced as a 20-page, A5 size self-administered booklet consisting of two main parts. The first part includes descriptive information about the two options for birth (trial of vaginal birth and elective caesarean birth), incorporating visual presentations of the probability information regarding risks and benefits of each mode of birth. The information for both birth choices are described in turn, with headings posed as questions. For example; "What is a trial of vaginal birth? What hap-

pens at the time of labour? What happens after the vaginal birth? What happens if I need to have a caesarean once labour has started?" For each birth choice, the possible benefits and possible problems are outlined, including both mother and baby. The review of birth choices then summarises advantages and disadvantages already outlined for trial of vaginal birth and elective caesarean birth on the same open page, so that women can review their options without searching through the text.

The second part involves a values clarification exercise to guide women through a summary of major pros and cons, based on the discussion within the body of the decision-aid. To assist women to consider how important each of these issues were to their individual situation, a scale using the terms "Not Important", "Some/Moderately Important" and "Very Important" is listed beside each issue and readers are instructed to rank each accordingly. Examples are used to explain the process. Women were asked to write down any additional thoughts or ideas they wished to add to the lists under the heading 'Your Ideas'. A 15-point Birth Preference Scale is utilised to elicit birth preference at the end of the activity. A space is provided for women to note any additional ideas or concerns about the options as well as for future consultations with the midwife or doctor. Details of the booklet development process can be found elsewhere (Shorten et al. 2004)

How well did it work?

Women who were allocated to the decision-aid group, receiving the booklet at 28 weeks of pregnancy, were compared to a control group of women who did not receive the decision-aid. All women received 'usual' antenatal care provided at their given hospital. There were four surveys administered, three during the pregnancy and one after the birth, to assess the effect of the decision-aid. The major outcomes of interest were women's level of knowledge about their options (including the risks and benefits), women's readiness for decision-making in terms of decisional conflict, choices for mode of birth and actual outcomes of the birth.

The Birth Choices decision-aid was very successful in improving women's knowledge of their options. Regardless of the baseline level of knowledge at 28 weeks of pregnancy, prior to receiving their decision-aid, women who received the decision-aid scored significantly higher on the knowledge test at 36 weeks when compared to women in the control group (a difference of 2.30 points out of 15 $p<0.01$). In fact the level of knowledge for many women in the control group did not change at all over the course of their pregnancy. This leads us to question the adequacy of verbal information exchange alone during antenatal visits for a range of models of care. The team midwifery model was the best in this regard when compared to GP-shared care, private obstetrics and standard hospital prenatal clinics, which adds weight to the proposed advantages of continuity models of midwifery care.

The booklet appears to have achieved what it set out to do when we read this postnatal reflection;

"I really felt the book was helpful. I now understand the terms and feel more informed about my choice. I took the booklet with me to my midwife and we looked at it together…I feel peaceful about this decision as it cuts out the mystery and the chance of an emergency Caesar which I want to avoid at all costs. It meets the needs of everyone in my family, me, the baby and my children and husband"

Women who received the decision-aid experienced a greater reduction in decisional conflict and were therefore more likely to be in a position to make a decision. They were more likely to have made a decision about what type of birth they wanted at 36 weeks of pregnancy when compared to women in the control group. When it comes to the type of choices women made, the decision-aid did not appear to push women to either trial of vaginal birth or elective caesarean. The balanced information allowed women to come to their own conclusions about what was best for them.

When we ask the question, "well what happened to the women", there are some important issues raised. The answer is, "well it depend on which hospitals they attended for the birth". If they were at the hospital that has a high caesarean section rate and low VBAC rate, then they were more likely to have a caesarean section. If they attended the hospital with the high VBAC rate, then they were more likely to have a trial of vaginal birth - even in some cases if they had indicated that they would prefer a caesarean section. In fact some of the women were very concerned during their pregnancy that they did not really have choices at all or that there were biased views coming from their practitioners about

what they should do;

"...was very confused by the end of pregnancy and by then not in a state to make a rational decision. Often the views of health-care providers come across when asked questions. Tried to do my own research but the information was often biased"

As midwives we should acknowledge that if we inform women and invite them to participate in the decision made about their care, we can experience conflict about what we might think is best for women and what informed women believe is best for them. This can create anxiety for both midwives and the women we work with and can communicate unwarranted feelings and personal values. This is illustrated in the comment below regarding one woman's preference for caesarean section;

"..changed to a private doctor. Really want a caesarean section [I] had no choice last time and feel angry that midwives make me feel that I am a failure and shouldn't want a caesarean".

It also appears that we make an assumption that the notion of informed choice and working in partnership with women exists for women. For some this is merely rhetoric. The quotations below are very telling in terms of the powerlessness women may feel if the decision for birth is not their own.

"I've been told the choice is not mine. I have been told the decision is not mine as I don't have Private Health Insurance. The decision will be made at 36 weeks by an obstetrician. I strongly would like another caesarean due to the stress my last baby went through. I wish the decision was mine"

The emotional impact can be significant when the opportunity to make a choice is taken away, regardless of whether it is a vaginal or caesarean birth that is desired. The impact of the following woman's experience was such that she stated that;

"I hated it [elective caesarean] so much I won't have more kids. I feel like sitting down and cry or may be I would like to have somebody to blame because it is NOT fair and NOT a satisfied experience to be dreaming for so long with the beauty of having a baby naturally (as it is supposed to be) and in the end I had simply NO CHOICE AGAIN! I was simply told it was best for me and the baby if we just had another caesarean...It was the doctor who decided in the end."

In the climate of evidence-based informed choice and consumer participation in health care, the quotation above was unexpected. Perhaps it reflects the true situation for women whose choices fall outside the practice patterns of individual hospitals.

Looking to the Future

Decision-aids are a potentially useful tool to assist women and their families in becoming informed about their options and making a decision about what might be best for them. This is of little value if we are not prepared to support informed choices in the current healthcare system. There are legal imperatives that may drive practice patterns within individual hospitals, and therefore sway women's choices to comply with organisational norms. Therefore if decision-aids are to work effectively, we need strategies that will assist practitioners, both midwifery and medical, to document and support informed consumers more effectively.

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