

Journal Pre-proofs

Full length article

Consent on the labour ward: a qualitative study of the views and experiences of healthcare professionals

Sophie Kennedy, Anne Lanceley, Melissa Whitten, Clodagh Kelly, Jacqueline Nicholls

PII: S0301-2115(21)00338-9
DOI: <https://doi.org/10.1016/j.ejogrb.2021.07.003>
Reference: EURO 12111

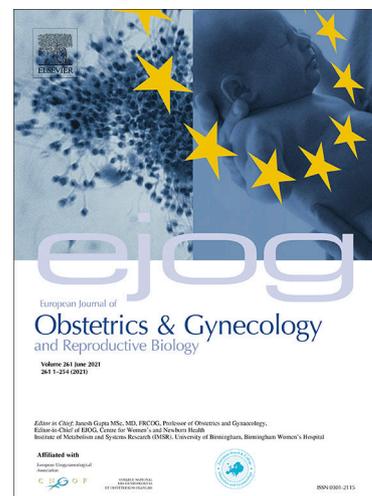
To appear in: *European Journal of Obstetrics & Gynecology and Reproductive Biology*

Received Date: 5 March 2021
Revised Date: 31 May 2021
Accepted Date: 2 July 2021

Please cite this article as: S. Kennedy, A. Lanceley, M. Whitten, C. Kelly, J. Nicholls, Consent on the labour ward: a qualitative study of the views and experiences of healthcare professionals, *European Journal of Obstetrics & Gynecology and Reproductive Biology* (2021), doi: <https://doi.org/10.1016/j.ejogrb.2021.07.003>

This is a PDF file of an article that has undergone enhancements after acceptance, such as the addition of a cover page and metadata, and formatting for readability, but it is not yet the definitive version of record. This version will undergo additional copyediting, typesetting and review before it is published in its final form, but we are providing this version to give early visibility of the article. Please note that, during the production process, errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

© 2021 Elsevier B.V. All rights reserved.



Title Page

Title:

**Consent on the labour ward: a qualitative study of the views and experiences of
healthcare professionals**

Authors:

Sophie Kennedy^{1*}, Anne Lanceley¹, Melissa Whitten^{1,2}, Clodagh Kelly¹, Jacqueline Nicholls¹

1. University College London Medical School, Institute for Women's Health, 74 Huntley Street, London, WC1E 6AU, UK.
2. UCLH, Division of Women's Health, 235 Euston Road, London, NW1 2BU, UK

*Corresponding author at: University College London Medical School, Institute for Women's Health, 74 Huntley Street, London, WC1E 6AU, UK. Email address: sophie.kennedy.17@ucl.ac.uk. Phone number: 07917755577

Author email addresses:

- Sophie Kennedy (sophie.kennedy.17@ucl.ac.uk)
- Anne Lanceley (a.lanceley@ucl.ac.uk)
- Melissa Whitten (melissawhitten@gmail.com)
- Clodagh Kelly (clodagh.kelly.17@ucl.ac.uk)
- Jacqueline Nicholls (j.nicholls@ucl.ac.uk)

Consent on the labour ward: a qualitative study of the views and experiences of healthcare professionals

Authors: Sophie Kennedy, Anne Lanceley, Melissa Whitten, Clodagh Kelly, Jacqueline Nicholls

Abstract

Objective:

Consent on the labour ward is a complex and controversial topic which is poorly understood. Consenting labouring women is recognised as challenging and problematic, and thus, it is uncertain that pregnant women experience true informed consent during labour. This project aims to explore healthcare professionals' views and experiences of consent practice on the labour ward.

Design:

Qualitative research performed in a tertiary hospital labour ward in Central London with 5,500 patients annually. Eleven obstetricians and seven midwives participated. In-depth one-on-one semi-structured interviews were conducted, and the data were analysed by thematic analysis.

Results:

Three themes were identified: 1) *The value of women's choice*: healthcare professionals framed consent as an agreement process rather than an exercise of choice. Implicit paternalism was evident with some healthcare professionals imposing their own recommendations upon patients. 2) *Communicating risk*: many participants viewed full risk communication, including extremely rare risk disclosure as their duty to ensure the validity of obstetric consent despite the risk of overwhelming women. 3) *Law and professional practice*: many healthcare professionals lacked knowledge of the implications to practice of current law.

Conclusion:

Healthcare professionals' experiences of consent on the labour ward reflect uncertainties and ambiguities in consent practice such that it sometimes falls short of legal and professional requirements. Difficulties in discussing risk with women in an appropriate way at an appropriate time threatens the lawfulness of consent. If consent is to remain as the legal standard of autonomy, we recommend the provision of specialist training to assist professionals in providing timely consultation dialogues which endorse women's right to choose.

Key words: Consent; Choice; Labour ward; Autonomy; Montgomery; Healthcare professionals' views.

1 INTRODUCTION

Informed consent has been in the spotlight in recent years following emerging legal developments. Good consent practice enacts patient autonomy in a manner reflective of professional and legal requirements and ensures that patients comprehend all the information necessary to make informed decisions regarding their care. How women perceive the consent process in labour can substantially affect their current and future childbirth experiences,¹ and properly informed consent is associated with improved patient outcomes and satisfaction.²

International case law is a testament to the global courts' increasing appreciation of patient autonomy over traditional paternalistic care. The Australian case of *Rogers v Whitaker* [1992]³ heralded the end of healthcare professional (HCP) -dominated care but in the UK, it was not until the 2015 case of *Montgomery v Lanarkshire Health Board*⁴ when the courts provided strong legal endorsement to the end of paternalistic decision-making. HCPs must now inform patients of the material risks of both recommended treatments and reasonable alternatives. The materiality test sets out that risks should be disclosed if a reasonable person in the patient's position would deem those risks noteworthy or where a particular patient would be likely to attach significance to them.⁴ Subsequent cases have attempted to clarify when this test should be applied⁵⁻⁹ yet opinions vary as to whether these cases have changed the practice of information provision in obstetric consent or merely provided legal clarification to existing professional guidance.¹⁰⁻¹⁴

This uncertainty is brought into sharp focus on the labour ward where the need for a change to an intended plan of action can emerge rapidly at a time when women may be anxious, exhausted and in pain.¹⁵ Undertaking dialogical consultations which truly support autonomous decision-making in these circumstances is potentially challenging to HCPs. Understanding their experiences of consent is a first step towards improving such consultations. The experiences of HCPs when consenting women on the labour ward

contributes to the literature by investigating the unique perceptions of obstetricians and midwives as they navigate the challenges of labour ward consent.

The objective of this study, believed to be the first of its kind, is to explore HCPs' experiences of consenting women on the labour ward, to investigate their views of communicating risk and their knowledge of current consent law and its influence on their practice.

2 METHODS

Qualitative methods are utilised to permit exploration of individuals' perceptions, motivations and ideologies.¹⁶ This qualitative study consisted of face-to-face interviews loosely based on a topic guide (Table 1) designed to facilitate in-depth discussions with a wide range of professionals.

2.1 RECRUITMENT

HCPs were recruited from the labour ward of a Central London hospital which provides care to 5,500 women annually. Eligible participants were midwives or obstetricians who consent women regularly on the labour ward. Recruitment was conducted using opportunistic and purposeful sampling to obtain maximum variation of HCPs.

Participants were provided with a study information document and the opportunity to ask questions.

2.2 DATA COLLECTION

Demographic details were collected. Audio-recorded semi-structured interviews were conducted with 18 HCPs after written consent was obtained. A topic guide formed the basis of the interviews (Table 1).

Table 1: Topic Interview guide

Section	Questions
Purpose of consent	What do you consider to be the main purpose of the consent process and how does it relate to your view of shared decision making? What do you think makes consent valid?
Approach to consenting	How do you approach consenting a patient during labour? (Prompts: What if the patient is in severe pain? What if you are unsure about their capacity?) How do you approach consent in an emergency? To your knowledge is consent always obtained on the labour ward?
Who is responsible for gaining consent	Does consent on the labour ward usually involve one or several members of the team? What preparations do you make to obtain consent? (Prompt: When do you start discussion about possible eventual procedures in women you see as high risk?) What do you think the patient's role is in the consent process on the labour ward?
Issues and information covered	What do you think are important things to address when consenting women on the labour ward? What factors influence the information you give to a patient during the consent process? (Prompt: What if a complication is rare but severe? Does a patient's level of anxiety influence what you discuss?) Do you discuss risk vs benefit? How?
Experiences of the consent process	Have you heard of the Montgomery case? What do you know about it? Has it influenced your practice? What difficulties, if any, have you experienced when seeking consent on the labour ward? Has anyone refused an intervention? (Prompts: how do you balance persuasion vs coercion? Do you proactively look for capacity issues in these women?) Have you come across women with capacity issues? How useful do you find the consent form? Are there any labour ward procedures that you think are consented particularly well/poorly for? Do you have any suggestions for how consent on the labour ward could be improved? (Prompt: is training sufficient? Is there more patient information that we could provide?)

2.3 DATA ANALYSIS

Interviews were transcribed verbatim and anonymised to protect the participants' identities. To ensure transcription accuracy, all transcripts were compared with the audio files for quality assurance before data analysis commenced. In the latter interviews data saturation was achieved, and this was confirmed by initial coding of the transcripts.

Transcripts were analysed utilising the qualitative Braun and Clarke six-phase method.¹⁷ This thematic analysis method involved the researcher rereading the transcripts multiple times and generating codes from the data set. These codes were then grouped into potential themes which were checked and refined until three main themes were established.

Transcripts were coded systematically by SK. To ensure coding consistency and accuracy, random transcripts were inspected for adequate coding by authors independent to the researcher (AL & JN). Any variance was discussed and resolved by comparing the variant codes and discussing which codes were most likely in the context of the interviews.

3 RESULTS

Eleven obstetricians and seven midwives participated. Interviews lasted 15-40 minutes.

Demographic data are in Table 2.

Table 2: Patient demographics

Participant	Doctor/ Midwife: position or grade	Years qualified as a doctor or midwife	Gender
1	SHO	8	Female
2	Specialty doctor	27	Male
3	ST6 Obstetrics and Gynaecology Registrar	8.5	Female
4	Specialty doctor	16	Female
5	SHO	3	Female
6	Specialty doctor	21	Male
7	ST2 Obstetrics and Gynaecology Registrar	6	Male
8	ST6 Obstetrics and Gynaecology Registrar	11	Female
9	Specialty doctor	11	Female
10	Consultant	20	Female
11	Consultant	32	Male
12	Band 7 midwife	11	Female
13	Band 7 midwife	8	Female
14	Band 6 midwife	8	Female
15	Band 7 midwife	27	Female
16	Band 6 midwife	15	Female
17	Band 6 midwife	2	Female
18	Band 5 midwife	0.5	Female

Quotations are marked with the letters HCP followed by numbers (1-18) to reflect the range of professionals' views. E.g. HCP1 for participant 1.

The interview data depict the complex interaction of law, professionalism, and personal views within obstetric consent practice. This was well represented by three themes.

3.1 THEME 1: THE VALUE OF WOMEN'S CHOICE

Participants were asked about their views regarding the main purpose of labour ward consent. Most HCPs believed that consent must be obtained before any interventions in care. Participants had two main ways of framing this: some obstetricians and midwives placed more importance upon patient compliance than informed decision making. These HCPs were more focused on obtaining a signed consent form than supporting women's choices.

"Sometimes there is no choice on what we are going to do, if section is needed you need to get consent for that"-HCP1

However, other participants viewed the labour ward consent process as an opportunity to maximise informed choice. This was further supported by three midwives referring to their patients as 'clientele'.

"I think it has been a big step forward that we recognise the right of the patient to be part of the management and treatment and decision-making process"-HCP2

“Its up to people now, to the clients to make their choice”-HCP12

Nonetheless, there was variation in how participants imposed their own recommendations on patient choice. Most midwives and half the obstetricians viewed themselves as fact providers and claimed to have no vested interest in persuading patients to agree to their recommendations.

“Our job is to offer things, and it’s entirely the woman’s autonomous decision to decide whether she wants it or not”-HCP11

However, some clinicians were more emotionally involved with their patients’ decisions and found the rejection of their recommendations *“challenging”* (HCP7) and *“really frustrating”* (HCP13). This was due to participants feeling culpable if women’s choices resulted in subsequent harm.

“They (pregnant women) want to take the decision, but they don’t want to take the responsibility... they are going to blame you” (HCP13).

A quarter of participants, mostly doctors, thought it was important to persuade patients to agree to their recommendations and viewed their duty to save the baby as a priority. This involved being *“more emotive”* (HCP10) and sending in other HCPs to *“sort of sway someone”* (HCP5). The prioritisation of fetal wellbeing over maternal autonomy is displayed in Table 3.

Table 3. Prioritising fetal wellbeing over maternal autonomy

“If I feel that it is a lifesaving procedure or something like that and they [the patient] are trying to avoid it, I have to push the patient. I mean it’s my duty to try and save the patient as well as the baby” -HCP9

“I know sometimes I don’t feel like they [the patient] completely have a choice because actually it’s a really difficult choice to make because if you stop a bit longer, you pose risk to the baby -HCP13

“I think from our point of view, we think, ‘Well it’s [instrumental delivery] not really anything that you should consent for,’ because we have to do it because we have to get this baby out” -HCP10

“If there is such an emergency that we need to act on, as HCPs we wouldn’t let you die, or your baby die if we know it’s not safe, even yes you said maybe no [even if you said no]” - HCP18

The concept of illusory choice was also evident, particularly when women refused recommended interventions. These scenarios consisted of providing time for patients to change their minds and having ‘discussions’ with women. The view that patients will eventually ‘agree’ was evident across multiple responses.

“They’ll end up saying yes but it takes a long discussion. They prolong the procedure in that sense”-HCP12

3.2 THEME 2: COMMUNICATING RISK

Many participants remarked that full risk disclosure on the labour ward including extremely rare risk communication was essential to allow patients to make an informed choice.

“I think when you are pregnant, you need to have as much information as you possibly can”-HCP15

However, some participants, mostly doctors, viewed this ‘full risk disclosure’ practice as wrong and expressed concern at overwhelming patients with information. These professionals were more likely to be selective in what they communicated to women and feared the psychological burden that may result from information overwhelm. (See Table 4)

Table 4: Scope of risk disclosure

<i>“Nowadays we are bombarding patients with a lot of complications and liability issues, and oh it’s too much. And they end up not liking this, not enjoying this and getting more anxious about the whole thing” -HCP2</i>
<i>“If I was the patient and I was given all those risks myself, I would feel overwhelmed by the length possibly of the consenting.” -HCP8</i>
<i>“Completely and utterly [worried about full risk disclosure], especially as a midwife because we can scare the women so much” -HCP14</i>

Nonetheless, for most HCPs incomplete risk disclosure was viewed negatively, and some commented on perceived time pressures leading to substandard risk disclosure.

However, other participants felt that convention of risk provision based on specific procedures was a stronger determinant of incomplete risk disclosure. Many obstetricians

and midwives felt that traditional practice played a powerful role in the risks they disclosed to women. This was especially evident around blood transfusions and episiotomies.

“People say, ‘Are you happy to have a blood transfusion?’ and they tick a box... I wouldn’t say people always go into the fine details of what can go wrong”-HCP5

“There tends to be an ‘I’m going to do a cut now’, because it’s standard protocol to do an episiotomy to prevent tearing and things like that. But that’s not consent, telling them you’re going to do something”-HCP17

3.3 THEME 3: LAW AND PROFESSIONAL PRACTICE

Awareness around current consent law and the *Montgomery case* was poor; three midwives and two obstetricians had no knowledge of the ruling. Two midwives recalled the case after a hint, and three obstetricians were aware that it was ‘something about informed consent.’ Only half of the obstetricians and a third of the midwives knew the details of the case.

“I know it was wrong, something in the process of the consent”-HCP9

Of those who felt their obstetric practice had changed post-*Montgomery*, many professionals had variable views on how their practice was influenced. Some obstetricians applied the case literally by modifying their practice in pregnant diabetic women.

“I think everybody is conscious that with any patients that are diabetic, we do talk about the risk of shoulder dystocia... I certainly talk about elective C-sections generally as options for birth with patients more”-HCP3

However, other HCPs took a more medicolegal approach by operating defensively. They believed that the potential legal consequences for inadequate obstetric risk disclosure required defensive practice in which all known risks must be disclosed to the patient.

“We need to tell the patient everything, every complication, whatever the smallest risks, because there is no excuse”-HCP6

Only two obstetricians identified the importance of tailoring information to the patient, with one participant viewing tailored risk disclosure as a professional responsibility, even if women do not verbalise their main concerns.

“Patients haven’t necessarily thought about or articulate with you at the time what they think...so I think, yes the onus is probably on us to ask them more about what they consider the most important thing”-HCP3

Of the participants who thought their labour ward consent practice remained unchanged, only one obstetrician felt it was because the new legal requirements were too challenging to implement into their personal practice.

“We can’t spread 100% and cover 100% [can’t tailor information to everyone] no matter how much we are trying”-HCP4

However, the remaining HCPs felt that their unchanged actions were due to their practice already aligning with the *Montgomery guidance*. Many commented on their quantity of information provision as the reason why they felt their labour ward consent practice was compliant.

“It [Montgomery] hasn’t changed the way I take consent from women because I always give all the information necessary.”-HCP15

For one obstetrician, the case was simply a legal endorsement of the current professional approach to informed consent.

“I think it [Montgomery case] just solidified good practice”-HCP7

4 DISCUSSION

Most HCPs regard patient choice as a key component to obstetric consent, yet this study revealed a mismatch between HCPs’ beliefs and actions. Implicit paternalism was evidenced, with many participants expecting compliance with their recommendations. Consent was thereby framed as an agreement process rather than a choice process, a finding consistent with previous studies.^{18,19} This is concerning as there is a thin line between legitimate persuasion and unacceptable coercion, and the lack of literature surrounding

women's refusals of obstetric interventions may infer that pregnant women do not feel that they can refuse professional recommendations.

Prioritising fetal health over maternal autonomy was also evident in this study with some HCPs feeling duty-bound to prioritise fetal wellbeing despite RCOG guidance advising to the contrary.²⁰ This "fetal-focused decision making" reinforces concerns about the genuineness of obstetric consent and reflects claims of paternalism in patient experience surveys.^{21,22} Moreover, many professionals expressed frustration towards patients who refused recommended procedures. HCPs are poor at disguising their emotions from patients,²³ and their communication may be perceived as non-verbal persuasion. This explicit and implicit persuasion creates an unsettling environment in which only women who are willing to 'fight' for their choices may engage in genuinely autonomous decision making.

Fear of litigation governed the amount of information some participants imparted to women. Many professionals practised full risk disclosure as they considered high quantities of information a vital ingredient of valid consent practice. This is concerning as previous obstetric consent work has shown that pregnant women feel overwhelmed with the quantity of information provided by HCPs.¹⁰ The *Montgomery ruling (para 90)*⁴ cautioned against overwhelming patients and our results reaffirm concerns about defensive practice in response to recent legal developments.²⁴

The *Montgomery case* is viewed as a landmark judgement in informed consent. Yet many obstetricians and midwives lacked knowledge about the case and there was considerable variation in professionals' views on the implications of *Montgomery* on obstetric consent practice; a variation reflected in the literature.¹⁰⁻¹³ This variation and the consistency of full risk communication revealed in this study demonstrates the confusion that HCPs feel regarding the implications of *Montgomery's* vague materiality test. Obstetricians and midwives need support to fully understand the new legal standards. The introduction of updated guidance was supported by many participants who requested official training

sessions around obstetric risk communication instead of the current 'learn on-the-job' approach.

There are unique challenges inherent in obstetric consent and risk communication. Recent legal developments have seen dramatic changes to what is considered acceptable consent practice and this study underlines a significant education deficit with regards to appropriate risk communication in line with the new legal standards. This deficit requires attention from practising obstetricians and midwives as well as HCPs in all specialties to improve the informed consent process and provide optimum care.

To our knowledge this is the first study to specifically focus on the views and experiences of healthcare professionals' consenting women in a labour ward setting. Our qualitative method of open-ended interview questions allowed for insightful exploration of professionals' perceptions of the obstetric consent process. Data were collected at a single site and different experiences may be revealed in other contexts. Whether the results are transferable and match the readers own clinical experiences remains to be seen though responses to this paper may strengthen such generalisability

This study builds on previous published literature^{10,25} and American birth experience surveys^{20,21} which have highlighted the inadequacies of consent practice in obstetric care from the patient's perspective, particularly the issue of expected compliance with professional recommendations. Healthcare professionals also have concerns about consent practices and more work is urgently needed to promote autonomy in labouring women.

5 CONCLUSION

Our findings demonstrate that labour ward consent in its current form does not meet legal or professional requirements. If consent is to remain as the legal standard of autonomy, our

study underlines the need for specialist training to inform HCPs of important legal changes so that they may practice in accordance with the law. We hope that this will reduce medico-legal fear and assist HCPs to provide tailored information to women instead of simply providing high quantities of information. This is crucial to promote women's autonomy in childbirth.

6 DISCLOSURE OF INTERESTS

None declared

7 CONTRIBUTION TO AUTHORSHIP

Anne Lanceley (AL), Jacqueline Nicholls (JN) and Sophie Kennedy (SK) designed the study. AL was the principal investigator and SK and JN determined the methodology. Melissa Whitten (MW) assisted with implementing the study and MW and SK recruited the participants. JN and AL conceived the interview guide and SK and Clodagh Kelly (CK) modified it to make it specific to a labour ward setting. SK organised and performed the interviews, performed the data analysis and wrote the paper. AL, JN and CK assisted with data analysis and AL, JN, MW and CK made significant contributions to writing and revising the paper.

8 DETAILS OF ETHICS APPROVAL

Ethical approval was obtained from the Health Research Authority (REC Reference: 17/YH/0212, IRAS Project ID: 226,310)

9 FUNDING

AL and JN are HEFCE funded. Project costs were met by UCL

10 ACKNOWLEDGEMENTS

The authors would like to thank the midwives and obstetricians that participated in this study for their invaluable opinions and honesty.

11 REFERENCES

1. Hayes-Klein H. Informed Consent in Childbirth: Making Rights into Reality [Internet] Birthrights; 2013 [accessed 15 July 2020]. Available from: <https://www.birthrights.org.uk/2013/07/10/informed-consent-in-childbirth-making-rights-into-reality/#:~:text=Informed%20Consent%20is%20the%20bridge,legal%20right%2C%20the%20constitutional%20right.>
2. Hallock J, Rios R, Handa V. Patient satisfaction and informed consent for surgery. *American Journal of Obstetrics and Gynecology*. 2017; 217(2): 181.e1-181.e7.
3. *Rogers v Whitaker* [1992] 67 ALJR (High Court of Australia)
4. *Montgomery v Lanarkshire Health Board* [2015] UKSC 11
5. *FM v Ipswich Hospital NHS Trust* [2015] EWHC 775 (QB)
6. *Webster v Burton Hospital NHS Trust* [2017] EWCA Civ 62
7. *Jones v Royal Devon and Exeter Foundation NHS Trust* [2015] 9 WLUK 420
8. *Spencer v Hillingdon Hospital NHS trust* [2015] EWHC 1058 (QB)
9. *Gallardo v Imperial College Healthcare NHS trust* [2017] EWHC 3147 (QB)
10. Nicholls J, David A, Iskaros J, Lanceley A. Consent in pregnancy: A qualitative study of the views and experiences of women and their healthcare professionals. *European Journal of Obstetrics & Gynecology and Reproductive Biology*. 2019; 238:132-137.

11. Bolton H. The Montgomery ruling extends patient autonomy. *BJOG: An International Journal of Obstetrics & Gynaecology*. 2015;122(9):1273-1273.
12. Chan S, Tulloch E, Cooper E, Smith A, Wojcik W, Norman J. Montgomery and informed consent: where are we now? *BMJ*. 2017; 357: j2224.
13. Farrell A, Brazier M. Not so new directions in the law of consent? Examining *Montgomery v Lanarkshire Health Board*. *Journal of Medical Ethics*. 2015; 42(2):85-88.
14. Decision making and consent [Internet]. *Gmc-uk.org*. 2020 [cited 3 January 2021]. Available from: <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent>
15. Smith M, Levy K, Yudin M. Informed Consent During Labour: Patient and Physician Perspectives. *Journal of Obstetrics and Gynaecology Canada*. 2018; 40(5):614-617.
16. Hesse-Biber S. Qualitative Approaches to Mixed Methods Practice. *Qualitative Inquiry*. 2010;16(6):455-468.
17. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006; 3(2):77-101.
18. Dignity in Childbirth: The Dignity Survey 2013: Women's and midwives' experiences of dignity in UK maternity care [Internet]. *Birthrights.org.uk*. 2013 [cited 15 July 2020]. Available from: <https://birthrights.org.uk/wp-content/uploads/2013/10/Birthrights-Dignity-Survey-1.pdf>

19. Dixon-Woods M, Williams S, Jackson C, Akkad A, Kenyon S, Habiba M. Why women consent to surgery, even when they don't want to: a qualitative study. *Clinical Ethics*. 2006;1(3):153-158.
20. Obtaining Valid Consent: Clinical Governance Advice No. 6 [Internet]. Rcof.org.uk. 2015 [cited 3 July 2020]. Available from: <https://www.rcog.org.uk/globalassets/documents/guidelines/clinical-governance-advice/cga6.pdf>
21. Declercq E, Sakala C, Corry M, Applebaum S, Herrlich A. Listening to Mothers III Pregnancy and Birth [Internet]. Nationalpartnership.org. 2013 [cited 5 July 2020]. Available from: <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/listening-to-mothers-iii-major-findings.pdf>
22. Declercq E, Sakala C, Corry M, Applebaum S. New Mothers Speak Out [Internet]. Nationalpartnership.org. 2008 [cited 5 July 2020]. Available from: <https://www.nationalpartnership.org/our-work/resources/health-care/maternity/listening-to-mothers-ii-new-mothers-speak-out-2008.pdf>
23. Vilela da Silva J. Physicians Experiencing Intense Emotions While Seeing Their Patients: What Happens? *The Permanente Journal*. 2016; 20(3):15-229.
24. Buttigieg G. Montgomery and its impact on current medical practice – good or bad? *Medico-Legal Journal*. 2019; 87(2):80-83.
25. Jou, J, Kozhimannil, K, Johnson, P and Sakala, C. Patient-Perceived Pressure from Clinicians for Labor Induction and Cesarean Delivery: A Population-Based Survey of U.S. Women. *Health Services Research*. 2015; 50(4): 961-981.