

Patient Engagement and Shared Decision Making in Maternity Care

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The 2001 Institute of Medicine report *Crossing the Quality Chasm* outlined six key aims for national health care quality improvement. One central aim was that care be patient-centered, meaning that the care provided to patients be “respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.”¹ With patient-centered treatment, the care-delivery system incorporates the decisions and preferences of patients into the clinical calculus. Despite the importance of patient preferences, several studies have shown that these often are not taken into account by physicians in medical decision making.²

The maternity care that many women in the United States receive is becoming increasingly procedure-intensive. For example, the cesarean delivery rate rose by 53% from 1996 to 2007.³ The interventionist nature of our obstetric culture can lead to overuse of procedures and interventions for which harms may outweigh benefit and underuse of beneficial practices such as waiting for spontaneous labor in healthy women before 41 weeks.⁴ In addition to these challenges, there is broad practice variation in cesarean delivery and assisted vaginal delivery rates across geographic areas, facilities, and health care providers.⁵ The

issue of overuse of tests and procedures is not unique to the field of obstetrics and gynecology. This year, nine U.S. specialty societies, including the American Academy of Family Physicians, the American College of Cardiology, the American College of Radiology, and the American College of Physicians developed lists of “Five Things Physicians and Patients Should Question,” recognizing the importance of patient and physician communication to improve care, with the goal of eliminating unnecessary tests and procedures.⁶

Despite the importance of involving women in decision making, multiple studies demonstrate that many women have inadequate knowledge to make informed choices about their pregnancies and maternity care. A 2009 study of 650 recently postpartum women revealed that 24% considered a fetus of 34–36 weeks of gestation to be full term, 50.8% believed full term was at 37–38 weeks, and only 25.2% considered 39–40 weeks full term.⁷ A national survey of postpartum women found that most new mothers thought it was necessary to know most or all complications of cesarean deliveries or inductions before making decisions about them, yet most were unable to answer basic questions on risks of both interventions correctly, whether or not they had undergone them.⁸ In the same study, more than half of survey respondents interested in vaginal birth after cesarean were denied the option owing to caregiver unwillingness or hospital refusal. Too often, women are not full partners with providers in decision making. Institutional and caregiver policies and practices can take precedence over patients’ informed choice, even when patient preference is supported by best available evidence.⁹

Patient education is a major focus of efforts to assist childbearing women and their families in making informed decisions about their care and navigating the complex health care system. Women receive information from a variety of sources, including physicians, but many receive their information from television and print media, and many cite mass media or “reality” TV programming as a source of

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information about childbirth.¹⁰ These often sensationalized programs can be lacking in accuracy and can foster misperceptions about what interventions are necessary to achieve healthy birth outcomes.¹¹

Several national organizations have taken leadership roles in balancing popular culture media with accurate and science-based pregnancy education. The March of Dimes for almost a decade has been running a large-scale patient and family education campaign around issues relating to prematurity prevention. Childbirth Connection, a national organization focusing on providing women and health professionals with evidence-based information on safe and effective maternity care, is now expanding its focus to promote maternity care shared decision making. The American College of Obstetricians and Gynecologists also makes significant contributions to patient education through widely distributed patient educational materials and recently has taken a leadership role in promoting shared decision making in its 2011 Committee Opinion titled "Effective Patient-Physician Communication," which states that patient engagement, satisfaction, and treatment adherence can be improved through shared decision making as well as risks reduced and outcomes improved.¹²

Shared decision making is a collaborative process between patients and their providers to make health care decisions together, taking into account the best available scientific evidence on possible benefits and harms of all treatment options, along with the patient's values and preferences. Strategies to implement shared decision making are receiving growing attention from health-policy makers as a way to integrate patient-centered concepts into health care. The Affordable Care Act authorized several key provisions related to shared decision making for patients. The Center for Medicare & Medicaid Innovation received funding to test innovative delivery models to improve the quality and costs of health care, including the shared decision-making model. States also are engaged in various activities to incorporate shared decision making into the health care system: Vermont and Washington have enacted shared decision-making legislation, and additional states are in the process of doing so, including Connecticut, Massachusetts, Minnesota, New Hampshire, Oklahoma, and Oregon.¹³ This growing health-policy focus is supported by policy research that indicates that shared decision making may reduce overuse of tests and procedures, thereby reducing costs.¹⁴ One cost analysis estimates that implementing shared decision making for 11 common procedures would save more than \$9 billion in health spending over 10 years.¹⁵

Given the dearth of information women have about their medical choices, more investment is needed in patient education and tools for shared decision making in clinical settings. A recent Cochrane review of shared decision-making tools demonstrates multiple benefits for patients, including more informed values-based choices, enhanced communication with providers, increased involvement of patients in medical decisions, improved knowledge and realistic perceptions of outcomes, reduced patient choice of elective surgery, and no apparent adverse effects on health outcomes or satisfaction.¹⁶ A systematic review of the evidence for shared decision making in maternity care showed promising results: improved knowledge, reduced decisional conflict and anxiety, increased perception of having made an informed choice, and improved patient satisfaction.¹⁷

To address current barriers to shared decision making and consumer choice, Childbirth Connection and the Informed Medical Decisions Foundation partnered to establish The First National Maternity Care Shared Decision Making Initiative. The partners are currently producing a suite of evidence-based, publicly available decision aids for a broad range of treatment options in maternity care. Tools being developed are web-based and interactive and will allow the woman to understand her condition and the context of her decision, explore her options in depth, clarify her preferences and values, and engage with her obstetric provider in decision making. Decision support tools and related content will be available on a multimedia web site, with the goal of integration with innovative technologies such as mobile applications and electronic and personal health records. The collaboration will also break new ground by producing and evaluating maternity decision support resources for women with low literacy and numeracy.¹⁸

The 2003 National Assessment of Health Literacy found that 60% of Medicaid beneficiaries had basic or below basic health literacy in comparison with 24% of those with employer-provided coverage.¹⁹ Women with low literacy skills are less likely to have a high school education compared with those with adequate literacy skills, be they women with low income or racial or ethnic minorities, and are at risk for poorer health outcomes.^{20,21} Literacy-appropriate decision aids have the potential to empower and engage those with low health literacy in a shared decision-making process. Physicians must be diligent in efforts to identify accurately patients with low literacy skills, and a few widely respected tools are available for this purpose, including the Rapid



Estimate of Adult Literacy in Medicine and the Test of Functional Literacy in Adults.^{22,23}

The decisions that childbearing women and their obstetric providers make have considerable implications for the health of women and newborns. However, implementing shared decision making in an office setting is not simple and requires enhanced engagement of patients in the care process. Obstetrician–gynecologists face tremendous demands on time during office practice, including clinical productivity and documentation requirements.²⁴ Although efforts to increase patient engagement increase demands on physician and staff time in the short term, in the long run shared decision making has the potential to increase efficiency through improved patient adherence and understanding of the care plan, leading to the need for fewer follow up calls and visits. This shared decision-making framework also has the potential to decrease litigation through improved patient satisfaction.²⁵ Suggestions for better integration of these concepts include payment models that allow for consideration of the time shared decision making takes and practice algorithms using e-mail or physician extenders or both, whether office staff or interactive web-based before and after appointments.²⁶ Initial results of shared decision making applied to maternity care are promising, and further research is needed to evaluate the use of decision aids in routine clinical practice.

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