Informed choice? Evidence of the persuasive power of professionals

Richard Johanson, Robin Burr, Nicola Leighton and Peter Jones

Introduction

Two themes feature prominently in current National Health Service (NHS) priorities: the importance of evidence-based health care and the value of informed choice for users of health services. There is evidence both within and outside health care showing that choices are influenced by the way options are presented.1

Nearly 20,000 women each year in the United Kingdom will have an uncomplicated breech pregnancy at term. The Royal College of Obstetricians and Gynaecologists (RCOG) has recommended that they should be offered ‘external cephalic version’ (ECV). ECV is a safe and cost-effective procedure that significantly increases a mother’s chance of having a normal cephalic vaginal delivery, halving the caesarean section rate.2

Despite the recommendations of the Royal College (which have been echoed by the US College), there remains a reluctance amongst senior obstetricians to accept the procedure. Although ECV was rarely undertaken by the consultants in North Staffordshire before 1995, it was one of the top topics prioritized in a multidisciplinary democratic forum Achieving Sustainable Quality in Maternity (ASQUAM). Indeed, thereafter acceptable levels of offering ECV (over 90 per cent in all the consultants’ antenatal clinics) and of successful ECV (about 50 per cent) were soon achieved. This study was undertaken to establish the proportion of women accepting the procedure after being offered ECV.

Methods

The data were collected prospectively, initially as part of a regional project on the management of term breech pregnancies being carried out by R.B. The proforma was completed in the Antenatal Clinic after the mother-to-be had been counselled. The options discussed and offered were recorded by the midwife present. Completeness was ensured by checking the ECV register and by obtaining the notes of all women who had a caesarean section or vaginal breech delivery.

Results

Overall 65 per cent (210/323) of women accepted the offer of ECV. From the Table it can be seen that the proportion accepting was very different between consultants (from about one in three to four out of five). The differences between consultants (accumulated figures over the 3 years) were highly significant statistically \[\chi^2(6 \text{ df}) = 45.75, p < 0.001\].

Discussion

Although our service offers a high proportion of women ECV, acceptance rates varied significantly according to the health professional offering the procedure. This phenomenon has been observed in other antenatal areas. For example, uptake of HIV screening has been shown to vary widely according to which midwife presents the test.3 Given that another study has shown a 78 per cent acceptance rate,4 it is possible that we were generally under-persuasive, although one consultant might have been over-persuasive. From our findings it appears that the clinician still carries the trust of the patient and that it is

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<td>Overall</td>
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relatively easy to demonstrate the influence of a consultant’s opinion on the practice of their clinic.

Research evidence shows that women want more detailed and reliable information on options in pregnancy and childbirth, so that they can make informed decisions. Oliver et al. have previously identified obstacles to the process of promoting informed choice in pregnancy. These included professionals being resistant to evidence-based health care and concerns that informed choice may create anxiety. Both of these factors may have contributed to the situation that we describe in relation to how ECV is offered.

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References


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