ORIGINAL RESEARCH ARTICLE

Opinions and practices of midwives working in the delivery rooms on informed consent in vaginal deliveries

DOI: 10.29063/ajrh2023/v27i11.3

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Abstract

Obtaining informed consent from women for vaginal birth both safeguards their autonomy and establishes a legal foundation for midwives. This study aimed to determine the opinions and practices of midwives on obtaining valid informed consent for vaginal deliveries. This descriptive study was conducted between November 2021 and December 2022 in two different cities of Turkey, Bursa and Kocaeli. Data were analyzed with Chi-square test. In the study all midwives who had not received ethics training had a common perception that informed consent merely involved obtaining a signature and was a standard practice for vaginal birth (p=0.002). In the study, 92.9% of the midwives reported that they found it necessary to obtain informed consent in vaginal deliveries, 97.6% reported that they provided verbal information. However, information provided by midwives for valid informed consent was mostly not comprehensive (range 44.4%-80.2%). Most midwives (80.2%) focused on highlighting the benefits of vaginal birth for mothers, with comparatively less emphasis on communicating information regarding the potential risks and complications associated with vaginal birth for newborns. The high percentage of midwives who considered it necessary to obtain informed consent in vaginal deliveries in our study suggests that these midwives are well aware of the significance of informed consent. *(Afr J Reprod Health 2023; 27 [11]: 18-25).*

Keywords: Vaginal delivery, informed consent, midwife, women's rights

Résumé

L'obtention du consentement éclairé des femmes pour un accouchement vaginal garantit à la fois leur autonomie et leur établit une base juridique pour les sages-femmes. Cette étude visait à déterminer les opinions et les pratiques des sages-femmes concernant l'obtention d'un consentement éclairé valide pour les accouchements par voie vaginale. Cette étude descriptive a été menée entre novembre 2021 et décembre 2022 dans deux villes différentes de Turquie, Bursa et Kocaeli. Les données ont été analysées avec le test du Chi carré. Dans l'étude, toutes les sages-femmes qui n'avaient pas reçu de formation en éthique avaient la perception commune que le consentement éclairé impliquait simplement l'obtention d'une signature et constituait une pratique standard pour l'accouchement vaginal (p = 0,002). Dans l'étude, 92,9 % des sages-femmes ont déclaré qu'elles jugeaient nécessaire d'obtenir un consentement éclairé lors d'un accouchement vaginal, 97,6 % ont déclaré avoir fourni des informations verbales. Cependant, les informations fournies par les sages-femmes pour obtenir un consentement éclairé valide n'étaient pour la plupart pas complètes (plage de 44,4 % à 80,2 %). La plupart des sages-femmes (80,2 %) se sont attachées à souligner les avantages de l'accouchement vaginal pour les mères, en mettant comparativement moins l'accent sur la communication d'informations concernant les risques et les complications potentiels associés à l'accouchement vaginal pour les nouveau-nés. Le pourcentage élevé de sages-femmes qui ont jugé nécessaire d'obtenir un consentement éclairé lors d'un accouchement vaginal dans notre étude suggère que ces sages-femmes sont bien conscientes de l'importance du consentement éclairé. *(Afr J Reprod Health 2023; 27 [11]: 18-25).*

Mots-clés: Accouchement vaginal, consentement éclairé, sage-femme, droits des femmes

Introduction

Obtaining informed consent for vaginal deliveries allows women to protect their autonomy and to allow or reject certain interventions[1]. Informed consent has two compatent: information and consent. Written consent merely serves as evidence of consent: if the elements of voluntariness, appropriate information and capacity have not been satisfied, a signature on a form will not make the consent valid. For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention[2]. In Turkey, women have the right to receive adequate health care. One component of this health care is care during birth. It is important

that women are informed about a way of birth as well as interventions during labour. Their decisions should be respected so that their rights are not violated during birth-giving. The duty of informing and raising awareness women's about their rights during birth falls especially to midwives working in the delivery room[3]. In Turkey, midwives independently perform vaginal deliveries and carry significant responsibilities. Notably, the existing regulations do not provide a specific job description concerning midwives' responsibilities in obtaining informed consent for these procedures[4].

Although vaginal birth is a safe birth way, it can cause many complications. Perineal trauma, urinary incontinence, and anal sphincter injuries are potential complications of vaginal deliveries [5]. It is considered necessary to inform women about all these physical complications and to explain that there is an alternative such as a cesarean section. However, it has been demonstrated in a study conducted in Bangladesh has revealed that valid informed consent was rarely obtained from women who underwent vaginal deliveries, highlighting the need for improvement in this aspect of healthcare. Rarely, written consent (not informed consent) was obtained by mothers (3%). During immediate postpartum care, verbal consent was given in a range of 50% to 72% of cases for examinations[1]. In study conducted in England 26% of women stated that they were not always involved in the decisions taken about during delivery[6].

In a town in Ethiopia, it was strikingly revealed that the most frequently violated women's right during childbirth was the right to informed consent, with an alarming rate of 92.5%[7]. Informing and obtaining consent for virginal birth is a foundational principle of woman-centred care. It constitutes a fundamental right for women and is both a legal and moral obligation[8]. When informed consent is obtained for vaginal births, women who do not receive prenatal care have the opportunity to discuss a lot of information about birth, can make their own decisions, accept responsibility for their decisions, participate in the implementation of the care plan, and are protected from unethical and illegal practices[8]. Women have the autonomy to choices regarding the method of vaginal or cesarean childbirth[9].

Midwives should offer comprehensive information to women, empowering them to make informed decisions regarding vaginal delivery. Nevertheless, there is a scarcity of studies that investigate midwives' willingness to obtain informed consent in the context of vaginal deliveries and their perspectives on this crucial issue[10,11]. For this very reason, this study was undertaken to assess the viewpoints and practices of midwives operating in delivery rooms concerning the need for securing informed consent for vaginal births and the essential information that should be provided to expectant mothers.

Methods

Study design

To analyze data from a population at a specific time point and to identify relationships between variables, cross-sectional and descriptive-correlational study was conducted.

Place and time of the study

The study was condu
cted from November 2021 to December 2022 and involved midwives currently employed in the delivery rooms of public hospitals located in the provinces of Kocaeli and Bursa, Turkey.

Population and sample of the research

The study took place in two different Turkish provinces, Kocaeli and Bursa, which share similar fertility characteristics. The study was carried out in two training, research, and practice hospitals, along with six state hospitals in Kocaeli and Bursa. No specific sample selection was applied. The birth rates in Kocaeli and Bursa provinces fall within the range of approximately 10.1 to 15.0 per thousand, according to data from the Turkish Statistical Institute in 2021. These provinces also experience high rates of immigration. The inclusion criteria for this study were based on being actively employed in a delivery room. As the aim was to encompass all midwives working in delivery rooms, no specific sampling method was applied. Midwives who voluntarily participated in the study were informed of their right to withdraw from the study at any point. At the time of the study, a total of 160 midwives were actively working in the delivery rooms of public hospitals. The initial aim was to involve all midwives in the study. However, due to

various reasons such as some midwives being on leave during the study's duration and others not willing to participate, the study was ultimately concluded with the participation of 126 (75%)midwives.

Inclusion criteria for the study were as follows:

- Volunteering to participate in the study.
- Having at least one year of experience working as a midwife.
- Being currently employed in a delivery room.

Exclusion criteria were as follows:

- Being on annual leave.
- Being on sick leave.

Data collection forms

Questionnaire prepared by the researcher: an anonymous self-administered questionnaire in Turkish language was used. The first section included 8 questions that collected demographic information about the midwives, such as their age, number of children, education level, employing institution, length of employment, status of receiving ethics training, and their perception of their knowledge about informed consent. The second section consisted of 9 questions focused on gathering information about the perspectives and practices of midwives concerning informed consent. The following open-ended questions were posed: What recommendations can you provide for women to enhance their understanding of informed consent in the context of vaginal births? From your perspective, what are the key concerns that expectant mothers are most interested in learning about regarding vaginal birth? Furthermore, could you elaborate on the ethical challenges faced by midwives in this context?

Data collection

The study aimed to gather insights into the opinions and practices of midwives working in delivery rooms regarding informed consent in vaginal deliveries. The midwives who agreed to take part in the study were provided with the study forms and asked to complete them on the same day. In cases where midwives on duty were unavailable, the study forms were delivered to and collected a week later. The study form was delivered to the supervising midwives or unit managers and collected a week later.

Data analyses

The collected data was analyzed through IBM SPSS version 20.0 (IBM Corp. Released 2011. IBM SPSS Statistics for Windows, Version 20.0. Armonk, NY: IBM Corp.), for proper analysis the data was presented as absolute frequency (n) and relative frequency (%). The comparison involved evaluating the sociodemographic characteristics of the midwives, as well as their perspectives and practices concerning informed consent in vaginal deliveries, and the information they provided to expectant mothers. The data comparisons were performed using the Chi-squared test or Fisher’s exact test, as deemed suitable for the specific circumstances. Additionally, 95% confidence intervals (95% CI) were computed for the results.

Ethical approval

This study received approval from the Ethical Committee on April 15, 2021, with the approval number 2021/115. Midwives were explicitly informed that their participation in the study was entirely voluntary and that their confidentiality would be safeguarded. The study adhered to the Principles of the Declaration of Helsinki and obtained written consent from the participating midwives through the use of the 'Informed Voluntary Consent Form'.

Results

In our study 89.7% of the midwives reported that they received ethics training, 81.0% reported that their knowledge of informed consent was sufficient, and more than half of the midwives (62.7%) reported that they did not need training on informed consent. All of the midwives who stated that they did not receive ethics training think that informed consent is obtained only to perform the procedure ($p=0.002$). More than half of the midwives working in Kocaeli (63.3%) stated that midwives should provide verbal information in vaginal deliveries ($p=0.001$). More than half of the midwives (59.8%) who considered their knowledge of informed consent sufficient stated that the women understood the information they provided ($p=0.034$) (Table 1).

Table 1: Opinions and practices of midwives about informed consent

Characteristic	N (%), N=126	p-value
Should informed consent be obtained for vaginal deliveries?		
Yes	117 (92.9)	
No	9 (7.1)	
Why should informed consent be obtained from expectant mothers?*		
To protect healthcare professionals and patients	112 (88.9)	
To enable the patient to participate in information about himself/herself	83 (65.9)	
Because there is a procedure for the process to be carried out	78 (61.9)	0.002
Reasons for not obtaining informed consent in vaginal deliveries*		
They cannot understand what is being said because they are in pain.	44 (34.9)	
It is a natural process	25 (19.8)	
Information about risks may scare expectant mothers	11 (8.7)	
It does not legally protect midwives	2 (1.6)	
When should oral information be given? *		
Before delivery begins	117 (92.9)	
Between contractions during delivery	17 (13.5)	
During pregnancy	9 (7.1)	
Who should give verbal information about vaginal deliveries?		
Physician	52 (41.3)	
Midwife and physician	44 (34.9)	
Midwife	30 (23.8)	0.001
Do expectant mothers understand verbal information?		
Yes	69 (54.8)	0.034
No	57 (45.2)	
Do you think that expectant mothers are involved in their decisions about themselves?		
Yes	35 (27.8)	
No	91 (72.2)	

*Each participant gave two or more answers.

Table 2: Information given to expectant mothers during the informed consent process and issues that expectant mothers wonder

Characteristic	N (%)	P- value
On which subjects are expectant mothers mostly informed? *		
Benefits of vaginal delivery for expectant mothers	101 (80.2)	
Benefits of vaginal delivery for newborns	88 (69.8)	
That induction may be applied during vaginal delivery and its risks	85 (67.5)	
That episiotomy may be performed if necessary during vaginal delivery.	80 (63.5)	0.031
		0.014
Risks and complications of vaginal delivery for mothers	76 (60.3)	0.034
The average duration of a vaginal delivery	75 (59.5)	
Risks and complications of vaginal delivery for newborns	56 (44.4)	
The issues the expectant mothers wonder*		
When the delivery will take place and they will get rid of the pain	87 (69.0)	
Will an episiotomy be performed	27 (21.4)	
Health status of their babies	20 (15.9)	
Whether to apply induction	7 (5,6)	
May a relative or friend stay with her	4 (3.2)	
When and how to push	4 (3.2)	
Who will help her to give birth	3 (2.4)	
When will she be discharged	3 (2.4)	
When and how to breastfeed her baby	4 (3.2)	

*Each participant gave more than one answer

Table 3: Obstacles and recommendations of midwives in obtaining informed consent

Characteristic	N (%)
The issues about obtaining informed consent *	
Inability to speak the same language as the expectant mothers	91(72.2)
Inability to allocate time for informed consent due to hard work	75 (59.9)
Lack of information on informed consent	10 (7.9)
Recommendations on informed consent *	
The expectant mothers should be informed during pregnancy	39 (31.0)
It should be discussed at the pregnant school	13 (10.3)
Information should be given in a way they can understand	9 (7.1)
Consent forms should be read	7 (5.6)
Consent form should be given at the final control	7 (5.6)
Informed consent should be obtained by the physicians	7 (5.6)
It should be obtained before labour pains begin	5 (4.0)
Consent forms should be understandable	5 (4.0)
The number of employees should be sufficient	2 (1.6)
Experiencing ethical dilemmas while giving information to expectant mothers	
Yes	42 (33.3)
No	84 (66.7)
The ethical dilemmas experienced	
Should we talk about the risks of vaginal delivery?	7 (5.6)
Should the time of birth be told?	3 (2.4)
Should an episiotomy be performed?	3 (2.4)

*Each participant gave more than one answer

Midwives working in the delivery room mostly told the expectant mothers (80.2%) the benefits of vaginal delivery for the mother during the verbal information. The women who were hospitalized to give birth mostly asked the midwives (69.0%) when the birth would take place and the pain would end (Table 2).

More than half of the midwives (59.9%) who stated that they could not allocate time for informed consent were those who did not receive in-service ethics training (0.038%). The midwives recommended that women be informed during their pregnancy regarding informed consent (31.0%). It was observed that 33.3% of the midwives had ethical dilemmas while informing women, and they mostly (5.6%) had dilemmas about whether they should talk about the risks of vaginal delivery or not (Table 3).

Discussion

Midwives highly value informed consent because it empowers patients to make autonomous decisions and upholds their rights. In our study, midwives who had received ethics training and possessed knowledge about informed consent exhibited a more positive attitude and appreciation for the subject. Our study revealed that a significant majority of midwives (92.9%) recognized the importance of obtaining informed consent for vaginal deliveries (Table 1). Conversely, midwives without ethics training tended to view consent as a mere formality, limited to acquiring a signature (p=0.002). This may be because not receiving ethics training causes an obstacle to understanding the importance of informed consent. In Turkey, not all midwives receive ethics training of the same quality[12].

In our study, 97.6% of the participating midwives reported providing verbal information to patients. Contrarily, a study in Bangladesh demonstrated that only a consent form was signed during vaginal deliveries and postpartum care, with no accompanying verbal information[1]. Additionally, Öztürk *et al.*'s study found that 62.1% of healthcare professionals in the delivery room did not offer information to pregnant women[13]. While nearly all midwives in our study offered information, this disparity may be attributed to variations in socio-cultural contexts, women's decision-making rights, and limitations in other regions[1].

It is accepted that oral information and obtaining consent should always be done by the

healthcare professional who will perform the procedure[14]. In Turkey, midwives perform vaginal deliveries having the responsibility on their own. They only inform the attending physician when there are difficulties, problems at delivery. Remarkably, there is no specific job description in the regulations outlining the midwives' responsibility for securing informed consent[4]. In our study, midwives in Kocaeli province expressed a significantly higher preference (p=0.001) for midwives to deliver verbal information (Table 1). Conversely, the midwives in Bursa who participated in the study seemed to lean toward physicians providing verbal information regarding vaginal deliveries. This preference might be attributed to the fact that these midwives predominantly work in training and research hospitals, where women often face substantial risks during vaginal deliveries, either to themselves or their babies[15].

Expectant mothers can better comprehend information when it is conveyed to them effectively. When planning any procedure during delivery, it is crucial to provide explanations during the periods between contractions, as these intervals offer some relief from the pain - a noteworthy consideration [5]. In our study, midwives who believed they possessed sufficient knowledge regarding informed consent reported that women grasped the information provided (p=0.034) (Table 1). This result suggests that capable midwives place emphasis on obtaining valid informed consent and deliver information in a manner that expectant mothers can understand during the less painful interludes between contractions[8].

Informed consent allows women to decide on the vajinal birth of their own free will. To ensure valid informed consent, women should be thoroughly informed about the vajinal birth, including its benefits, alternatives, and associated risks 16. Additionally, the information provided must be understood**.** However, a study involving surgical patients revealed that not all elements of informed consent were adequately communicated, with the focus primarily on understanding the risks of the procedure[17]. In our study, midwives predominantly explained the benefits of vaginal delivery for both the mother and baby, as well as the potential risks and complications associated with vaginal delivery, including the possibility of episiotomy (Table 2). Notably, midwives with 1-10 years of experience and those with undergraduate or higher education provided more comprehensive information, possibly due to their better retention of knowledge acquired during formal education. Additionally, midwives with longer professional experience may have encountered emotional exhaustion and desensitization, which could explain their approach[15].

In our study, more than half of the midwives reported their inability to allocate time for obtaining informed consent (p=0.038). Notably, 54.7% of the midwives who expressed this constraint were those who had not received in-service ethics training. The absence of such training may have hindered these midwives from knowing how to handle situations that could potentially impede the acquisition of informed consent.

Moreover, a substantial percentage of midwives (72.2%) identified another challenge in obtaining informed consent - their inability to communicate in the same language as expectant mothers. This language barrier issue is not unique to our study; a study involving midwifery students in Turkey found that 89.8% of students encountered communication difficulties while providing care to refugee or asylum-seeker women[18]. Similarly, Kırca's research with nurses and midwives in obstetrics clinics highlighted the impact of language barriers on communication[19]. A study conducted in Malawi also revealed that the inability to converse in the same language hindered the acquisition of informed consent for caesarean sections[20]. These results may be attributed to the significant presence of immigrants in both our country and others. In our study, the inability of midwives to communicate effectively due to language differences raised concerns about potential violations of the woman's right to informed consent[21]. The language barrier creates a significant communication gap between women and midwives when it comes to allowing or refusing certain medical interventions. This gap not only hinders mothers from making informed decisions but can also contribute to instances of disrespect and abuse during childbirth[1].

Strengths and limitations

The strengths of this study are' including the evaluation of the perspectives and practices of

midwives in delivery rooms concerning informed consent, as well as the inclusion of midwives from two distinct cities. This study is expected to serve as a valuable foundation for shaping research questions in future studies related to informed consent in vaginal deliveries. It will offer insights into the areas that warrant closer examination in more comprehensive research endeavours. However, a key limitation of the study is the absence of in-depth interviews with the midwives.

Conclusion

Midwives who received ethics training and considered their knowledge sufficient had more information about informed consent and performed it. It may be useful to ensure that midwives, receive qualified ethics training to support women's autonomous decision-making, review the training content and presentation style, and distribute the midwives according to their workload.

Acknowledgment

We would like to thank all midwives for their participation in this study.

Authors' contributions

Conceptualization, methodology, data collection, writing original draft PS and NU data collection, and writing review and editing.

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