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Less or more? Maternal requests that go against medical advice

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ABSTRACT

Problem and background: This study explores the experiences of Dutch midwives and gynaecologists with pregnant women who request more, less or no care during pregnancy and/or childbirth.
Methods: All Dutch midwives and (trainee) gynaecologists were invited to fill out a questionnaire specifically designed for the purposes of this study. Holistic midwives were analysed separately from regular community midwives.
Findings: Most maternity care providers in the Netherlands receive requests for less care than recommended at least once a year. The most frequently maternal requests were declining testing for gestational diabetes (66.3%), opting for a home birth in case of a high risk pregnancy (65.3%), and declining foetal monitoring during labour (39.6%). Holistic midwives are more convinced of an increasing demand for less care than community midwives (73.1% vs. 35.2%, $p = <0.001$). More community midwives than hospital staff reported to have declined one or more request for less care than recommended (48.6% vs. 27.9%, $p = <0.001$). The majority of hospital staff also receive at least one request for an elective caesarean section every year.
Discussion and conclusion: Requests for more and less care than indicated during pregnancy and childbirth are equally prevalent in this study. However, a request for less care is more likely to be declined than a request for more care. Counselling women who disagree with their care provider demands time. In case of requests for less care, second best care should be considered.

Statement of significance

Problem

Some women request more or less care than recommended during pregnancy and childbirth.

What is already known

Why women decline recommended care or request an elective caesarean, and how maternity care providers feel about delivering more care than indicated.

What this paper adds

Requests for less care are equally common as for more care in the Netherlands. Requests for less care are more frequently rejected. Holistic midwives receive most of these requests and are most afraid of legal problems. Providing better care for these women requires a multidisciplinary approach.

Abbreviations: UC, Unassisted childbirth; CDMR, caesarean delivery at maternal request; OB/GYN, obstetrics and gynaecology; BMI, body mass index; PPH, post partum haemorrhage.

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1. Introduction

In recent years, there have been signs that an increasing number of Dutch pregnant women are choosing a level of maternity care based on their personal preferences rather than as prescribed by national guidelines and the advice of health professionals. This phenomenon is not unique to the Netherlands. A growing list of publications from different countries examines women's motivations for refusing recommended care during pregnancy and/or childbirth.[1–6] This research encompasses women with a high risk pregnancy who choose to give birth at home attended by a midwife, and women who choose to give birth unattended (unassisted childbirth/UC). Publications about the opposite, women requesting more care than indicated, also seem to be increasing, with a growing number of articles examining the phenomenon of caesarean delivery at maternal request (CDMR).[7,8] However, there is a paucity of data about the experiences of midwives and gynaecologists with women who decline recommended care during pregnancy and childbirth, with the exception of women declining an emergency caesarean section.[9–12]

In the past five years, declining recommended care has been a hotly debated subject in Dutch maternity care, inspiring many conferences, workshops and symposia, and even resulting in a new national guideline for maternity care providers on how to cope with these refusals.[13] Whether refusals are truly increasing or if this is merely the personal impression some providers have, based on certain reported cases and growing publicity, is thus far unknown.

The WONDER study (Why women want Other or No DElivery care) is a mixed methods study exploring the phenomenon of birth choices against medical advice in the Netherlands. The qualitative part consists of studies examining the motivations of women who elected to go against medical advice in their choice of place of birth and/or birth attendant,[6] and those of their partners and their caregivers. The WONDER study also contains a literature review on women's motivations[14] and a commentary on legal and ethical perspectives.[15] The quantitative part is the subject of this paper. This study explores the experiences of Dutch midwives and gynaecologists with pregnant women who request more, less or no care during pregnancy and/or childbirth. We analyzed whether maternity care providers perceived an increase in these requests, what type of requests they received during antenatal checks and if this differed between levels of care. We were also interested in why and how often requests were granted or declined, the willingness to refer to a colleague and the extra time spent on counselling the women concerned. Finally, we examined the differences in experience and attitude regarding this topic between community midwives and ("holistic") midwives who are willing to assist during a home birth in a high risk pregnancy.

2. Participants, ethics and methods

2.1. Questionnaire

An anonymous questionnaire specifically designed for the purposes of this study was made available online through Survey Monkey. The questionnaire contained 33 items: nine questions on demographic data and type of practice, fifteen on personal experience with requests for either more or less care than indicated. Nine statements with Likert scales reflecting the attitude of caregivers towards requests for less or more care were incorporated with the purpose to describe the results in a separate paper, because the extensiveness of these results would not justify discussion within the context of one article. The questionnaire remained online for approximately nine weeks in the autumn of 2015.

2.2. Setting and participants

An attempt was made to reach all registered, practicing obstetrician–gynaecologists and midwives in the Netherlands. To this end, an email with the request to participate was sent to all (trainee) members of the Dutch Society of Obstetrics and Gynaecology (NVOG), of which virtually every practicing gynaecologist and trainee in OB/GYN in the country is a member (N = 1408). After two weeks a reminder was sent through the same channels. Midwives were approached through the Royal Dutch Organization of Midwives (KNOV), who included the request to participate in the "call" section of their monthly newsletter. Not all practicing Dutch midwives are members of this organization (N = 2733, 2304 community midwives and 429 clinical midwives) and the "call" section of the newsletter is not very well read. Therefore, the request to participate and disseminate the link to the survey was also sent to all regional organized groups of midwives and to hospital-based midwives who are members of an NVOG working group for clinical midwifery. There is a small group of midwives active in the Netherlands who are willing to assist women with a high risk pregnancy during a home birth, who we qualified in this study as "holistic midwives". Their actual number is unknown, but self-reported to be in the range of 20–30, depending on which definition is used. For the purposes of this questionnaire, we asked community midwives who participated to label themselves as "midwife in regular practice" or "holistic midwife". These two groups will from here on be referred to as "community midwives" and "holistic midwives". Many holistic midwives are not part of any professional organization. Therefore the link to our survey was also posted on the closed facebook page of a group of holistic midwives (N = 23 at the time of the survey).

Holistic midwives in the Netherlands often work solo or in couples (case-load). In order to be able to provide one-on-one continuity of care, they usually only accept a handful of clients per month. Most of them started out in group practices, but found themselves at odds with their colleagues when they discovered they wanted to comply with women who declined certain protocollized care (less care).

Since the aim of the study was to gain insight in practitioners' experiences and opinions, the following participants were excluded from analysis due to insufficient (recent) clinical experience: newly qualified doctors without a training post, trainee midwives, and retirees or those no longer working in patient care.

Ethical approval was deemed not necessary by the ethics committee of the X University of X (autumn of 2015).

2.3. Sample size

The sample size was calculated using the following formulas:

Sample Size = (Distribution of 50%)/((Margin of Error 5%/Confidence Level 95%) Squared)

Finite population correction:

True Sample = (Sample Size × Population)/(Sample Size + Population − 1)

For a representative sample we needed responses from 329 community midwives and 330 hospital staff (clinical midwives and (trainee) gynaecologists).

2.4. Analysis

Data were analyzed in SPSS version 22 (IBM Corporation Inc., Armonk, NY, USA) and free text fields were recoded into existing

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categories or made into new ones. Responses were compared according to level of care; community midwives versus hospital staff (trainee gynaecologists, gynaecologists and clinical midwives). A separate analysis was performed to determine any differences between community midwives and holistic midwives, since it was expected that holistic midwives would have different opinions and different (more) experience relative to the subject in question, due to their role as "last resort" for women with requests for less care.

Chi-square tests were used to analyze categorical variables, and ordinal variables were analyzed using Mann–Whitney U tests. A p-value of <0.05 was considered significant.

Results are divided into three sections. Responses in "Less care than indicated" and "More care than indicated" were compared between hospital staff and community midwives. A third section is devoted to differences between community midwives and holistic midwives.

3. Results

Of 1066 questionnaires, 134 were excluded due to incomplete data, four responses were from recently graduated doctors without an OB/GYN training post and 28 responses from retirees or those who were no longer working in patient care. This left 900 questionnaires, for a total response rate of 21.7%, assuming all (trainee) gynaecologists and all practicing midwives with a KNOV membership were reached. When divided by level of care the response was 455 (19.7%) for community midwives, and 445 (24.2%) for hospital staff (gynaecologists, trainees and clinical midwives). Seventeen responses contained only demographic data and were excluded from further analysis. This left 883 questionnaires for final analysis (Fig. 1). We needed 329 completed questionnaires from community midwives and 330 from hospital staff. Therefore, the response can be considered as representative for the groups being studied.

Table 1 shows the characteristics of the participants. Eighty-eight percent of participants were female, with 40% of participants between 30 and 40 years old and 18% over the age of 50. More than half of the participants had 10 or more years of work experience.

3.1. Less care than indicated

The first part of the questionnaire addressed the participants' personal experience with pregnant women requesting less care than indicated during pregnancy and birth.

A minority of both midwives and gynaecologists experienced an increase in women with high risk pregnancies wanting a home birth over the last five years. Community midwives were less convinced this phenomenon had increased over the last five years than hospital staff (35.2% vs. 45.7%, $p = <0.001$). Of the community midwives, 88.9% had received a request for less care in the year before the survey, versus 83.5% of hospital staff ($p = 0.03$). There was no difference between caregivers with more than 10 years or less than or equal to 10 years of experience in maternity care.

The most frequently mentioned maternal requests were declining testing for gestational diabetes (66.3%), opting for a home birth in case of a high risk pregnancy (65.3%), and declining foetal monitoring (both continuous and intermittent) during labour (39.6%). Hospital staff reported significantly more declining foetal monitoring, assisted vaginal birth (ventouse or forceps) and caesarean section, and community midwives reported significantly more requests for home birth in high risk pregnancies, declining diabetes testing, and women planning UC (Table 2). However, only a small minority of participants in both levels of care reported to

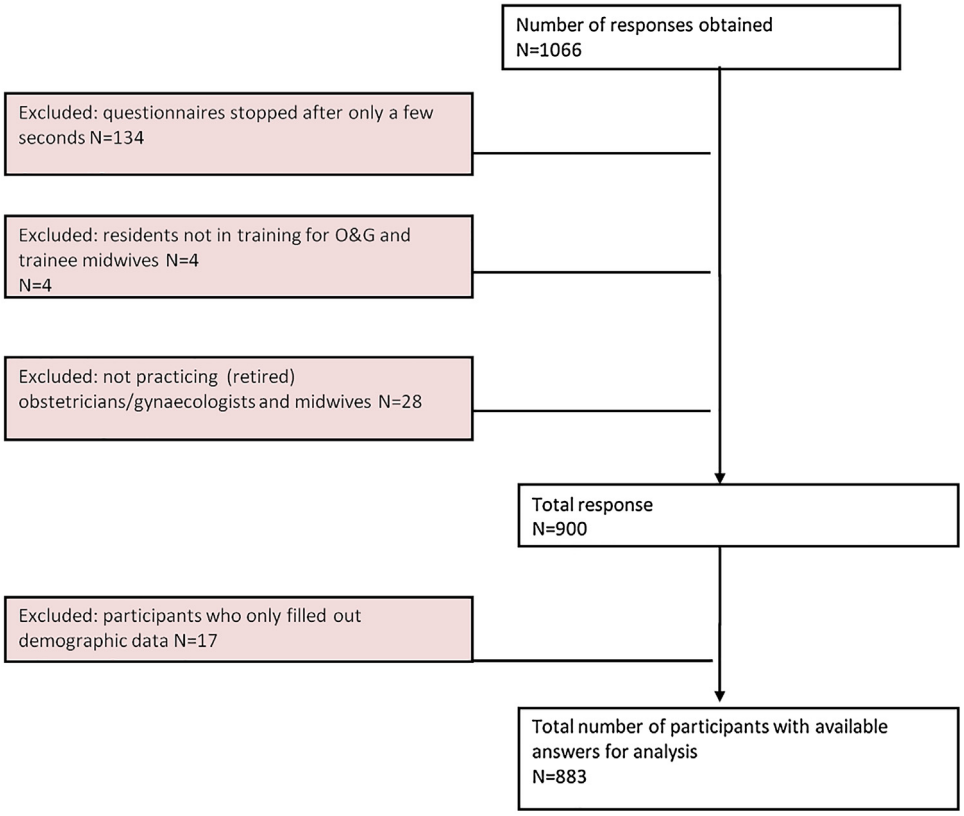

Fig. 1. Responses and exclusions.

Table 1
Characteristics of participants (N = 900).

Characteristics	Participants N = (%)
Gender	
- Male	108 (12.0)
- Female	792 (88.0)
Age (years)	
- <30	174 (19.3)
- 31–40	357 (39.7)
- 41–50	204 (22.7)
- 51–60	129 (14.3)
- >60	36 (4.0)
Profession	
- Primary care midwife	455 (50.6)
• Community midwife	429 (47.9)
• Holistic midwife	26 (2.7)
- Hospital based midwife (secondary care)	113 (12.6)
- Gynaecologist	239 (26.6)
- Trainee gynaecologist	93 (10.3)
Work experience (years)	
- 1–2	61 (6.9)
- 3–5	135 (15.0)
- 6–10	215 (23.9)
- 10–20	274 (30.4)
- >20	199 (22.1)
- Missing	16 (1.8)

Table 2
Nature of requests for less care according to participants.

Request[a]	Community midwives N (%)	Hospital staff N (%)	p-Value
Wanting home birth in high risk pregnancy	293 (72.5)	215 (57.3)	<0.001*
Declining diabetes testing	310 (77.1)	199 (54.2)	<0.001*
Declining foetal monitoring	112 (28.6)	189 (51.2)	<0.001*
Declining assisted vaginal delivery	86 (21.9)	176 (48.0)	<0.001*
Wanting unassisted childbirth	71 (18.1)	43 (11.8)	0.03
Declining indicated caesarean section	42 (10.8)	96 (26.5)	<0.001*

* Significant difference.
[a] Rare refusals (mentioned less than five times in the free text fields) were labour augmentation, pelvic exams, active management of the third stage, manual placental removal, routine lab testing, routine ultrasounds, doptone during antenatal check-ups, number of routine antenatal check-ups, biometric ultrasound for suspicion of IUGR or macrosomia, indicated antibiotic prophylaxis, episiotomy, vitamin K, PKU testing for the neonate and precautionary iv access during labour.

have received any of the requests mentioned above more than twice in the previous year, with the exception of declining diabetes testing, which was quite prevalent.

The most frequently given medical reasons for recommending hospital birth in women requesting home birth against medical advice concerned a high body mass index (BMI) (41.8%), post term pregnancy (36.7%) and a previous caesarean section (32.9%). Hospital staff significantly more often received requests for home birth from women with a previous caesarean section and women who had a breech position or a twin pregnancy, whereas community midwives were significantly more often confronted with requests for home birth in case of a high BMI (Table 3). Very few participants encountered more than five of any of these requests in that year, and no participants had received more than five requests for a home breech- or twin birth in the previous year.

Significantly more community midwives than hospital staff reported having declined one or more request for less care than recommended: 48.6% vs. 27.9% (p = <0.001). On average between both hospital staff and community midwives, 39.6% declined at least one request for less care. Most frequently indicated reasons for declining by both levels of care were "want to have intervention possibilities if necessary" and "don't want to be (morally) responsible for a bad outcome". Other reasons were "harmful for interdisciplinary cooperation", "not feeling competent", "fear for legal repercussions" and "fear of reputation damage". There was a significant difference regarding fear for legal repercussions between community midwives and hospital staff (30.3% vs. 9.5%, $p < 0.001$).

In cases where requests for less care are not honoured by the caregiver, referral to a colleague is possible. Significantly more community midwives than hospital staff have availed themselves of this option at least once (48.0% vs. 23.1%, p = <0.001). When seriously concerned for the health of the unborn child, some participants reported a pregnant woman to child protective services—which has no legal justification in Dutch law-, although incidences of this were low and not significantly different between community midwives and hospital staff (1.8% vs. 2.5%, p = 0.52).

A third (36.2%) of the participants, community midwives as well as hospital staff, reported that consultations with women requesting less care than indicated took up on average 15–30 min extra time. Another third (33.9%) spent more than 30 min of extra time discussing such a request, and for five percent it took even more than 60 min extra.

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Table 3
Requests for home delivery according to the indication for secondary care.

Indication[a,b]	A: community midwives N (%)	B: hospital staff N (%)	C: holistic midwives[c] N (%)	p-Value (between A and B)	p-Value (between A and C)
BMI >40	198 (48.4)	123 (34.1)	13 (61.9)	<0.001*	0.34
Post term pregnancy	157 (38.5)	123 (34.4)	18 (85.8)	0.49	<0.001*
Previous caesarean section	111 (27.2)	124 (38.8)	16 (76.2)	<0.001*	<0.001*
Ruptured membranes >24 h	118 (29.1)	85 (23.7)	13 (61.9)	0.18	<0.001*
Previous PPH >21	77 (19.1)	71 (19.7)	8 (38.1)	0.98	0.02*
Hypertensive disorders	48 (11.9)	61 (17.0)	11 (52.4)	0.13	0.11
Preterm delivery	49 (12.3)	35 (9.8)	11 (52.4)	0.28	<0.001*
Breech birth	8 (2.0)	34 (9.5)	9 (39.1)	<0.001*	<0.001*
Diabetes requiring insulin	11 (2.8)	15 (4.2)	3 (N/A)	0.52	N/A
Twin birth	5 (1.2)	18 (5.0)	2 (N/A)	<0.001*	N/A
Declined requests for home delivery in case of at least one of the above indications	201 (48.6)	105 (27.9)	16 (66.7)	<0.001*	0.08
Been called for help with an UC	39 (9.6)	26 (6.2)	6 (28.6)	0.07	0.01*

* Significant difference.
[a] Rare indications (mentioned less than five times in the free text fields) were IUGR, Jehovah's Witness, positive culture for GBS.
[b] Twin birth and diabetes requiring insulin were too rare in the group of holistic midwives to calculate.
[c] Midwives who classified themselves as working in a holistic setting.

A small and comparable minority of both community midwives and hospital staff indicated having performed pregnancy checks on women who planned a UC in the previous year (12.7% vs. 9.7%, p = 0.17). Among community midwives, 9.6% reported that they had been called to assist during or after a planned UC at least once, vs. 6.2% of hospital staff who had received UC women in their clinic (p = 0.07). Reported reasons for being consulted were "complications during birth" (46.8%), "postpartum check requested" (29.0%) and "woman changed her mind" (24.2%).

3.2. More care than indicated

The second part of the questionnaire involved CDMR. One or more requests for CDMR in the previous year were reported by 88.1% of hospital staff and 79.7% of community midwives (p < 0.001). Of hospital staff, 75.6% indicated that such requests have increased in the past five years, and 71.7% of those who received one or more requests for CDMR honoured at least one, with 28.3% refusing all such requests.

Almost half (44.8%) of participants reported that consultations with women requesting a CDMR took up 15–30 min extra time, a quarter (26.8%) needed more than 30 min extra, and 2.4% took more than 60 min of extra time.

Most important reasons (more options possible) for CDMR according to both community midwives and hospital staff were "Fear of vaginal birth" (93.8% vs. 96.2%), "Fear of pain" (68.4% vs. 68.0%), "Autonomy" (41.1% vs. 49.3%), "Concern for foetal health"(33.8% vs. 47.2%), "Fear of pelvic floor damage" (31.8% vs. 29.7%) and "Practical reasons" (24.0% vs. 26.8%). The options "Autonomy" and "Concern for foetal health" were filled out more frequently by hospital staff (p = 0.01 and p = <0.001).

3.3. Holistic midwives

Twenty-six midwives classified themselves as "holistic". According to several of them, this comprised the majority of those who were active in this setting in the Netherlands at the time of the survey. Seventy-two percent of holistic midwives reported that they regularly provide care outside guidelines/protocols on maternal request, which means they regularly attend home births in high risk pregnancies. The other 28% do so more rarely. Holistic midwives received more requests for home birth in high risk pregnancies than community midwives for all indications, the most prevalent of which were post term pregnancy (85.8% vs. 38.5%, p = <0.001), previous caesarean section (76.2% vs. 27.2%, p = <0.001) and prolonged (>24 h) ruptured membranes (61.9% vs. 29.1%, p = <0.001) (Table 4).

Holistic midwives have had more clients who planned a UC than community midwives (38.1% vs. 12.7%, p = <0.001), and they were also more often called on to assist during a planned UC (28.6% vs. 9.6%, p = 0.01).

Holistic midwives were much more concerned for legal repercussions than community midwives after delivering care outside guidelines or protocol (44.4% vs. 8.5%, p = <0.001). However, only seven of them (27%) reported that concern for legal repercussions has prompted them at least once to decline the requested care. More holistic midwives than community midwives have declined a request for less care than indicated at least once

Table 4
Rate of midwives receiving requests for home birth according to indication for secondary care.

Indication[a]	Holistic midwives[b] (%)	Community midwives (%)	p-Value
Post term pregnancy	85.8	38.5	<0.001*
Previous caesarean section	76.2	27.2	<0.001*
BMI >40	61.9	48.5	0.34
Prolonged (>24 h) ruptured membranes	61.9	29.1	<0.001*
Preterm delivery	52.4	12.3	<0.001*
Hypertensive disorders	52.4	23.8	0.11
Breech birth	39.1	2.0	<0.001*
Previous post partum hemorrhage >21	38.1	19.1	0.02*

* Significant difference.
[a] Twin birth and diabetes requiring insulin were too rare to calculate.
[b] Midwives who classified themselves as working in a holistic setting.

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(66.7% vs. 48.6%, p = 0.08), although this is a non significant difference, most likely due to small numbers. They are also more convinced of an increasing demand for such care than community midwives (73.1% vs. 35.2%, p = <0.001).

Compared to community midwives, holistic midwives spend more extra time on counselling women who request less care than recommended: a third spend more than an hour longer compared to 6.6% of the community midwives.

4. Discussion

It is not very well known how often maternity care providers actually encounter a pregnant woman who declines a recommended procedure or place of birth, and how they manage this situation. In this nationwide survey, we found that more than 80% of caregivers received at least one request for less care than advised in the preceding year. Furthermore, almost 90% of gynaecologists had encountered a request for CDMR in the preceding year. Finally, almost 75% of holistic midwives regularly work outside protocols.

In interpreting these data, it is important to realise that the societal position of medical professionals has changed. Unlike in previous times, shared decision making and informed consent should by now have become the norm, as recommended in all recent professional guidelines. This should certainly apply in maternity care, where pregnant women have become critical health care consumers, who no longer automatically accept the advice of their caregiver. Instead, they are less accepting of a "one size fits all" approach and more inclined to decide for themselves which (level of) care they desire.[16,17]

With the requirement of informed consent comes the option of informed refusal. In certain fields of medicine, there is ample experience with patients who decline treatment for themselves, for instance in oncology.[18] This is usually accepted by medical professionals in accordance with the ethical principle of autonomy. However, when pregnant women decline the recommended policy, midwives and gynaecologists often feel that optimal care is declined for the child, and this can cause conflict between the pregnant woman and her care provider.[15] This situation is often referred to as maternal–foetal conflict[19] and has, in several other countries, notably the United States, led to care providers resorting to a court-ordered caesarean section.[20,21] The justification given in those circumstances for not honouring a pregnant woman's informed refusal of a recommended intervention or place of birth is a danger to the health of the child in utero, since caregivers believe that the woman's refusal of the proposed intervention poses an acute danger to her child. In such instances, care providers are convinced that honouring the woman's refusal will or may very likely lead to damage to or death of the child. In these situations, care providers place a higher value on the ethical principle of beneficence (to the child) than autonomy (of the mother).

In the Netherlands, there are no legal grounds for overriding a competent adult's refusal, hence there have been no court-ordered caesareans here to date. In Dutch law, a child does not legally exist before it has been born, and therefore has no enforceable rights before birth. However, it does have a moral right to have its wellbeing protected, which becomes stronger with increasing gestational age. Dutch jurisprudence has always let maternal autonomy and her right to bodily integrity prevail over the child's right to protection of its wellbeing. The high value attached to maternal autonomy in Dutch society could also form part of the explanation for the increase in acceptance of CDMR (autonomy) over not doing unnecessary harm to the woman's body (non-malificence).

To date, no studies have been done linking a previous traumatic experience in childbirth to either declining care or a CDMR in the next pregnancy. However, a recent qualitative study by this same group as part of the X study interviewed 28 women who chose to have a home birth in a high risk pregnancy or a UC.[6] Most of them mentioned a traumatic experience during a previous birth as contributing to their decision to accept less care than recommended. Traumatic childbirth experiences unfortunately are quite common, and insight into their causes could aid professionals in their attempts to provide conditions for better birth experiences.[22] It would therefore seem to be a worthwhile approach for caregivers to explore the reasons behind a woman's request for less care, in addition to trying to prevent the initial trauma during the first birth.

4.1. Less care

The perception of many regular maternity care providers in the Netherlands that there is a trend toward an increase of maternal requests for less care could not be confirmed in this study. However, most participants had personal experience with women who declined (part of) the indicated and offered care. Community midwives were less often convinced that refusals were increasing than hospital staff. This could be explained by the fact that most interventions take place in a hospital setting, where there is simply more to decline. In cases of declining hospital birth for a high risk pregnancy, the more serious indications (previous caesarean section, breech and twin pregnancies) were more often encountered in a hospital setting than in the practice of a community midwife, whereas midwives encountered more requests for home births from women with a BMI over 40. Interestingly, significantly more community midwives reported declining a request for less care than hospital staff. This could be explained by the fact that community midwives can refer both to the hospital and to a holistic colleague, whereas hospital staff may believe they are the last avenue of recourse and are not accustomed to refer women to community or holistic midwives in case they are unable to reach an agreement. If hospital staff decline a request for less care, they may believe most if not all women will go along with the proposed standard treatment regimen, although some women will in actuality feel that the only option left to them is to turn to UC, or to a holistic midwife[6]. However, community midwives did not give any different reasons for declining requests than hospital staff did, with the noticeable exception of fear of legal repercussions, which is well known to be a factor in the increase of defensive medicine.[23] Finally, a minority of participants had come into contact with the phenomenon of UC. In the absence of any official records, the best guess of the incidence of UC in the Netherlands is around 200 cases per year.[24] The most common reason for the participants to be consulted was the occurrence of unexpected complications. Since there is no registration, it is impossible to say if UC is increasing, or even how long it has been around. However, there are indications that knowledge of the existence of UC as a birth option has increased through the availability of the internet (for instance unassistedchildbirth.com/birthwithoutfearblog.com/trustbreathebirth.com.au). UC could be considered as a counter movement of women who reject institutionalized maternity care and the biomedical model.[2,4]

4.2. More care

There is a variety of requests for more care than indicated, such as elective induction of labour, prenatal care and birth in secondary care without an indication, non medically indicated ultrasound scans and CDMR.[25] Many of these requests have become so common that they are not even registered as being against guidelines. For the purposes of this study we focused on CDMR, since most providers still consider an operation without indication on a healthy woman as an increased risk option which should not

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be honoured without (a certain measure of) discussion and counselling.[7] Other requests for more (elective) care are even more prevalent than CDMR and will meet with less opposition from providers.[25]

Approximately the same percentage of hospital staff that reported a request for less care (83.5%), received one or more requests for CDMR (88.1%). Hospital staff was also more convinced of an increase in CDMR (75.6%) than of an increase in declining recommended care (45.7%). This is in line with current trends in the Netherlands, where an increasing number of women are opting for elective obstetrical care such as use of an epidural or birth in secondary care without medical reason.[26]

Almost seventy-two percent of hospital-based participants who received one or more requests for CDMR honoured at least one. It appears that getting a non medically indicated caesarean section has become easier for women in the Netherlands in the past decade. In a nationwide survey by Kwee et al.[7] in 2004, two entirely elective fictitious cases were proposed to the participants. Only between 19 and 24% of obstetricians were willing to comply with a CDMR in that year, which fits with the increasing trend of medicalisation of childbirth in recent decades.[27]

When pregnant women decline certain interventions, an often heard complaint involves the burden of extra time it takes to counsel them. This study shows, however, that providers need approximately an equal amount of extra time counselling women who decline recommended care, as they need to counsel women who request a CDMR.

4.3. Holistic midwives

Women have found their way to holistic midwives, as demonstrated by the fact that 72% of holistic midwives reported receiving these refusals regularly, and strengthened by the fact that more holistic midwives (73.1%) than community midwives (35.2%) are convinced requests for less care are increasing. Even though most do not advertise the way they work, holistic midwives can be easily found by women through social media and client platforms, when a woman's request for less care has been declined by her provider.[6] The previously mentioned professional guideline on dealing with requests for less care[13] counsels providers to refer a pregnant woman to a colleague if they are unable to reach an agreement regarding the requested care. Holistic midwives are often the only providers willing to take these women on, thereby helping obstetricians and community midwives to fulfil their obligation to find another carer.

Because most of them work on a case-load basis, accepting only a few clients per month, holistic midwives have (or take) much more time to counsel women who request a home birth in a high risk pregnancy than community midwives, with 75% taking at least 30 min of extra time, and the other 25% taking over an hour more. Understandably, all requests for home birth in a high risk pregnancy as well as UC were more prevalent among holistic midwives, and they were also more often consulted during an ongoing UC. It also stands to reason that many of the clients who were declined and referred by their community midwife for requesting less care than recommended were referred to a holistic midwife, since that request was more likely to be honoured there.

The holistic midwives in this survey reported being more afraid of the legal repercussions of assisting in a high risk home birth or UC than community midwives. However, only a minority has declined a request for less care because of this fear.

Holistic midwives' fear for legal repercussions could be caused by a highly publicized court trial in 2013, where three midwives were disciplined for assisting in several high risk home births.[28] One of these involved a breech birth, and two were twin births. Ultimately, one midwife lost her license, but the verdict was later overturned by a higher court, citing women's right to choose their own place of giving birth, and acknowledging the fact that any support (of a maternity care provider) in those situations is better than none (UC). Nonetheless, this may have caused a certain measure of caution in holistic Dutch midwives, although the majority has not changed her practice.

4.4. Strengths and limitations

There are some limitations to the study. First, the total response rate was 21.7%, which appears rather low. However, more responses were collected than were needed according to the sample size calculation. In addition, there is the likelihood that, despite best efforts, not all members of the target population were reached, since the call section of the newsletter from the organization of midwives is not very well read, which is a known problem. Therefore it could well be that the percentage of community midwives who both read and replied to our invitation is actually significantly higher than 19.7%, thereby increasing the total response rate. Finally, medical professionals receive a large number of questionnaires on a monthly basis. It is therefore to be expected that response rates are not high due to "survey fatigue".

A second limitation could be the possibility of recall bias. Some questions in the survey specifically enquired into contacts with pregnant women during the year prior to filling out the questionnaire. Faulty recall could have led to both under- and overestimation. However, for most caregivers it concerned special cases which tend to leave a lasting impression.[29]

The main strength of this study is the fact that it is the first to report how often medical professionals in the Netherlands, a country known for its physiological approach to childbirth, receive requests for more or less maternity care, and how they deal with such requests. It is also the first time there is a record of how often maternity care providers are confronted with women who desire a home birth in case of a high risk pregnancy, and which high risk situations these are.

Another strength of this study is that it reports on the practice and experiences of holistic midwives working in a country were the maternity care system accepts home birth for low risk women as a regular option and where low risk women can choose to deliver at home, in a birth centre or in a hospital.

4.5. Implications for practice

Most maternity care providers will encounter pregnant women who request care that goes against medical advice. In those situations, as in others, shared decision making should be the norm. Counselling women who disagree with their care provider demands time, interest and conversational skills. It also requires a joint effort between primary and secondary care providers. A designated multi-disciplinary clinic, where community midwives and hospital staff together see women who have requests that go against recommendations, is worth considering. In case of persistent requests for less care, second best care (in the opinion of the providers) should be considered. Second best care in this context could for instance be a hospital birth after a previous caesarean section but without (or with limited) foetal monitoring, or a home birth after 42 completed weeks of pregnancy. Allowing this as second best care could prevent women from choosing a solution that poses even more risk to them and their baby, like electing to attempt a UC.

5. Conclusion

The vast majority of maternity care providers in the Netherlands are, at least once a year, confronted with requests

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for less care than recommended according to guidelines and protocols. This ranges from declining glucose tolerance testing to home birth in a high risk pregnancy or even unassisted childbirth. A comparable percentage of hospital staff receive at least one request for a non-medically indicated caesarean section every year. Refusing requests for less care is common, especially by community midwives, who in that case often refer to either the hospital, or to a colleague who is prepared to provide care outside the guidelines, as is recommended in the recently developed multidisciplinary Dutch national guideline "Maternity care outside guidelines".[13]

Although 40% of maternity care providers in the Netherlands (with the exception of holistic midwives) experienced an increase in requests for home births in high risk pregnancies, a majority saw no increase in these requests. However, they indicated getting more requests for non-medically indicated caesarean sections now than ten years ago.

The majority of Dutch maternity care providers spend at least 15–30 min more time on counselling women who decline the recommended policy, and an equal amount of extra time on women who desire a caesarean section without a medical reason.

In conclusion, considering the physiological approach to childbirth that the Netherlands is known for, requests for both more and less care than indicated during pregnancy and childbirth are about equally prevalent. In this study, 39.6% of hospital and community maternity carers (with the exception of holistic midwives) declined at least one request for less care, while only 28.3% of hospital staff declined all CDMR. Therefore, a request for less care is more likely to be declined than a request for more care.

Ethical statement

The authors state that: ethical approval was requested from and waived by the ethical committee of the Radboud University Medical Centre, Nijmegen, the Netherlands.

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