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ORIGINAL ARTICLE

BIRTH ISSUES IN PERINATAL CARE WILEY

Informed consent in episiotomy: Co-analysis with midwives and distillation of best practice

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Abstract

Background: Performing an episiotomy where clinically indicated is a key intervention in the Obstetric Anal Sphincter Injury Care Bundle (OASI-CB) implemented across England and Wales to reduce the risk and increase the detection of severe perineal trauma after birth. Standards of consent provided to people in maternity care generally and for episiotomy specifically have been reported as suboptimal. Compromising birthing people's personal autonomy or sense of control has been linked to a dissatisfying birth experience, negative psychological sequelae, and litigation.

Methods: This study explored experienced midwives' practice of informed consent for episiotomy during a midwife-led birth. We sampled 43 midwives across eight NHS Trusts in England and Wales using online focus groups and telephone interviews about their experience of consent in episiotomy. Using qualitative content analysis and art-based co-analysis methods with eight midwives from across the research sites, we co-analyzed and co-constructed three themes and four practice recommendations from the data.

Results: Three themes were constructed from the data: Assent rather than consent, Change in culture to support best practice, and Standardized information. These themes informed the shaping of four recommendations for best practice in episiotomy informed consent.

Conclusion: This study has shown how variations in midwifery practice and culture may impact birthing people's experience of informed consent in episiotomy. Midwives may not have the knowledge or skills to conduct a detailed consent conversation, leading to variation in practice and messages for birthing people. The use of antenatal discussion aids can offer women the opportunity to become informed and fully participate in the decision-making process.

KEYWORDS
informed consent, midwifery, qualitative research

1 | BACKGROUND

An episiotomy is a cut made through the vaginal wall and perineum to make more space for the baby to be born during the second stage of labor.[1] Episiotomy rates in the UK vary with an average rate of 15.5% across all births (including assisted births), and 8.7% in spontaneous onset of labor with a vertex presentation.[2] The international literature has firmly established the merit of moving practice from routine episiotomy during birth to selective use of the procedure where clinically indicated.[3] Performing an episiotomy where clinically indicated is a key intervention in the Obstetric Anal Sphincter Injury Care Bundle (OASI-CB) implemented across the UK to reduce the risk and increase the detection of severe perineal trauma after birth.[4] The care bundle engages pregnant people antenatally to raise awareness of the potential risks of OASI during birth and the care interventions recommended to mitigate these risks. Implementation of the OASI-CB is described as underpinned by good communication and informed consent of the birthing person to apply the OASI-CB to their birth.[4]

For consent to be informed, the person must be given full information about the treatment or intervention, including the risks, benefits, alternatives, and what would happen if the treatment did not go ahead.[5] The law says pregnant people are entitled to make autonomous decisions in the same way as any other person. Even if health care professionals disagree with their decisions, they must respect them[6] (Section 2.5); thus, if a person's consent is not obtained, the medical treatment will be illegal.[7] Standards of consent in maternity care have been reported as suboptimal.[8,9,10,11] A recent study of maternity care practitioners in The Netherlands reported the involvement of pregnant people in the decision for episiotomy to be minimal, with real informed consent not taking place antenatally or during labor.[12] Compromising personal autonomy or sense of control in birthing people has been linked to a dissatisfying birth experience, negative psychological sequelae, and litigation.[13,14] This study explores (i) what informed consent for episiotomy looks like in UK NHS midwifery practice and (ii) how can it be improved.

2 | METHOD

This study was part of a larger qualitative study exploring decision-making for and practice of episiotomy in midwife-led births. Between July and December 2021, we sampled midwives across eight NHS Trusts in England and Wales who self-identified as confident in the practice of episiotomy. Midwives were sent a study information sheet and consent form by the perineal specialist midwife of their NHS Trust and were invited to contacted the study team to arrange participation. Following discussion of the information sheet and receipt of verbal consent, data were collected by JM and JG through 10 single episode online focus group discussions and 12 one-to-one interviews. Interviews were conducted when participants had been unable to attend the scheduled focus group because of work commitments. Recruitment was challenging because of COVID-19 absences in practice and general NHS workload pressures; however, we recruited until data saturation was reached.

The topic guide was developed by (JM, SSW, JG), piloted with two midwives and refined. (SSW and JG) are clinical academic midwives with different views on the place of episiotomy in the midwifery tool kit. (JM) is a qualitative health services researcher who added a systems perspective to the team. (JG) facilitated the focus groups, (JM) took field notes. Both (JM and JG) conducted interviews, discussed findings and field notes after each interview/focus group. Audio recordings were transcribed verbatim, checked by an independent researcher against the original recording and loaded into NVIVO 10, the data analysis software. Transcripts were not returned to participants for checking.

Data were analyzed using qualitative content analysis.[15] (JM and JG) independently coded the transcripts, and discussed the coding frame and results in regular analysis meetings with (SSW). The emerging categories were used to structure a co-analysis workshop with eight senior midwives from the participating Trusts who had not participated in the study.[15] They were coached in qualitative content analysis by (JM). They looked at word frequency counts in the de-identified transcripts, to reveal the content of participants' consent conversations, alongside the linguistic environment of these words of interest to expose the surrounding context.[16] The co-analysis midwives worked creatively in three groups to code the transcripts, and record their findings visually with the help of a narrative artist facilitator (CB).

The use of visual methods, primarily collaging, supported the analysis process as the team worked with concepts and phrasing that may not reflect best practice in consent. This allowed them to detach from judging individual practice and focus on the data. Each group presented their findings via collage boards to the whole workshop group, (JM and JG) presented the preliminary academic analysis. In a whole group discussion the themes were co-constructed through linking, explaining, exploring and prioritizing (supplementary file S1).[16] This process expanded the preliminary academic analysis to describe the current practice of consent for episiotomy (Objective i). It highlighted components of best practice embedded within the data, and the group discussed how

they could be implemented across NHS maternity services in practice recommendations (objective ii).

3 | RESULTS

We interviewed 43 midwives with an average of 15 years of clinical experience (2–38 years) (Table 1). Their roles ranged from community and birth center, to labor ward and rotational (6 months in each clinical area). Interviews/focus groups averaged 39 minutes (13–69 minutes). The co-analysis constructed three themes from the data: Assent rather than consent, Change in culture to support best practice, and Standardized information, and generated four recommendations to implement best practice.

4 | ASSENT RATHER THAN CONSENT

Most of the participants first mentioned episiotomy during labor when the clinical decision to proceed had already been made. There was an assumption among participants that birthing people had made a preinformed decision about whether to accept an episiotomy or not. Thus, participants presented their rationale for offering episiotomy and sought assent rather than initiating a full consent discussion. Participants focused on the benefit of episiotomy to relieve the immediate risk of a potentially serious tear or consequences of a sustained low fetal heart rate. Where permission was given but the quality of informed consent was questioned, midwives described feeling dissatisfied.

> "It was the fact that I had to almost, bribe is not the right word but I had to say to her, your baby is not well if you don't have this done... It's not threatening but I've got to get my point across as quick as possible... I found it quite stressful."
>
> EP08 (Birth center midwife).

If the birthing person had limited proficiency in English, supporting them in labor was described by participants as challenging and stressful if their partner could not be relied on to interpret. Despite NHS Trust provision of interpreter support, some participants did not feel this was an option.

> "For me it would be impossible to use language line [telephone interpreting service] in that situation, it's just not happening, you don't have the time"
>
> EP11 (Labor ward midwife).

In contrast, one participant working with a very diverse population did feel supported to uphold the rights of the birthing person and access professional interpreter support for informed consent.

> "We can take verbal consent usually for episiotomy and we explain to our clients, if they won't give consent we cannot physically do it... if they can't speak the language we can bring in DORA [Tablet device on wheels for audio/video interpretation], and contact an interpreter to go through, to get consent if we need to but that all takes time and if it's a dire emergency, you still have to hang fire because we need the consent to be able to do it."
>
> EP16 (Labor ward midwife).

If participants felt unable to explore the refusal and the fetus was showing signs of distress, management of the birth would be handed to the medical team for instrumental birth support. This would inevitably involve an episiotomy, as expected by birthing people from their antenatal preparation.

It was acknowledged among participants that it was better to discuss the potential need for an episiotomy during a midwife-led birth in the antenatal period, rather than during labor when the risk situation could overwhelm the conversation. However, participants admitted that they themselves never talked about episiotomy antenatally outside the context of instrumental birth.

> "I think every woman should be aware of in case it does happen but I feel like are probably not discussed as in depth as they could be at 36 weeks"
>
> EP09 (Labor ward midwife).

Opening the subject antenatally was described as allowing time for a holistic discussion about perineal health. It

TABLE 1 Participant characteristics.

Area of practice				Years of experience		
Rotational	**Community**	**Birth Center**	**Labor Ward**	**Less than 5**	**5–10 y**	**More than 10**
7	13	9	14	3	15	25

put the procedure in context, allowed time for the birthing person to ask questions and be fully informed to make their decision about whether or in what circumstances to accept an episiotomy.

5 | CHANGE IN CULTURE TO SUPPORT BEST PRACTICE

Episiotomy was framed by the most of the participants as an intervention that precedes an instrumental assisted birth rather than a skill in the tool box of the midwife to potentially prevent the need for an assisted birth.

> "I don't remember it actually being taught, or even seeing it as a student. It was very much a theoretical thing for me...You know that belonged to obstetricians"
>
> EP26 (Labor ward midwife).

Some participants even focused on episiotomy as a challenge to their midwifery practice.

> "why would I cut the muscle I am trying to protect"
>
> EP02 (Community midwife).

This prompted discussion in the co-analysis group of "scissor shaming" as colleagues judged each other's practice negatively.

> "I think working on the birth centre there is definitely a reluctance to do an epis because it's a birth centre where it should be natural... but there is that mind set 'oh it's a bit of an intervention'... sometimes its maybe frowned upon."
>
> EP17 (Birth center midwife).

This could explain the frequent reports of interview participants requesting confirmation of decision-making from a colleague to support their offer of an episiotomy.

> "you want someone else to think that she needs one too. Because otherwise, if you come out and somebody says 'Why did you do that?" you can both be like "Well because this was happening and that was happening"
>
> EP12 (Labor ward midwife).

The variation in midwifery training and practice was a strong theme within the data. Participants described how integrating episiotomy into student and qualified midwives mandatory update training would support competence in consent for and practice of the procedure by midwives.

> "I think perhaps it needs to be 'decriminalised' for students, because ... you can't guarantee who they're gonna be mentored by [...] it needs to be part and parcel of midwifery training because episiotomies are part and parcel of midwifery care."
>
> EP26 (Labor ward midwife).

If confident, fully consented episiotomy behavior was modeled, colleagues viewed the intervention more positively, as supporting physiological birth while keeping it safe.

> "I do think there is an indication for doing them ...I think sometimes it would stop the lady from having an instrumental delivery if the midwife had just done the episiotomy."
>
> EP16 (Labor ward midwife).

> "I prefer midwives to do an episiotomy than call the doctors in, if they can, 'cause it means that there's not more people that they don't recognise in the room-the oxytocin levels aren't gonna go, you're gonna have a nicer experience,"
>
> EP27 (Rotational midwife).

This acceptance of episiotomy in the midwife's repertoire was informed by a clear ability of participants to read warning signs of when it may be indicated. This allowed early opening of a conversation with the birthing person about the management of their labor, giving time for confirmation of consent alongside a controlled, stepped intervention. The birth setting remains calm, and the birthing person is informed and supported to feel in control of their labor.

> "So in that situation what I've done is talk to the mum and infiltrate the perineum with local anaesthetic and then done it like a step. Got consent, explained, do the anaesthetic and then I'm gonna wait for that to take effect and sometimes even that helps them to relax and push the baby out and then if the next contraction, baby is not born, at least you have got really good pain relief there if you need to do an episiotomy"
>
> EP01 (Community midwife).

There was a split among participants in their view of whether episiotomy had a place in midwifery practice. This

view was described as creating a culture of practice that could impact a midwife's management decisions during midwife-led labor and birth, in contrast to decisions that take a more holistic person-centered approach.

6 | STANDARDIZED INFORMATION

When the information about an intervention is standardized, participants described how birthing people know what to expect and quality of care is ensured. One participant gave an example of how the message (and practice) is now standard across maternity care that episiotomy in midwifery-led care is not routine practice.

> "I normally say I would only ever do it if I thought those few minutes of time were important for the baby's wellbeing...I think the message has gotten out that it is not routine... it won't happen unless necessary."
>
> EP15 (Community midwife).

Despite this selective application, participants described strong feelings among birthing people and midwives about episiotomy, linked to a lack of information on the selected indications for doing episiotomy in contrast to its historical routine performance.

> "there's a lot of emotion I think around episiotomy...we try to...demystify it and to then actually take away some of the fear factor"
>
> EP12 (Labor ward midwife).

The midwifery participants in this study were able to articulate the risks of episiotomy when questioned, but overwhelmingly prioritized the benefit of expediting birth. This impacted the emphasis on risk in the labor consent discussions with the birthing person.

> "when I buzz for my second midwife. I asked for lidocaine and episcissors [...] and then before I've got to the end of that sentence, the woman has interrupted me and said, what's that for? It's like, OK, this is your baby's heart rate is in his boots. You can hear it, it's slower. I think we need to deliver your baby and I need to do, I would like to do a small cut to make that quicker."
>
> EP34 (Labor ward midwife).

Participants described how guidelines recommending antenatal conversations about the OASI-CB leave the content of this discussion up to the professional. If midwives have had little or no training in perineal care and episiotomy, they felt it unrealistic to expect them to be appropriately prepared for an in labor consent conversation.

> "you know we do our mandatory training and sometimes they'll throw in some perineal stuff and they'll talk about all the muscles of the perineum and everyone looks blankly and can't ever remember what any of their names are."
>
> EP36 (Birth center midwife).

> "We didn't have any proper official training in episiotomy, [...] we've had proper training on suturing, but never actually anything official on episiotomy, it was just from watching other people do it, learning on the job, really."
>
> EP39 (Labor ward midwife).

Participants described how acceptance of restrictive episiotomy into the midwifery tool kit would standardize teaching on the indications for doing an episiotomy in a midwife-led birth, open the debate about risks and benefits of the procedure, and consequently prepare midwives to conduct full informed consent conversations. This would develop an evidence-based and standardize episiotomy consent practice across the midwifery-led care pathway.

7 | DISCUSSION

7.1 | Summary

This study has shown there are variations in midwifery practice and midwifery practice culture impacting the content and timing of an informed consent conversation for episiotomy. All participants emphasized the importance of informed consent for episiotomy and how they would not perform the intervention without such consent. However, on analysis, the quality of the consent conversation was questioned, suggesting variability in standards of care. Consent was frequently described as gaining assent for the procedure in light of the clinician's assessment of concerning clinical signs, without a guaranteed antenatal conversation to inform this assent.

7.2 | Strengths and limitations

These interviews were conducted during the COVID-19 pandemic in the UK when pressure on maternity staff was

high. The use of online data collection methods widened participation in the study because of social distancing restrictions, people isolating in their homes, and workload commitments. However, side conversations between participants were difficult to capture and required active listening of the second facilitator to capture. Our purposive sampling means we are unaware of the experiences of those who chose not to participate. However, the data show variability in the practice of consent even among this self-defined "confident" group. The main strength of this study was the variety of experience in the research and co-design team that brought different perspectives to the data, challenged interpretations to produce a robust analysis, and implementable practice recommendations.

7.3 | Comparison with existing literature

Consent is a legal and ethical principle, making permissible a wide range of conduct that would otherwise be wrongful.[17] Consent is a positive act that goes beyond acquiescence or compliance with the instructions of a clinician. Evidence from a study in The Netherlands documents women reporting unconsented procedures during labor that include episiotomy,[18] and reinforce earlier findings from a study with clinicians that informed consent in labor does not really happen.[12] An observational study of consent conversations within antenatal care in the UK by Nicholls et al[10] found clinical risk to dominate the discussion, missing opportunities to assess what really mattered to the pregnant person, the offer of reasonable alternatives or confirming the person's understanding. This approach to consent does not consider individual preferences or frame the intervention as in the person's control to accept or decline.[11]

Documenting the rationale for performing an episiotomy is an important component of quality and accountable care. However, citing an emergency situation as the reason for proceeding without appropriate consent would not pass in a court of law as the three conditions of the emergency exception for the need for informed are not fulfilled.[19] Concerns raised by participants in this study about the quality of consent with birthing people of low English proficiency, raises questions about their access to and uptake of NHS interpreter services[20,21] and the legitimacy of consent.[22] Supporting all pregnant people to consider and discuss their options in advance of the onset of labor can better prepare them for this decision-making. It also gives time for the engagement of a professionally trained interpreter if there are cross-cultural communication concerns, to ensure understanding of the discussion and to answer any questions.[5,23,21]

The pivotal legal case of Montgomery v Lanarkshire Health Board[24] emphasized the need for a discussion between the pregnant person and the health professional to review the risks of any potential procedure, any alternative treatments that are available, and the risks of doing nothing in the context of the individual's life. The antenatal discussion component of the OASI-CB offers an opportunity for this conversation.[25] Despite assessment for episiotomy being a component of the OASI-CB, the discussion guide does not cover the potential situations where an episiotomy may be offered, or the potential risks, benefits, or alternative options. This leaves the content of the conversation dependent on the practice experience and knowledge of the midwife.[12]

Wider debate about midwifery practice can polarize the topic of episiotomy to be viewed either as a skill in the midwifery tool kit or as a procedure in the obstetrician's tool kit. Not accepting the episiotomy procedure formally into the tool kit of the midwife means training and support are inconsistent. Consequently, midwives may not have the knowledge or skills to conduct a detailed consent conversation about the risks and benefits of episiotomy in different contexts, leading to variation in both practice and messaging for birthing people. There are no discussion guides or decision aids available for episiotomy in a midwife-led labor and birth that can support a consent conversation between the midwife and the birthing person. The use of decision aids can offer women the opportunity to become informed in a reliable, balanced way to participate in the decision-making process.[26,27] They can reduce variation in practice and have been considered an effective, feasible, and appropriate approach to promoting woman-centered pregnancy care on other topics.[23,28]

8 | RECOMMENDATIONS

- Discuss the risks, benefits, and alternatives for episiotomy in a midwifery-led birth antenatally to support decision-making. Reconfirm the pregnant person's decision on admission in labor.
- Ensure the birthing person can ask questions and articulate back the information.
- Frame restrictive episiotomy as an infrequent but potentially valuable tool in the midwifery toolbox to optimize birth outcomes.
- Draft an evidence-based, informed consent conversation guide for episiotomy to support midwives in practice.

9 | CONCLUSION

Our study has exposed examples of suboptimal consent for episiotomy in midwifery-led births in UK NHS

maternity services. Practitioners value the concept of consent but are not facilitating it, compromising their standards of practice and birthing people's autonomy. A lack of standardized teaching on perineal care and the potential indications for, risks and benefits of episiotomy appear to result in a risk focused request for assent at the moment of birth. Optimizing a team approach to the pregnant person's care journey informed by evidence could contribute to an improvement in standards of consent conversations for birthing people.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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REFERENCES

1. RCOG. *A-Z of Medical Terms*. Royal College of Obstetrics and Gynaecology; 2022 Available at: https://www.rcog.org.uk/en/patients/medical-terms/#e (Accessed 8/3/22)
2. NHS. *Maternity Stat 2020–21*. NHS Digital; 2021. Available at: hosp-epis-stat-mat-hesnational-2020-21.xlsx (live.com). (Accessed 08/03/22)
3. Jiang H, Qian X, Carroli G, Garner P. Selective versus routine use of episiotomy for vaginal birth. *Cochrane Database Syst Rev*. 2017;2(2):CD000081. doi:10.1002/14651858.CD000081.pub3
4. Bidwell P, Thakar R, Sevdalis N, et al. A multi-Centre quality improvement project to reduce the incidence of obstetric anal sphincter injury (OASI): study protocol. *BMC Pregnancy Childbirth*. 2018;18(1):331. doi:10.1186/s12884-018-1965-0
5. Department of Health 2009 *Reference Guide to Consent for Examination or Treatment*. 2nd ed. HMSO. Available at: dh_103653__1_pdf(publishing.service.gov.uk). (Accessed 09/03/2022)
6. NMC. *The Code*. 2018 Read The Code online - The Nursing and Midwifery Council. https://nmc.org.uk Accessed 09/03/22.
7. Birthrights. *Racial injustice in maternity care. A Human Rights Inquiry: Call for Evidence [Racial Injustice in Maternity Care - Birthrights]*. Birthrights; 2021.
8. Thompson R, Miller YD. Birth control: to what extent do women report being informed and involved in decisions about pregnancy and birth procedures? *BMC Pregnancy Childbirth*. 2014;14:62. doi:10.1186/1471-2393-14-62
9. Cook A. Midwifery perspectives: the consent process in the context of patient safety and medico-legal issues. *J Patient Saf Risk Manag*. 2016;22:1-29. doi:10.1177/1356262216672614
10. Nicholls J, David AL, Iskaros J. Consent in pregnancy - an observational study of ante-natal care in the context of Montgomery: all about risk? *BMC Pregnancy Childbirth*. 2021;21:102. doi:10.1186/s12884-021-03574-2
11. MacKenzie G. Understanding consent in maternity care: offers, threats, manipulation and force. *Pract Midwife*. 2021;24(6):8-13.
12. Seijmonsberger-Shermers A, Thompson S, Feijen-de Jong E, et al. Understanding the perspectives and values of midwives, obstetricians and obstetric registrars regarding episiotomy: qualitative interview study. *BMJ Open*. 2021;11:e037536. doi:10.1136/bmjopen-2020-037536
13. Lane J, Bhome R, Somani B. National trends and cost of litigation in UK. National Health Service (NHS): a specialty specific analysis from the past decade. *Scott Med J*. 2021;66(4):168-174.
14. Anderson A. Ten years of maternity claims: an analysis of the NHS litigation authority data – key findings. *J Patient Saf Risk Manag*. 2013;19:1-31. doi:10.1177/1356262213486434
15. NHS England. *A co-Production Model*. HMSO. 2020
16. Mayring P. Qualitative content analysis. *Forum: Qualitative*. 2000;1(2):20. https://coalitionforpersonalisedcare.org.uk/resources/a-co-production-model/
17. Miller FG, Wertheimer A, eds. *The Ethics of Consent: Theory and Practice*. Oxford University Press; 2009.
18. van der Pijl MSG, Hollander MH, van der Linden T, et al. Left powerless: a qualitative social media content analysis of the Dutch #breakthesilence campaign on negative and traumatic experiences of labour and birth. *PLoS ONE*. 2020;15(5):e0233114. doi:10.1371/journal.pone.0233114
19. Richards, E.P. *The Emergency Exception*. Louisiana State University. 1995 https://biotech.law.lsu.edu/Books/lbb/x268.htm. (Accessed online 01/02/23)
20. MacFarlane A, Singleton C, Green E. Language barriers in health and social care consultations in the community: a comparative study of responses in Ireland and England. *Health Policy*. 2009;92(2–3):203-210.
21. Bridle L, Bassett S, Silverio SA. "We couldn't talk to her": a qualitative exploration of the experiences of UK midwives when navigating women's care without language. *Int J Human Rights Healthc*. 2020;14:359-373. doi:10.1108/IJHRH-10-2020-0089
22. Nicholls J, David AL, Iskaros J, Lanceley A. Consent in pregnancy: a qualitative study of the views and experiences of women and their healthcare professionals. *Eur J Obstet Gynecol Reprod Biol*. 2019;238:132-137.
23. Kennedy K, Adelson P, Fleet J, et al. Shared decision aids in pregnancy care: a scoping review. *Midwifery*. 2020;81:102589.
24. Montgomery v Lanarkshire Health Board. 2015.
25. Jurczuk M, Bidwell P, Gurol-Urganci I, et al. The OASI care bundle quality improvement project: lessons learned and future direction. *Int Urogynecol J*. 2021;32:1989-1995.
26. Ledger S, Hindle G, McKee A, Smith T. *Mind the Gap: an Investigation into Maternity Training for Frontline Professionals across the UK (2020/21)*. Baby Lifeline; 2021.
27. Stevens G, Thompson R, Watson B, Miller YD. Patient decision aids in routine maternity care: benefits, barriers, and new opportunities. *Women Birth*. 2016;29:30-34.

28. O'Connor AM, Llewellyn-Thomas HA, Flood AB. Modifying unwarranted variations in health care: shared decision making using patient decision aids. *Health Aff*. 2004;23:VAR-63-VAR-72. doi:10.1377/hlthaff.var.63

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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