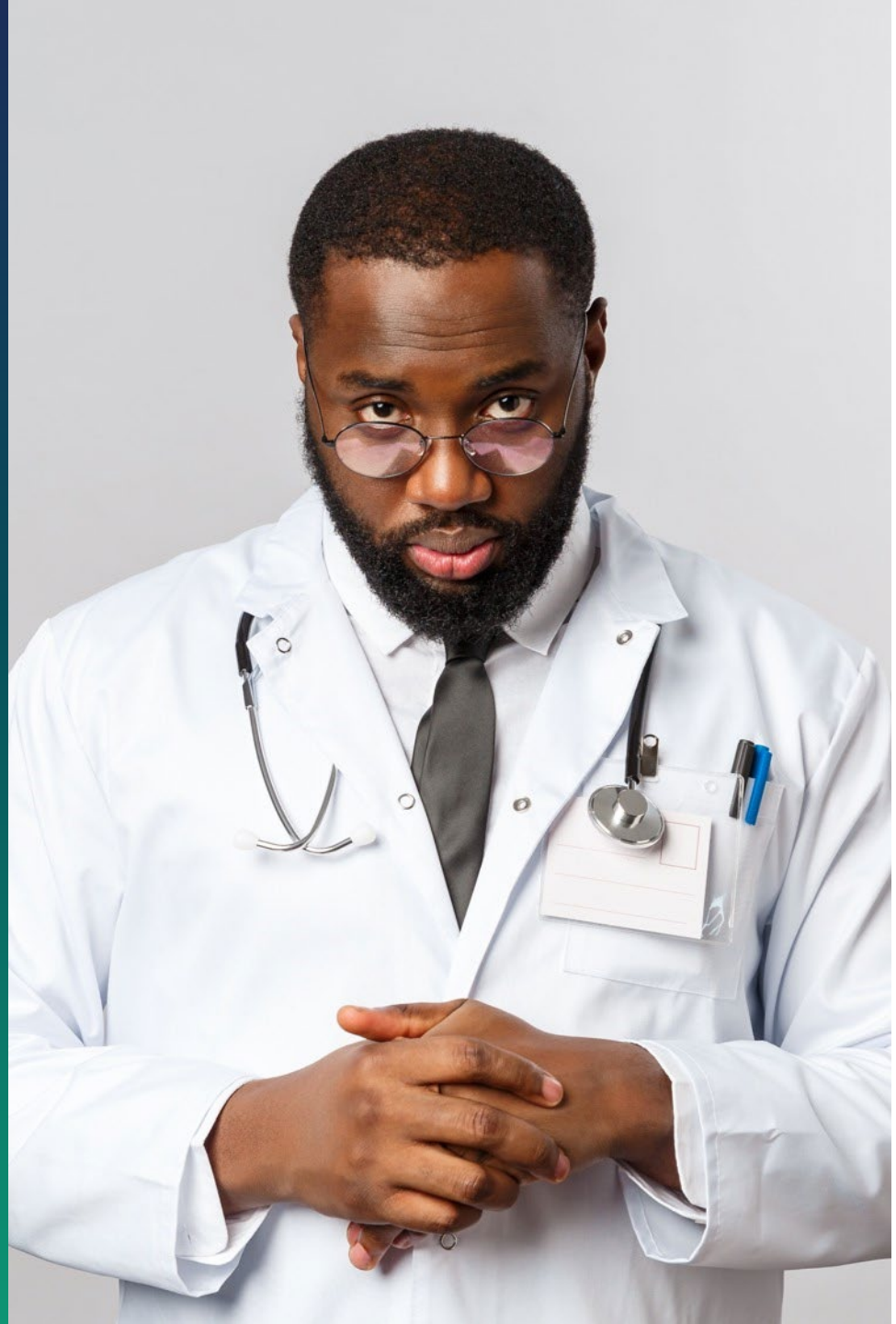
Person-Centered Decision Making Part 2

Modified from an Interprofessional module created by the UBC Birth Place Lab and adapted by UCSF

MATERNITY CARE EDUCATION
& PRACTICE REDESIGN



Why Do Providers Hesitate to Utilize PCDM?

- “It would take too much time to do all that.
- “I already do that.”
- “What about people who don’t want to be involved in their care?”
- “There are too many barriers to interprofessional person-centered decision making.”

“It would take too much time”

- Several studies have shown that providers trained in PCDM do not take significantly longer to conduct care
- Learning to use a logical sequence can help save time
- These skills are most frequently learned and utilized in non-urgent scenarios such as an office visit
- Shared decision making can also be used in urgent scenarios such as in a birthing context

“I Already Do That.”

- Evidence shows that providers and patients do not always communicate as well as they believe they do.
- Patients rarely give direct feedback about communication problems.
- This may lead providers to believe there is no need to improve or change
- Person centered decision-making requires knowledge of key communication techniques:
  - Paraphrasing
  - Summarizing
  - Reflecting
  - Open Questioning
  - Sending Messages

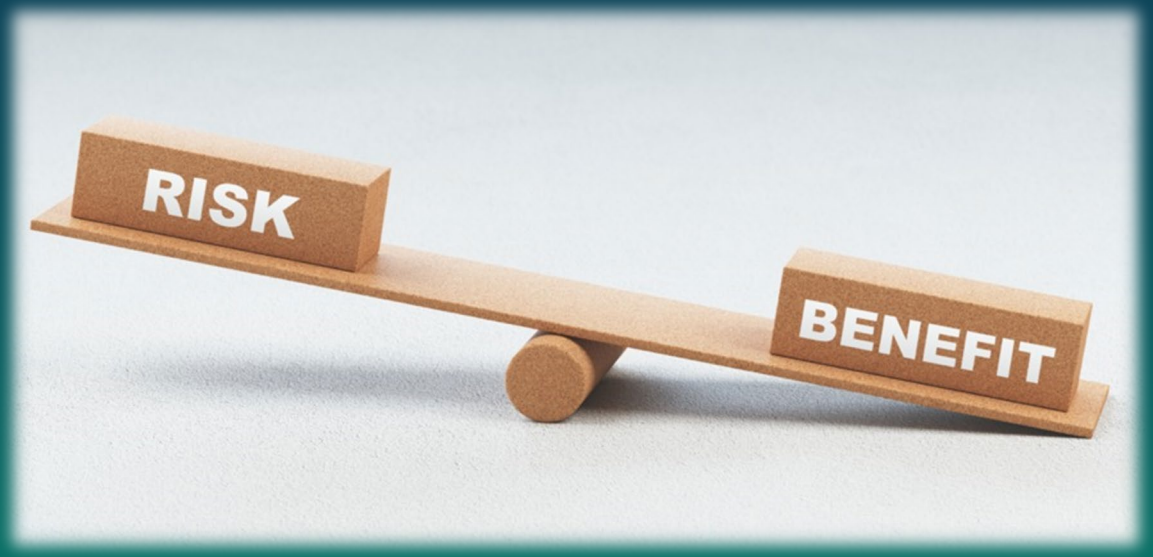
“What About People Who Don’t Want To Be Involved In Their Care?”

- People may feel uncomfortable with making healthcare decisions because they have never done it before.
- Providers should encourage autonomy in decision making
- Share necessary information and listen to what is important to the patient
- Avoid making cultural and professional assumptions about people which can strain relationships and limit dialogue

“There Are Too Many Barriers to Interprofessional Person-Centered Decision Making”

- Research shows that power differences attributed to gender, stereotypes, and social status affect collaboration
- By utilizing proven tools for interprofessional collaboration, barriers to PCDM can be decreased

Considering Risk and Benefit



To help people understand the risks and benefits of healthcare options in the context of their own lives, priorities and values, you will have to learn how to present statistical concepts like absolute versus relative risk in understandable terms.

Understanding Absolute versus Relative Risk

Absolute Risk

The chance an individual will experience a certain outcome over some period of time

Relative Risk

The chance that an individual will experience the outcome compared to someone else, based on their individual risk factors or circumstances

Absolute Risk: Women in the US have 1 in 8 (12%) risk of developing breast cancer over a lifetime.

Relative Risk: Compared to women who do not drink alcohol, women who have two or more drinks each day have a 50% higher risk of breast cancer over the course of a lifetime.

Clearly Communicating Risk to Clients

- Use plain language
- Present data using absolute risks
- If using graphs, present information in pictographs
- Present data using frequencies
- Use an incremental risk format
- Be aware the order of risks and benefits are presented can affect risk perceptions

Clearly Communicating Risk to Clients

- Consider using summary tables that include all the risks and benefits of every option
- Recognize that comparative risk information is persuasive and informative
- Present only the most critical information
- Repeatedly draw patients' attention to the time interval over which a risk occurs

Ethical Framework for Communication

Three principles of medical ethics that apply to all patient interactions:

- Beneficence: Doing good; helping
- Non-maleficence: Avoiding harm
- Autonomy: Client's input and role

The International Context of Care

The World Health Organization (WHO)

The Federation of International Gynaecologists and Obstetricians

The National Institute for Clinical Excellence (NICE)

The United Nations Population Fund (UNFPA)

The International Context of Care

These agencies issued reports that focus on patient experience as a key component of quality and safety in maternity care. They emphasize the following as essential in addressing disparities in health outcomes for both high and low resource countries

- Person-Centered Decision Making
- Choice of Birth Place
- Access to Regulated Providers
- Interprofessional Collaboration

“Many women globally experience poor treatment during childbirth, including abusive, neglectful or disrespectful care. Every woman has the right to dignified, respectful sexual and reproductive healthcare, including during childbirth.” (Bohren et al., 2015)

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Midwifery in U.S. History

- Early 1800s - rich history of midwives within communities attending home births
- Prior to the Civil War, the persons who performed all manner of healthcare were female midwives
- Half of the midwives who provided reproductive health care were Black women
- There were also indigenous and white midwives
- (Goodwin, 2020)

Midwives in the US 1830s- 1920s

Dr. Joseph DeLee was a strong opponent of midwifery and in a speech delivered in 1915 entitled “Progress Toward Ideal Obstetrics” wrote that midwifery was: "a relic of barbarism.” He elaborated by saying, “The midwife has been a drag on the progress of the science and art of obstetrics. Her existence stunts the one and degrades the other.”

There were overt efforts by male obstetricians to convince families that birth should take place in hospitals with the assistance of physicians and not at home with midwives; racist campaigns against Black midwives.

J. Marion Sims and Anarcha

“Humanization of Childbirth”

- In the 1970s, a global movement towards respectful care in midwifery began
- “Comprehensive efforts to overcome sociocultural, economic, geographical, and infrastructural obstacles to reaching facility-based care. Furthermore, it requires efforts to improve both the coverage and quality of care provided to women and health facilities, including women's rights to dignified and respectful care." (6, p. 2)

“Humanization of Childbirth” (cont.)

- ".... several recent studies and reports clearly indicate that many women globally experience poor treatment during childbirth, including abusive, neglectful, or disrespectful care.
- “Every woman has the right to dignified, respectful sexual and reproductive health care, including during childbirth, as highlighted by the Universal Rights of Childbearing Women charter.”
- In September 2014, a World Health Organization statement called for greater research, action, advocacy and dialogue on this important public health issue, in order to ensure safe, timely, respectful care during childbirth for all women." (6, p. 2)

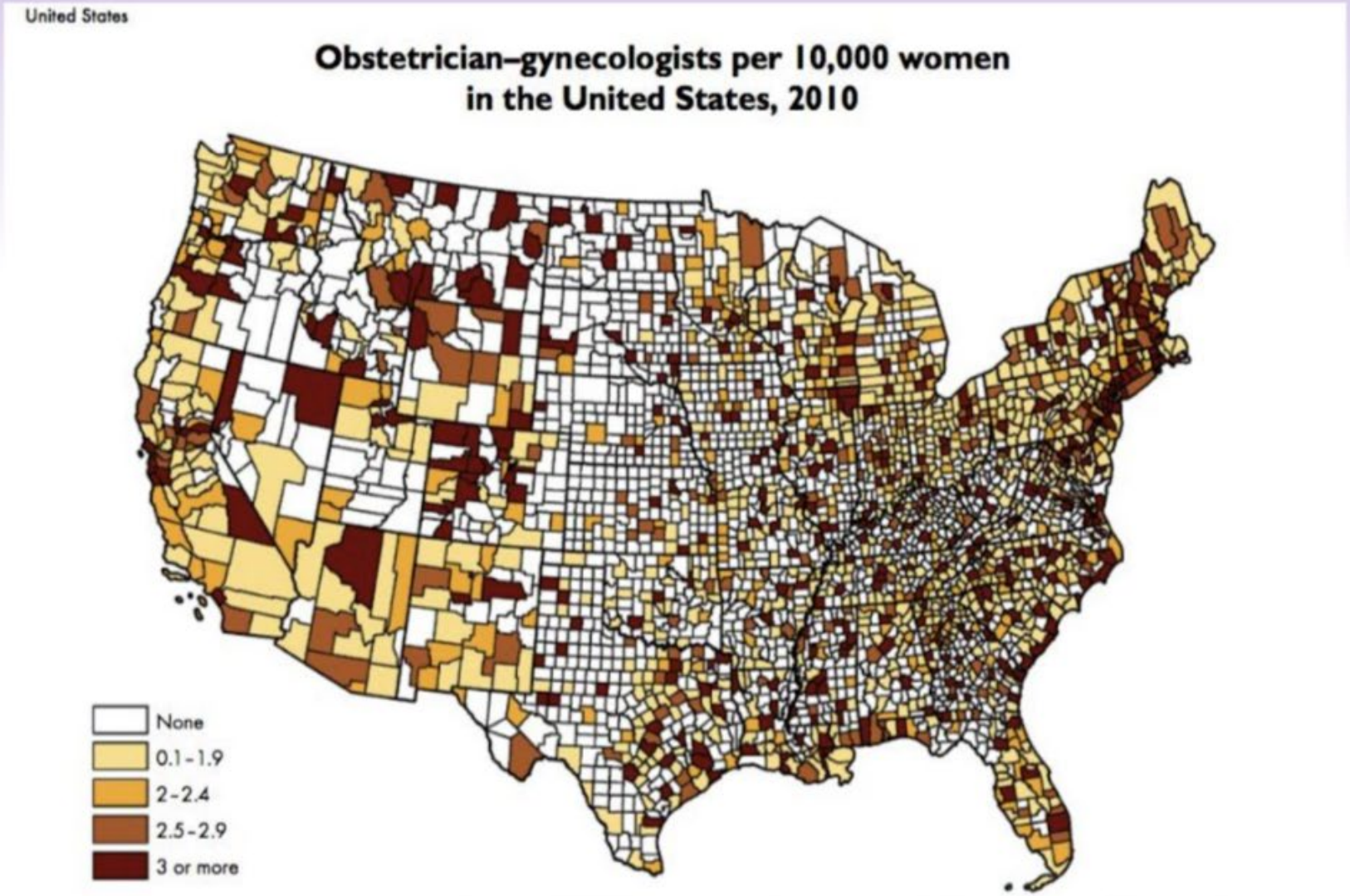
A Snapshot of the United States Context

- Physician-led, hospital-based care predominates
- American College of Obstetricians and Gynecologists (ACOG) most influential organization
- 1.5% of all births are in community-based, in home, and birth center settings (upward since 2004)
- Certified Nurse-Midwives (CNM) now attend 8.3% of total births in the US and 12.1% of all vaginal deliveries.
- The United States faces a shortage of obstetric care providers, especially in rural areas where more than 10 million women (8.2% of American women) live. About 49% of the United States' 3,143 counties do not have a single OB/GYN.

Recent Research Demonstrates Significant Benefits of Access to Midwifery

- Better Obstetric Outcomes
- Decreased cesarean birth rates
- Decreased preterm birth rates
- Decreased low birthweight rates
- Increased rates of breastfeeding
- Increased rates of vaginal birth after cesarean

Access to Maternity Care Providers



Sources: American Congress of Obstetricians and Gynecologists. Membership information. Washington, DC: American Congress of Obstetricians and Gynecologists; 2010 and American Fact Finder. American FactFinder. Washington, DC: US Census Bureau; 2012. Available at: http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml. Retrieved August 2, 2012.
Produced by: American Congress of Obstetricians and Gynecologists' Workforce Studies and Planning Group

9.5 million Americans live in rural counties with no ob-gyn (49% of counties)

ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

With a Shortage of Obstetrical Care Providers,
It is imperative we improve collaborative care!

Interprofessional Discussions Over Time

The Safety of Home Birth

Educational Standards for Midwifery Practice

Autonomous Practice of Midwifery

Progress?

Interprofessional Discussions Over Time

The Safety of Home Birth

Little progress

Educational Standards for Midwifery Practice

2006: ACOG Endorsed AMCB Education Standards

2015: ACOG published a statement in support of education and training standards of the International Confederation of Midwives (ICM)

Autonomous Practice of Midwifery

2011 ACOG published position statement in support of collaborative care and autonomy of CMs/ CNMs

Where Should Our Baby Be Born?

Choice of Birth Setting is Complex Process

Considerations Include:

- Physical Well-being
- Cultural Values
- Social Values
- Emotional Concerns
- Spiritual Values
- Personal Preferences

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- Autonomy -

- Safety -

- Choice -

Maternity Care Deserts

Patients may lack choices in pregnancy and birth care due to scarcity of resources:

Contributing Factors Include:

- OB/GYN Workforce Shortage
- State Specific Barriers
- Insurance Coverage Restrictions
- Distance from Care Settings
- Failure of Institutions to Credential and Facilitate Options for Care Such as Midwifery

What is Planned Home Birth?

- When, after the onset of labor, an essentially healthy pregnant person at term intends to deliver at home and is attended by qualified maternity care professionals.
- Standard labor and delivery equipment and medications are available in the home
- Access to hospitalization and/or specialist consultation, if necessary, are included in the plan.

Evidence-Based Selection of Birth Setting

- Since 2009, several large population based and matched cohort studies have established that for people without risk factors there are significant reductions in use of obstetric interventions when labor and birth occurs in homes, birth centers, and midwife-led hospital units.
- There were no significant differences in adverse outcomes (1, 10, 11, 20, 21)
- In high resource countries the absolute risk of adverse medical outcomes is extremely small in all settings (24)

Personalizing the Decision

Factors that influence a woman's immediate feelings of security and safety:

- Distance to the hospital
- Access to skilled personnel
- Specialized equipment
- Access to special foods
- Extended family support
- Ability to engage in rituals, undisturbed

People will respond differently depending on individual physical and life circumstances, possibly changing their initial birth site plan.

National Institute for Health and Care Excellence (NICE) recommends that providers:

- Explain to both multiparous and nulliparous women that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit) and support them in their choice of setting wherever they choose to birth

- Advise low-risk multiparous women that planning to give birth at home or in a midwifery-led unit is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared to an obstetrical unit in a hospital

Evidence-Based Guidelines to Establish a Culture of Respect

- Ensure that the birthing person is in control, listened to, and cared for with compassion
- Obtain appropriate informed consent
- Relate to birthing people **and** their companions
- Ensure a culture of respect for families who are undergoing a significant and emotionally intense life experience
- Senior staff should model with their own words and behavior, appropriate ways of relating to and talking about birthing people and their birth support people
- Utilize anticipatory guidance to help them make choices for care

Public Health Implications

- Birth environment affects the caregiver's use of technology and can influence the physiology of normal labor and birth
- Healthy people who choose low technology settings with skilled providers experience less intervention and reduce overall healthcare costs, even if they deliver in the hospital after transfer (36, 37)
- Public health researchers recommend maternity care occur in the lowest resource setting where the person feels safe and comfortable and can access skilled attendants as appropriate (15, 17)

Mortality Rate and Diversity

Structural racism correlates with poorer outcomes:

Causes of maternal mortality differ across racial and ethnic identities

Mortality Rate and Diversity (cont.)

US-born Latinx women experience a higher mortality rate from causes of pregnancy-related death that are in decline for US-born, non-Latinx women

These causes include:

- Hypertensive Disorders of Pregnancy
- Hemorrhage
- Venous Thromboembolism

Mortality Rate and Diversity (cont.)

Native American and Alaska Native Women Experience:

- Four times that rate of postpartum hemorrhage
- Three times the rate of gestational diabetes
- Nearly twice the rate of pregnancy-related hypertension

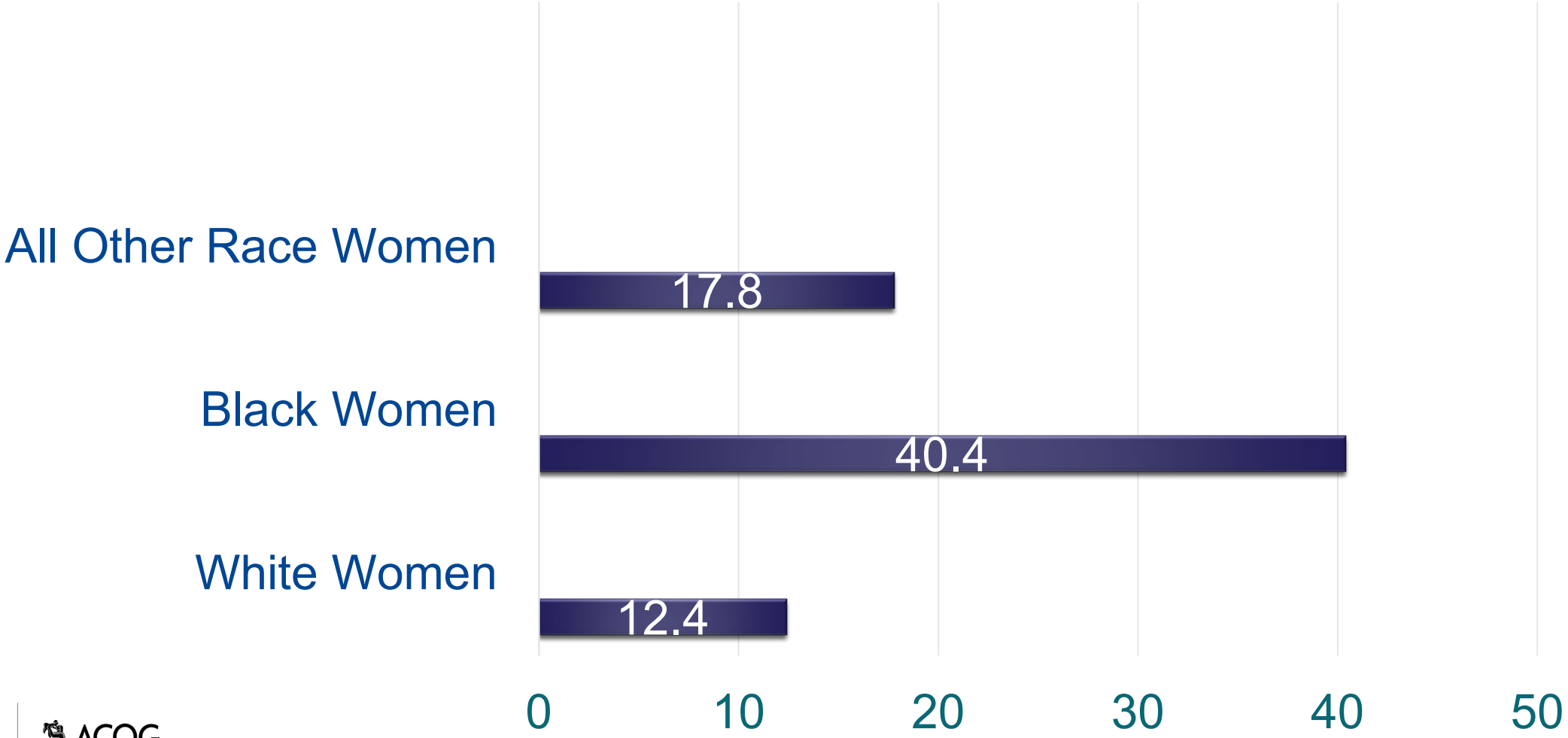
…as compared to women in the general US population

Mortality Rate and Diversity (cont.)

- Black women are 3-4 times more likely than white, Asian, or Latinx women to experience a pregnancy-related death
- According to , Dr. Ana Langer, director of the Women and Health Initiative at the Harvard T.H. Chan School of Public Health in Boston:
- "It's basically a public health and human rights emergency because it's been estimated that a significant portion of these deaths could be prevented."
- "Basically, Black women are undervalued. They are not monitored as carefully as white women are. When they do present with symptoms, they are often dismissed."

Maternal Mortality Rate and Race in the US

Maternal Deaths per 100,000 Live Births in US



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See part 3 slide deck for references and acknowledgements... Thank you!