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**Decision-making: do existing models reflect the complex and multifaceted nature of woman-centred contemporary midwifery practice?**

This article is the first in a two-part series exploring decision-making (DM) in contemporary midwifery practice. The first considers the role and nature of DM, and critiques two DM tools, while the second proposes a midwifery-specific DM tool in the context of a tripartite clinical decision, incorporating broader perspectives and ethical issues in DM.

DM is an integral part of midwifery practice, and is formally introduced to third-year student midwives (STMW) at the University of Southampton in an Autonomous Practice academic module that incorporates both DM and carrying a student caseload with the aim to support the transition from student to newly qualified midwife. The taught component of the module occurs over a one-week period, introducing students to the complexities and challenges encountered in clinical DM within midwifery practice. The module culminates in a written assignment exploring and critiquing DM theories and models, and applying a DM model to a tripartite clinical decision. As stated throughout the module and through research, most learning in reality occurs once qualified and a change in professional responsibility has been realised (Kitson-Reynolds, 2010; Kitson-Reynolds et al, 2014)

**DM in midwifery practice**

Midwives are autonomous practitioners working within a multidisciplinary team, and are the lead professional for low-risk women and the coordinator of care for high-risk women (Department of Health [DH] 2010). Clinical practice and patient outcomes are shaped by the decisions made by healthcare practitioners (HCP), although this does not consider DM as the process used to reach a decision, thus an understanding of DM theories and models is necessary to facilitate effective DM in practice (Raynor and Bluff 2005; Muoni 2012; Ménage 2016a). DM has been described as the:

“unemotional, rational weighing up of readily available, easily understood evidence based information” (Noseworthy et al. 2013 p43).

This definition, however, suggests that DM occurs out of context and is objective. Hastie and Dawes (2010) included the notion of the decision-maker’s subjective evaluations of possible outcomes to their definition of DM. This elevates DM from a process of rational and scientific objectivity to one that incorporates subjectivity and holism, which may be more appropriate to midwifery DM. This is particularly pertinent considering that through legislation, professional regulations, policies, guidelines and research, midwifery practice has evolved and metamorphosed to incorporate the woman-centred philosophy of care that is the cornerstone of contemporary practice (DH 1993; Carolan and Hodnett 2007).

**DM theory**

Theories of DM have traditionally been divided into three categories (Thompson and Dowding 2002; Standing 2010). Normative theories focus on the statistical probabilities of outcomes and inform rational and systematic DM. Descriptive theories focus on how an individual makes a decision, describing how cues are interpreted in context, and are more concerned with the process. Prescriptive theories combine elements of normative and descriptive theories, focusing on normative theoretical underpinning and the needs of the decision-maker. Two overarching rival theories of DM have been described: analytic/rational which comprises both normative and prescriptive theories, and intuitive/experiential which encompasses descriptive theories (Standing 2008, 2010). While traditional DM tools may be neatly categorised, for example the hypothetico-deductive model of cue acquisition and hypothesis generation that sits within descriptive theories (Elstein et al. 1978; Thompson and Dowding 2002), there is a need to renegotiate the parameters of DM theory and utilise models that consider the complexity and uncertainty of midwifery practice (Raynor and Bluff 2005; Ménage 2016a).

**Cognitive Continuum**

One such model transcending theoretical boundaries is the cognitive continuum. Standing (2008; Figure 1) proposed a variation of Hamm’s cognitive continuum (1988; Figure 2), replacing the six modes of inquiry with nine modes of practice. The modes of practice, situated along a scale from intuition to analysis, are intended to be more comprehensive than the original six modes. A perceived merit is that the modes are not numbered and therefore no hierarchy is indicated (Standing 2008, 2010a). The modes are, however, organised in an ascending continuum, and thus there could be a perceived hierarchical difference between intuitive judgement at the bottom left and experimental research at the top right. Midwifery practice has witnessed a shift from research-based to evidence-based practice (Cluett 2005), with the latter acknowledging that evidence, or knowledge, comes from a variety of sources, therefore the distinction between ‘judgements’ and ‘research’ on the continuum is contentious. The terminology may convey a hierarchy between subjective or intuitive judgements and objective or analytical scientific research. Furthermore, Hamm’s continuum may have attributed negative associations to intuitive judgement, which is said to be employed in ‘ill-structed’ DM, compared to the potential positive connotations conveyed by ‘well-structured’ DM that utilises research (Standing 2008). In the nine modes of practice (Standing 2008), ‘well’ and ‘ill’ are replaced by ‘high’ and ‘low’, and it could be questioned whether this modification has eradicated value-laden language from the model.

Standing’s cognitive continuum (2008) was developed for use within nursing and its relevance to midwifery care should be questioned, particularly as patient and peer-aided judgement is only one mode of the continuum. ‘Face-to-face’ decisions with the patient are noted in less structured DM, yet decisions are classified as ‘faceless’ in highly structured DM. The presence of the patient within the model, and the practitioner as the decision-maker using the model suggests a power imbalance, and the relevance of this continuum to woman-centred midwifery DM is questionable. The pictorial linearity of the cognitive continuum may not consider the complexities in midwifery DM, for example the interactions between decision-makers or potential conflicts that may arise. The cognitive continuum may, however, aid DM in time-poor clinical situations, for example obstetric emergencies when fast DM and rapid response may be the priority.

**Midwifery-specific DM model**

Developing DM tools is an iterative process and Ménage’s midwifery-specific DM model (2016b; Figure 3) sought to build upon antecedent tools, and places the woman, midwife and members of the multidisciplinary team as sources of evidence, alongside research evidence. This echoes the notion of evidence-based, as opposed to research-based midwifery practice, which broadens the base of knowledge contributing to DM (Cluett 2005; Siddiqui 2005). While Ménage (2016a) noted that DM in midwifery is based on partnership with women, her model does not consider the relationships and interactions between the four sources of evidence*.* As such, this article presents the newly developed and tested novel midwifery-specific DM model, which incorporates many of the positive aspects of Ménage’s tool such as environmental factors, and clinical skills of the multidisciplinary team. The key difference is that the new model recognises the centrality of the decision-makers, and the relationship between these players. This model will be introduced in the second article of this series and has been used to consider a tripartite clinical decision whilst working as a third year STMW.

**Conclusion**

The theoretical boundaries of traditional DM theory and existing DM tools may not account for the complexity and uncertainty of DM in contemporary midwifery practice. DM has been elevated from a rational and objective scientific process to one that is more subjective and holistic, which may be more congruent with the woman-centred philosophy of care to which we aspire. As such, midwifery-specific DM models need to recognise that the evidence influencing DM in practice may come from a variety of sources, including research, the midwife and other HCPs and, most significantly, from the woman herself.

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**Decision-making in contemporary practice: developing a model that reflects the complex and multifaceted nature of woman-centred midwifery**

This is the second article in a two-part series exploring decision-making (DM) in contemporary midwifery practice. The first examined the applicability of traditional DM theory and models to woman-centred care, and concluded that DM tools used within midwifery practice need to appreciate the complexities of care and use evidence from research, midwives, HCPs, and the woman herself to inform DM. While Ménage’s midwifery-specific DM model (2016b; Figure 1) recognises that contemporary practice is evidence-based rather than research-based, the interactions between the sources of evidence were not considered.

As such, this second article seeks to develop a novel DM model (Figure 2) that highlights the centrality of the decision-makers themselves in the DM process, and delineate factors that might influence their DM. The novel model will be used in the context of a tripartite clinical decision (Text Box 1) that was encountered during the key author’s final year as a student midwife (STMW) at the University of Southampton. DM is introduced to students at the university as part of the third-year Autonomous Practice module, which incorporates the academic module of DM and the practice-based student case-loading experience and supports the transition from student to newly qualified midwife (Kitson-Reynolds, 2010).

**Shared DM**

While Ménage placed midwives and women as separate sources of evidence contributing to DM, the novel model considers decision-makers as a collective, which places the emphasis on shared DM. DM can be seen to have evolved from a paternalistic process whereby the woman consents to the HCP’s decision, to one of informed DM whereby the woman makes a choice based on the unbiased information provided by the HCP, and latterly to one of shared DM (Dodds 2000; Noseworthy et al. 2013). Shared DM is based upon an ethos of mutualism: each player is committed to discussion and negotiation, and shares information about the available options and potential outcomes, including possible benefits and harm (Coulter and Collins 2011; Noseworthy et al. 2013). The novel DM model is intended to embed shared DM within woman-centred midwifery care.

**Decision-Making: A broader perspective and ethical issues**

The decision-makers, situated at the centre of the novel model, are encapsulated by key concepts, philosophies and values of care that may influence DM. Unlike Ménage’s model (2016b), this tool explicitly incorporates the choices, alternatives, and possible outcomes of DM, which serves to emphasise the need to discuss all possible interventions and eventualities. Similarly, the model highlights the importance of reflective and reflexive practice, whereby HCPs challenge their own beliefs and behaviours, enhancing responsiveness simultaneously and/or subsequently to a situation (Dewey 1910; Muoni 2012; Oelofsen 2012; Bolton 2014; Nursing and Midwifery Council [NMC] 2015). The central concepts of this model are surrounded by macro factors, which include legal aspects, guidelines, local datasets, professional standards, and research. The comprehensive design of this model reflects the non-linearity and complexity of DM in midwifery, which could make it a useful tool for pre and post-qualification registrants. Its use may, however, be impractical in the time-poor situation of an obstetric emergency.

**Novice to expert continuum**

Evidence from each player in the tripartite decision – woman; student midwife; consultant obstetrician - was presented during the DM process, although conflicting values, needs, and understanding of the clinical situation were evident. Dreyfus and Dreyfus’ model of skill acquisition (1980) proposed that learners progress through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. It could be said that prior to the DM process, the obstetrician was an expert in the clinical situation and a novice in the woman’s opinions, beliefs and preferences, while the opposite was true of the woman. In applying the model of skill acquisition to nursing, Benner (1984) recognised that the expert practitioner also considers the individual’s response to their condition or illness. Similarly, this DM tool aims to highlight the woman’s expertise in the DM process, the significance of her individual needs and preferences, and the contribution that she makes to her own health and care, as is consistent with professional standards for midwifery practice (Leap 2009; NMC 2015).

The STMW, who was caring for the woman as part of her third-year caseload experience, was cognisant of being situated between novice and expert both in terms of knowledge of the clinical situation and of the woman’s opinions, beliefs and preferences. The STMW acknowledged her role as advocate for the woman, and the relationship established between the woman and STMW thanks to continuity of carer throughout the antenatal period meant she was well-positioned to do so. The woman-STMW partnership was based on trust, reciprocity and an open dialogue, and was thus a solid foundation for woman-centred midwifery care and shared DM (Edwards 2003; Hunter 2004). The importance of being ‘with woman’, and forging a balanced woman-midwife relationship is not a novel concept (Mander 2011), although the notion of expanding that partnership to include a member of the multidisciplinary team may be problematic, particularly within an obstetric setting in which midwives risk assimilating to the pervading ideology of the organisation (Hunter 2004). The proposed DM model incorporates members of the multidisciplinary team, and recognises the importance of a variety of sources of knowledge and evidence (Siddiqui 2005; Coulter and Collins 2011), and the STMW was conscious of fostering an environment in which the woman could assert her power and autonomy (Benner 1984; NMC 2015).

**Autonomy**

Biomedical ethics recognise the autonomy of the woman, which means respecting her right to make decisions that contravene guidelines, and to accept or decline care (Beauchamp and Childress 1994; Dimond 2013), although feminist critique has questioned whether women are able to exert autonomy in inherently patriarchal medical institutions (Dodds 2000). By using the novel DM model, power is relocated, yet practitioners may feel that power sharing threatens professional autonomy, notably if a woman’s choice questions the status quo (Thompson 2013). In the tripartite decision, the obstetrician’s advice was focused on fetal outcomes and risk, and did not initially contemplate the woman’s preferences, which could have been detrimental to the woman’s autonomy and choice (Symon 2006).

**Gains and losses**

Although it is assumed that individuals are risk averse, Hardman (2009) proposed that potential DM outcomes are evaluated in terms of gains and losses, and this decision-weighting considers the effect of decision-makers’ preferences, particularly when the probabilities of outcomes are uncertain (Hardman 2009). Thus, a potential objective gain of an intervention may have been considered a loss by the woman. The woman’s original preference for hypnobirthing at the freestanding midwifery-led unit had already been compromised and she saw the commencement of intravenous Syntocinon as further deviation from her ideal, a loss in her opinion. The woman’s fast-thinking system had been activated and her affect heurist, the mental shortcut that enabled fast, intuitive DM influenced by her immediate emotional response, meant she initially declined intravenous Syntocinon (Kahneman 2012). Having reviewed the woman’s birth plan extensively, the STMW was aware that the woman wanted to discuss interventions when clinically indicated and, as such, the STMW was aware of her responsibility to initiate a balanced tripartite conversation. This facilitated the woman with the opportunity to demonstrate her autonomy and expertise by presenting her evidence, and supported the STMW and obstetrician to do so too. Shared DM within an unoppressive relationship does not compromise autonomy, but rather enhances it, which is central to the novel DM model (Dodds 2000).

**Accountability**

By asserting autonomy in shared DM, each decision-maker is also accepting responsibility for the process and the decision made (Mander 2011), although it could be questioned whether the woman’s accountability would be equal to professional accountability in the event of an adverse outcome, particularly if documentation were inadequate. Accountability and patient-focused care are particularly pertinent following systematic failings in care uncovered in Mid Staffordshire and Morecombe Bay NHS Foundation Trusts, and the commitment to quality healthcare lies not only with individual midwives, but so too within NHS organisations themselves (Francis 2013; Kirkup 2015). Organisational commitment to quality improvement is a statutory duty of clinical governance through clinical effectiveness, risk management, and patient focus and public involvement (Marshall et al. 2014). As such, aspects of clinical governance are incorporated into the novel DM tool: documentation, evidence-based practice, and client involvement.

**Documentation**

In an increasingly litigious society, maternity care is progressively risk averse and may rely excessively on guidelines to reduce potential risk and increase safety, to the detriment of woman-centred care (Dowding 2002; Thompson 2002; Ménage 2016a). Shared DM requires each decision-maker to be autonomous and assume responsibility for their role in the DM process, and documentation is integral to DM (Coulter and Collins 2011; Clarke 2015; NMC 2015). Following the tripartite discussion and DM, contemporaneous documentation recorded the players involved in DM, information given, opinions of each player, decision made, and subsequent plan of care. The development and refinement of DM skills, which includes clear and accurate documentation that captures the quality of DM, contributes to the position of midwifery as an autonomous profession (Kitson-Reynolds and Rogers 2011). Evidence-based DM that is clearly documented justifies DM and subsequent care plan, and demonstrates each decision-maker’s accountability (Mok and Stevens 2005; Barber 2012). While documentation is a legal requirement, it also serves as a written narrative of the childbirth continuum and can be accessed by service users to facilitate postnatal debriefing. As such, documentation is not only a medicolegal record, but it is also fundamental to woman-centred care, and acts as a mechanism of safeguarding and quality control.

**Conclusion**

To conclude, the profession of midwifery has undergone an evolution that situates midwives as autonomous practitioners within a multidisciplinary team caring for women on the childbirth journey. As such, midwives take part in clinical decision-making that has seen a progression from paternalistic to shared DM, the latter of which is a pivotal element of woman-centred care. The novel DM model proposed is intended as a comprehensive tool to assist decision-makers on the novice to expert continuum in non-emergency scenarios, and aims to renegotiate the parameters of DM and resituate decision-makers at the centre of the DM process. The model accounts for the non-linear, multi-faceted, uncertain and complex nature of midwifery DM, and acknowledges that evidence and experience may be drawn from a variety of sources, including concepts, philosophies and values of care, and such macro factors as professional standards, and evidence from research. The incorporation of reflective and reflexive practice within the proposed model is intended to highlight the importance of systematically evaluating the process of DM subsequent to the event, which may improve future involvement in DM. Use of the model may be particularly pertinent within a multidisciplinary team or obstetric setting, where institutional norms and perceived hierarchies of knowledge may threaten a woman’s ability to assert her autonomy, particularly if her decision does not conform to ‘expert’ advice. The model also recognises the importance of documentation as a medicolegal record in shared DM to ensure that all decision-makers assume responsibility for their role in the process and decision made. Traditional DM models have failed to appreciate the nature of DM in a midwifery context, and the novel model moves beyond the rational and scientific objectivity of normative theories of DM to encompass subjective and holistic elements of DM.

**Implications for practice**

The lack of comprehensive midwifery-specific DM models may be detrimental to student midwives attempting to incorporate woman-centred DM into practice. The development of the proposed DM model could be further refined and introduced to student midwives as part of a cohort study, exploring its implementation and ease of use in clinical DM throughout the pre-registration and post-registration periods.

**A personal perspective**

As a third-year student midwife on the cusp of qualification, the autonomous practice module gave me the opportunity to link theory and practice in a very tangible way. Furthermore, exploring DM while simultaneously carrying a caseload served to emphasise my role in advocacy throughout the childbirth continuum, and gave me the underpinning knowledge and confidence to be a more effective advocate for women. As a newly-qualified midwife who has been practising for six months, revisiting this body of work has prompted me to reflect on my role in DM throughout this period. I have had to consider whether I gather evidence from all available sources, how I incorporate this evidence into shared DM, and how I advocate for women effectively when I am often the most junior member of the multidisciplinary team.

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**Text Box 1: the tripartite decision**

The woman (not named to retain confidentiality, as per the Nursing and Midwifery Council *Code* [2015]) and the student midwife met at the initial booking appointment at approximately eleven weeks’ gestation, and care was consistently provided by the student, and overseen by her community mentor, throughout the antenatal period. The woman was primigravid, low-risk pregnancy, planning on hypnobirthing at the freestanding midwifery-led unit.

The woman experienced pre-labour rupture of membranes (PROM) at term, and an induction of labour (IOL) was booked. When the woman and her partner presented at the obstetric unit, the forewaters were artificially ruptured and a cervical dilatation of one centimetre was recorded. Local Trust guidelines recommend that nulliparas should commence intravenous Syntocinon infusion immediately following amniotomy, although the woman requested time to allow uterine contractions to establish spontaneously. After two hours, IOL, PROM and risk of infection were discussed between the student midwife, the woman and her husband. Another hour later, during the doctors’ ward round, the student midwife presented the woman’s situation and background to the consultant obstetrician, and the woman’s wishes to avoid intravenous Syntocinon were discussed. The consultant entered the room, and IOL and PROM were discussed between the woman, student midwife and consultant obstetrician, and the tripartite decision was subsequently made to commence Syntocinon.

**Figure 3: midwifery-specific decision-making model**

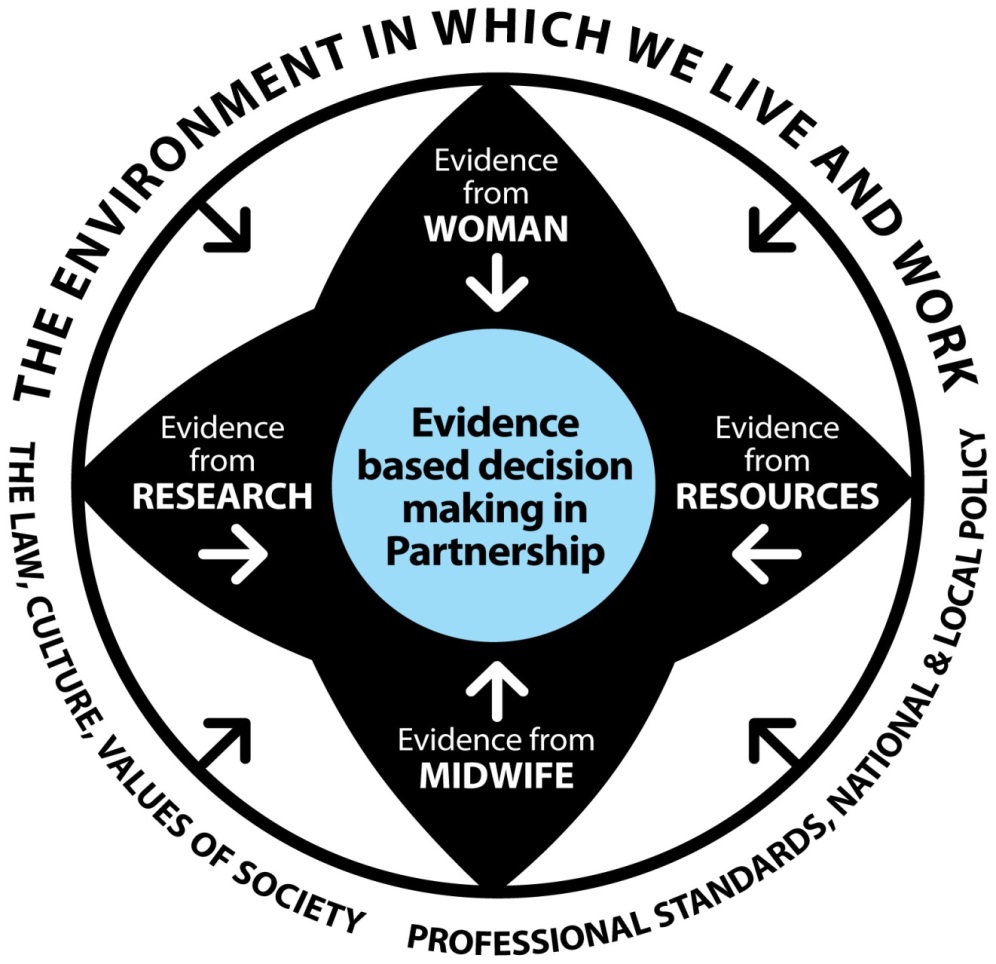


Figure 3: A new model for decision-making in midwifery (Ménage 2017 per comm)

**Figure 4: Novel midwifery-specific decision-making model**

Status of neonatal unit

Birth environment

Local guidelines

**Decision makers**

Skills of team

Politics & politics

Professional standards

Legal aspects

Time

National guidelines

Bed status of unit

Documentation

Care

Accountability

Communication

Consent

Shared DM

Justice

Mutualism

Intuition

Power

Security

Confidence

Expectations

Professionalism

Opinions

Responsibility

Nonmaleficence

Experience

Knowledge

Woman-centred

Empathy

Compassion

Advocacy

Emotions

Birth plan

Autonomy

Values

Preferences

Trust

Beneficence

Transparency

Risk factors

Social context & background

Local datasets

National statistics

Health & social needs

Culture

Family & support network

Staff and material resources

Quantitative research

Qualitative research

Relationships

Figure 2: Novel midwifery-specific decision-making model

**Key to Figure 4**

Decision-makers

Key concepts, philosophies and values of care

Choices, alternatives and possible outcomes

Macro factors

Reflective and reflexive practice