Midwifery 88 (2020) 102764

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw

Tensions and interplay: A qualitative study of access to patient-centered birth counseling of maternal cesarean requests in Norway

Kristiane Tislevoll Eide[a,*], Nils-Halvdan Morken[b,c], Kristine Bærøe[a]

[a] Department of Global Public Health and Primary Care, University of Bergen, Kalfarveien 31, 5018 Bergen, Norway
[b] Department of Clinical Science, University of Bergen, Bergen, Jonas Lies veg 87, 5021 Bergen, Norway
[c] Department of Obstetrics and Gynecology, Haukeland University Hospital, Jonas Lies veg 87, 5021 Bergen, Norway

ARTICLE INFO

Article history:
Received 6 December 2018
Revised 10 March 2020
Accepted 24 May 2020

Keywords:
Cesarean section
Maternal request
Access
Birth counseling
Patient-centered care
Midwife-led care

ABSTRACT

Objective: This study aimed to explore women's *access* to patient-centered counseling for concerns initiating cesarean requests in absence of obstetric indications in pregnancy, and to identify tensions, barriers and facilitators affecting such care.

Design, setting and informants: This qualitative study (June 2016 to August 2017) obtained data through semi-structured in-depth interviews with 17 women requesting planned C-section during birth counseling at a university hospital in Norway and focus group discussions with 20 caregivers (9 midwives and 11 obstetricians) employed at the same hospital. Analysis was carried out by systematic text condensation, a method for thematic analysis in medical research, presented within the frames of Levesque and colleagues' conceptual framework of access to patient-centered care.

Findings: The analysis revealed that there were considerable tensions in care seeking and provision of counseling for maternal requests for C-section. There was a prominent culture of vaginal delivery among caregivers and women. The appropriateness of CS on maternal request was debated and caregivers revealed diverging attitudes and practices when agreement with women was not reached. Women's views on their entitlement to choose were divided, but the majority of women did not support complete maternal choice. Midwife-led counseling were highly appreciated among woman as well as obstetricians.

Implications for practice: Tensions and barriers in care seeking and provision of counseling for women requesting C-section for non-obstetric reasons, call for standardized counseling in order for equal and adequate care to be provided across health care institutions and providers. Dialogue-based decision-making and midwife-led care may improve satisfaction of care, enhance spontaneous vaginal deliveries and avoid future conflicts.

© 2020 The Authors. Published by Elsevier Ltd.
This is an open access article under the CC BY-NC-ND license.
(http://creativecommons.org/licenses/by-nc-nd/4.0/)

Introduction

Cesarean section on maternal request (CSMR) is a CS conducted at the request of the mother in the absence of obstetric contraindications of vaginal delivery (VD) (D'Souza, 2013). The subject has received attention in public as well as academic debate, and appears to be controversial (D'Souza and Arulkumaran, 2013). Along with the physician-driven rise in CS, there has been an increase in maternally requested CS in many countries (Boerma et al., 2018). Meanwhile, there has been a shift in medical care from paternalistic practices towards patient-centered care and shared decision-making (Barry and Edgman-Levitan, 2012). There is growing concern about the world-wide increase in CS rates, with elevated maternal and newborn morbidity (Boerma et al., 2018; Sandall et al., 2018).

Fear of birth, previous traumatic birth experience and previous CS are important predictors of CSMR (Fuglenes et al., 2011; Ryding et al., 2016). A subjective traumatic birth experience is not, however, predictable by objective complicative events (Nilsson and Lundgren, 2009; Storksen et al., 2013). Over all, women requesting

* Corresponding author.
E-mail addresses: Kristiane.eide@uib.no (K.T. Eide), nils-halvdan.morken@uib.no (N.-H. Morken), Kristine.baroe@uib.no (K. Bærøe).

https://doi.org/10.1016/j.midw.2020.102764
0266-6138/© 2020 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license. (http://creativecommons.org/licenses/by-nc-nd/4.0/)

Abbreviations

CS	cesarean section
MR	maternal requests
CSMR	cesarean section on maternal requests
VD	vaginal delivery
FGD	focus group discussion

CSMR carry an overrepresentation of vulnerable psychosocial characteristics (Fuglenes et al., 2011; Ryding et al., 2016; Storksen et al., 2015; Sydsjo et al., 2015). Most Norwegian women with fear of childbirth deliver vaginally, but a previous traumatic birth experience is highly predictive of CSMR (Storksen et al., 2015). However, first time mothers requesting CSMR do not necessarily have clinically significant anxiety (Wiklund et al., 2008).

Attitudes towards providing CSMR vary widely among obstetricians across European countries (Habiba et al., 2006). The majority of Norwegian obstetricians consider CSMR as clinically problematic (Fuglenes et al., 2010). Although about half of the respondents were willing to perform CSMR in the absence of medical indications, just as many thought the physician should make the final decision. There are, to the best of our knowledge, no qualitative studies exploring both women and caregivers experience of such counseling in light of access to *appropriate* care. This study aimed to explore caregivers' provision of and women's access to patient-centered birth counseling for maternally requested CS in Norway.

Norwegian birth context

Norway has a publicly financed health care system where delivery care is free of charge. Primary care midwives and general practitioners (GPs) provide care during pregnancy, while birth and direct follow-up after birth is taken care of in public hospitals. A woman who requests a CS is referred for birth counseling at the hospital where she plans to give birth. Birth counseling is provided by obstetricians or midwives and the final decision about CS is made by a consultant in obstetrics. There is no established private alternative, and CSMR in the absence of a medical indications is not recommended according to obstetric guidelines (Norsk Gynekologisk Forening (Norwegian Society for Gynecology and Obstetrics), 2014). Whether fear of birth is to be regarded as a medical indication should be evaluated individually. The Norwegian Patients' Rights Act ensures patients the right to participate in decision-making concerning accessible and justifiable treatment options (Lovdata, 1999). Physicians in Norway are protected against economic responsibility for patient complaints and lawsuits through the Norwegian System of Patient Injury Compensation (Norsk Pasientskadeerstatning (The Norwegian System of Patient Injury Compensation) 2016).

Methods

In order to gain new understanding and insight into a complex subject we chose a qualitative explorative design. The study was conducted at a university hospital in Norway with approximately 5000 deliveries annually. The regional CS rate was 12.6%, representing one of the lowest CS rates in the country (The Norwegian Institute of Public Halth (Folkehelseinstituttet) 2020). Requests for planned CS were handled by midwives providing birth counseling at the hospital. Referrals came from primary care midwives or GPs, or from midwives and obstetricians working at the hospital. According to midwives working in counselling 70% of women changed their mind and opted for a vaginal delivery plan during counseling. If they persisted on a cesarean request, midwives would either make an agreement for CS with a consultant in obstetrics themselves, or refer the woman for final consultation(s) and decision by a consultant.

Table 1
Women's characteristics.

Characteristics	Number
Age	
27–32	6
33–37	6
38–42	5
Civil status	
Married	11
Cohabitant	5
Single	1
Education	
High school	4
Bachelor level	7
Master level	6
Immigrants	3
Parity	
Nullipara	1
Multipara, with previous nulliparous request	2
Multipara	14
Final delivery mode	
Planned cesarean section	10
Attempted vaginal delivery	7
N=	17

Data collection

Data were collected from semi-structured in-depth interviews with 17 women referred for birth counseling and 6 focus group discussions (FGDs) with caregivers, including 9 midwives and 11 residents or consultants in obstetrics (Tables 1 and 2). Women were recruited by midwives at the counseling center after provision of oral and written information about the study and if the woman was above 16 years, had presented an oral request for CS and had a normal pregnancy. Informed consent was gathered by the recruiting midwife or the first author before the interview took place and women were usually interviewed late in pregnancy (week 21–38). Four women were interviewed (2 weeks to 8 months) after birth due to practical difficulties. The interviews took place at the first author's office or at the informant's home according to preferences. One woman was interviewed before and after labor because of consecutive information relevant to the study question. The interviews were usually opened with the

Table 2
Caregivers characteristics.

Characteristics	Number
Profession	
Midwife	9
Physician	11
Resident	5
Consultant	6
Sex	
Women	16
Men	4
Age	
29–39	7
40–49	6
>50	7
Years of experience	
<5	5
6–10	6
11–20	5
>20	4
N=	**20**

Table 3
Interview guide for in-depth interviews with women.

No.	Question	Probes
1.	Would you like to tell me your story about why you are requesting a C-section?	
2.	What is the reason for your wish for a C-section?	
		2.1- What was it about the last birth? 2.2- What do you fear? ○ Pain? ○ Control? ○ Injury towards yourself or the child? 2.3- Is there anything or anyone who has influenced your choice and your attitudes towards this?
3	How has it been to talk to other people about this?	
		2.4- Who have you talked to about this?
4	What information have you gotten or searched for?	
5	How did you proceed to get help for this?	
6	Tell me about your experience with counseling.	
		2.5- Expectations, information, communication
7	Is there anything that could have been improved for you or others in your situation?	
8	Who do you believe should make the final choice of delivery mode?	
9	Is there something else you think I should know?	

encouragement of, “Would you like to tell me your story about why you want a planned C-section?”. Three informants were immigrants interviewed in either Norwegian or English, neither of which was their first language. Ten of the women gave birth by planned CS, while seven planned a vaginal delivery where three of them had an emergency CS.

Caregivers were chosen to facilitate a purposive heterogeneous sample of midwives working in counseling, delivery and postnatal care as well as obstetricians with varying length of experience. Caregivers were sent an invitation to participate by mail together with information about the study. Active participation was regarded as consent to participate. Short information about the study aim, confidentiality and right to withdraw was given prior to the FGDs. The FGDs were held at the hospital and comprised of 3–4 informants grouped by profession. All interviews were undertaken by the first author between June 2016 and August 2017. The transcripts and interview guides (Tables 3 and 4) were evaluated and revised and sample size (saturation) evaluated continuously by the first (a medical doctor) and last author (a bioethicist) during the interview process. Interviews lasted from 40 to 79 min, were audio recorded and transcribed verbatim by the interviewer. After 12 interviews with women and six FGDs with caregivers, we regarded the material as sufficient to illuminate the research question(s), in terms of information power (Malterud et al., 2015). Malterud recommends evaluating the information power of a sample rather than saturation, which is a concept originally applied in grounded theory (Malterud et al., 2015). Information power depends on a narrow aim, specific and relevant sample, support of established theory and good quality of dialogue and analysis (Malterud et al., 2015). A sample should be large enough to provide in-depth information on a research question, and should not be larger than necessary in order to prevent a superficial analysis. The interviews gathered data for two studies with separate research aims. Data derived from question 1–2 in the interview guide with women and question 1 in the focus groups with caregivers, have been analyzed separately and previously published elsewhere (Eide et al., 2019). This study’s aim was covered by discussion emerging from the remaining questions in the interview guides.

The interviewer was a female with no direct relation to the hospital. This facilitated an open dialogue about women’s help-seeking processes. The research team was multidisciplinary and consisted of a newly educated medical doctor and PhD student (the interviewer), an experienced obstetrician and a bioethicist. This influenced our preconception, approach towards and interpretations of

Table 4
Interview guide for focus group discussions with caregivers.

No.	Question	Probes
1	What is your impression of women who request cesarean?	
		1.1- Who are they? 1.2- Why do they want C-section?
2	How is it to work with these patients?	
		1.3- What kind of emotions do they evoke? 1.4- Do you experience any ethical challenges facing them?
3	Would you like to tell me about how you handle these patients?	
		1.5- Strategies? Improvements?
4	How do you think the decision should be made? Who should make the final choice?	
		1.6- Shared, doctor, midwife, the woman?

the subject of study, but enabled us to approach the research question and findings from multiple perspectives enhancing the credibility of our analysis.

Ethical approval

This study was approved by the regional committee for medical and health research ethics in Norway December 7th 2015 (Ref. 2015/2029REK vest) and the Norwegian Social Science Data Services November 20th 2015 (ref 45158/3/MSS).

Analysis

NVivo software version 11 (1999–2017 QSR International Pty Ltd.) was used to organize text and conduct coding. We used systematic text condensation, a cross-case thematic analysis for qualitative data to approach the material through four systematic steps (Malterud, 2011; 2012): (1) reading transcripts during data collection to obtain an overall impression and identify main themes, (2) coding of meaning units into main categories, (3) condensation of content in the categories by coding into subgroups, and (4) synthesizing the condensates into new descriptions and concepts. The first and last author collaborated on step 1 of identifying themes for further analysis, the first author subsequently had the main responsibility of coding and analysis, while the whole research team collaborated on the last step of analysis of data during discussions and reflection in a stepwise, flexible process. Levesque et al.'s conceptual framework of patient-centered access to health care was used during step 4 of the analysis to organize, structure and describe the content, according to distinctive dimensions of access. Hence, the analysis was originally data-driven, but eventually used a conceptual framework of access to illustrate and actualize the findings in line with an editing analysis style (Malterud, 2016). This enabled us to explore the material before choosing a relevant framework to complement the analysis, by adding flexibility to the process.

Framework: Patient-centered access to health care

Access to health care is a complex term with varying interpretations. Based on existing frameworks, Levesque and colleagues have developed a systematic framework of patient-centered access to health care, where access is defined as "the opportunity to reach and obtain *appropriate* health care services in situations of perceived need for care" (Levesque et al., 2013). Access is regarded as a result of the interface between characteristics of individuals demanding care, and characteristics of the health care providers. Relevant facilitators and barriers to such access are present from the supply side as well as the demand side of care in addition to factors in the process by which access is realized (as illustrated by the blue arrow in Fig. 1).

Levesque et al. presents five dimensions of accessibility of services with five corresponding abilities of individuals or populations seeking health care: 1) *Approachability* relates to whether people can identify that a certain service exists and a corresponding ability of individuals to perceive a need for care. 2) *Acceptability* relates to cultural and social acceptance of certain health services and the corresponding ability to seek care. 3) *Availability and accommodation* imply that health services can be reached in physical terms and in a timely manner and implies a corresponding ability of individuals to reach health services. 4) *Affordability*, and the ability to pay for care represent the economic capacity people have to spend time and resources on accessing care. Finally, 5) *Appropriateness* represents the fit between clients' need and services offered. Adequacy of the care given is dependent on appropriateness of the service provided, its quality, and individuals' ability to engage and participate in health care decisions. Consequently, Levesque and colleagues describe a comprehensive and dynamic model of access, where the abilities of individuals interact with dimensions of the health care services along the cumulative line of help-seeking and fulfillment of health care needs.

Results

Tensions and interplay were observed between and within the supply and demand sides of access to counseling for requested planned CS. Women requested planned CS based on a large variety of life experiences and rationales, but previous birth experience was very important to many of them (Eide et al., 2019). Many women experienced the accessibility of counseling for their cesarean request to be challenged by late referrals to counseling, a strong ideal of vaginal delivery, a long-lasting process of and late decision-making. Caregivers struggled between the responsibility for the individual woman and the responsibility towards the profession and society. Obstetricians revealed different opinions on the appropriateness of CSMR and thus to different degree involved women in the actual decision. The findings are structured according to Levesque's five dimensions of access in the following.

Approachability & the ability to perceive a health care need

Caregivers were concerned about how media and trends in society influenced women's perception of need for CS. While some midwives thought fear of birth had become an increasing problem over past decades, several obstetricians mentioned a shift and a positive trend over the last few years after bloggers and celebrities had advocated for own vaginal birth experiences in media. Many caregivers were concerned about the free access to unfiltered information on the internet, which was particularly unfortunate reading for women who were prone to anxiety.

> "It may be a trend in society, that we decide more how we want things. And we read up a lot more on our own. And that's great really. But there is something about where we get that information from." L1 Obstetrician

Several caregivers pointed out the importance of primary care midwives in preparing women for their births. They called for better access to and earlier appointments with midwives in pregnancy. Midwives believed that early exploration of thoughts about birth could help pregnant women normalize fear and avoid medicalization. Early processing of previous delivery was perceived as important for multiparous women.

> "They only get an appointment with a midwife in week 24 of pregnancy. Many of them are locked into specific thoughts by then. You're almost 6 months pregnant and you've heard all the stories." J6 Midwife

Most women had initiated the help-seeking process themselves. One of the women questioned why there was no screening or discussion of birth with women during pregnancy. She thought someone should inform her about the increased risks in the forthcoming delivery and the risks and benefits of the available delivery options, given her previous CS. Lack of outreach and information from the health care system made her even more concerned about the upcoming birth:

> "I don't think it's ever discussed (delivery mode) really, unless you bring it up yourself… So I think if I had been informed a bit at an earlier stage. Say, now you are in this or that situations, you have these risk factors, these are the benefits and disadvantages. Then I would have felt in safe hands." G17 Woman, gestational week 37

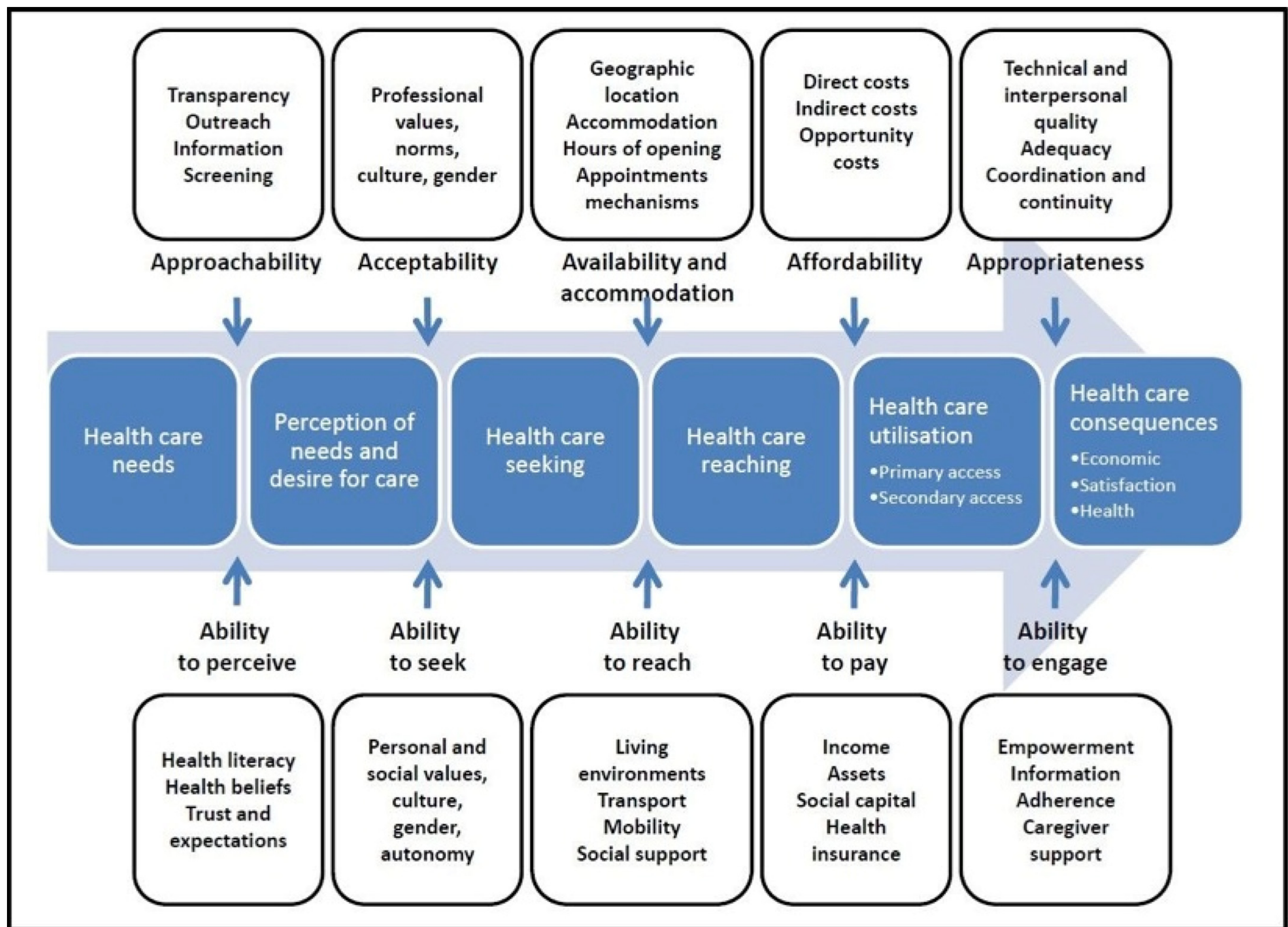

Fig. 1. Levesque et al.'s conceptual framework of access to care, licensed from (Levesque et al., 2013) http://creativecommons.org/licenses/by/2.0.

Acceptability & the ability to seek care

There was a prominent preference for VD as the outcome of counseling among all caregivers. Although planned CS could be advisable for women with a severe fear of childbirth, it was not regarded as a treatment for anxiety.

"This group I usually start by saying that surgery is not a treatment for anxiety. That's a bad strategy, because surgery itself provokes anxiety." L10 Consultant

Obstetricians balanced the responsibility towards the individual patient and the responsibility towards society during decision-making. Caregivers found themselves pulled between the expectations of their profession and the intention to do good for the individual patient:

"It's a bit odd, because occasionally I feel that if I get a woman who wants a C-section to change her mind to a vaginal delivery it feels just as if I've done a better job for my profession… And that dilemma I sometimes find difficult. Because if the goal itself is always a vaginal delivery, then I believe we have a preconception that isn't good for the woman's mental health" J3 Midwife

Several women had the impression that caregivers in primary and specialized care usually advocated strongly for VD. For some it appeared less trustworthy and lacking of neutral ground:

"When they talk about C-section and birth, then vaginal delivery is great. It's natural, good for the baby, complications can occur, but they don't talk much about that… But when they come to C-section…They put a red flag on it from day 1." G1 Woman, gestational week 36

There was a common understanding among women that the clinic was very restrictive in its policy towards CS. Women were aware that a VD was preferable for the child, and a planned CS was not regarded as an easy way out. Many women indicated that they would prefer a VD had it not been for the circumstances underlying their request. Several felt a bad conscience towards the child for not being able to manage a VD. A few women had felt ashamed and vulnerable when having to engage with the health system for a mental health reason, like this woman, who admitted she did not regard CSMR as acceptable until she suddenly experienced the need for it herself:

"And it's probably because of my own understanding of planned cesarean before, because I thought it was just nonsense. Oh my goodness, right. So I have probably met myself coming the other way." G8 Woman, gestational week 35

Availability & the ability to reach health services

A common complaint among women was that the birth counseling process was too long and that the decision was made too late in pregnancy, escalating psychological stress and uncertainty

during pregnancy. Prior to counseling, many feared they would not be understood or taken seriously and many were relieved to find the opposite. Several women were not able to enjoy their pregnancy until the decision on delivery mode was taken.

> "And even when the decision came, when she telephoned me, it was only when I got it by mail, and even then a week passed before I was able to relax." G8 Woman, gestational week 35

Caregivers emphasized the importance of getting into dialogue with women early on in pregnancy and giving the process time to mature and follow its course. Midwives spent time exploring women's fear and reestablishing safety and trust in order to help the woman find the best solution for herself.

> "Yes, and then we really want to see them again, and maybe another time, and perhaps even one more time. Just to try to accompany them towards the goal and see how do your thoughts develop?" J2 Midwife

Affordability & the ability to pay

The Norwegian health system provides delivery care free of charge. There is no private alternative for women approaching birth. The health budget for delivery clinics is performance based and paradoxically pays more for a CS than a VD. This was not regarded as an incentive among obstetricians for increasing CSMR. The clinics' capacity for surgery was otherwise fixed. Obstetricians were concerned that a rise in CS rates would mean a reduction in surgery capacity for other gynecologic conditions.

> "The capacity for surgery is fixed. So if you increase the C-section rate 1%... Then someone else won't get (surgery)." L3 Consultant

Appropriateness & the ability to engage (in decisions)

Midwives working with counseling described how they invested time and effort in establishing a good dialogue with women. Showing respect and taking women seriously often helped them reestablish trust, which had commonly been lost in an earlier birth experience. Through conversations, they guided the woman to find the right solution for her. They spent time making a birth plan, which was a document providing safety for the woman. Their goal was to follow the women, guide them through a thought process and deliver them as confident as possible to the delivery situation, irrespective of mode.

> "I believe it is very important that the woman feels she has been taken seriously. That she's been heard. That's more important than the delivery mode itself." J2 Midwife

Achieving a good dialogue was important. Both midwives and obstetricians highlighted the advantage of midwives, without mandate to make the final decision, to promote a constructive dialogue. There was a challenge of identifying which women were capable of coping with a new vaginal birth experience. Evaluating the woman's mental health was regarded as highly subjective and difficult:

> "It's you as a person sitting here, and none of us are psychiatrists. There are no kind of scoring systems where you can sit and pick out these patients. It's very much about how the patient is presenting it." L2 Consultant

Several doctors had developed strategies to avoid making the situation more tense, by avoiding a negotiation table, facilitating a shared decision-making process and acknowledging mental health problems. This would enable a better dialogue, provision of information and evoke a thought process among women.

> "These consultations I usually start by disarming the situation. We aren't going to make a decision today. Today we are just going to map out your point of view... So that it doesn't become a fight from the first time." L6 Obstetrician

Women were generally very pleased with the birth counseling provided by midwives. They usually felt seen, heard, respected and trusted on their stories. They appreciated going through previous birth records and clearing up misunderstandings and questions.

> "I am very grateful for being heard and believed by the hospital. That's what I am left with, I feel trusted on my experience, my personal subjective birth experience the first time." G4 Woman, two months postpartum

While some women felt well-informed before and during the counseling process, others expressed an unmet need for information. Some women wanted more facts presented in numbers and percentages and adapted to their specific obstetric history. No written information was given in the decision-making process. After the decision was made women scheduled for planned CS were sent a standard information sheet about the procedure and its risks.

> "But they did not have any proof in their hand. They just, like how these religious people how they convince you. How Christianity is the best. They just blindly convince you to go for normal delivery." G9 Woman, one month postpartum

Most caregivers believed the medical responsibility of the final decision should be held by the obstetrician. Patient autonomy with regards to delivery mode was usually interpreted as a right to say no to treatment, but not the right to demand an intervention without a medical indication. Professional autonomy and the right to refuse to operate on a healthy woman was mentioned.

> "You cannot come and claim a surgical intervention if we know there's a safer alternative. And it's undeniably safer." L6 Resident

Some obstetricians saw it as their main responsibility to inform the patient and help the patient make an informed choice about mode of delivery. If she were able to make an informed choice, her choice should be respected:

> "We cannot force them to give birth. It's their choice, really." L7 Resident

No clear difference of opinions was found between residents and consultants. There were variations in opinions in both groups. However, obstetricians expressed varying practices when it came to declining requests. Some obstetricians saw it as the right thing to do, or their duty, to decline a request if a woman came with a non-medical indication. Especially in low-risk pregnancies were the evidence suggest a VD was undeniably the safest option for mother and child, if the woman was very young and if she did not understand implications of surgery, making an informed process difficult.

> "Really, if I believe that there is absolutely no advantage with a C-section, and of course if they have real anxiety it's something completely different. But those who are, "No, I don't really want to give birth," right, at that level, and it's a low risk pregnancy, no contraindications to vaginal delivery. Then I make that decision." L6 Resident

Other obstetricians did not feel comfortable denying a woman a CS if she was completely reluctant towards giving birth, even in cases where fear was not prominent. They regarded it as wrong to force a woman into a VD against her will and did not see it worth their time and resources when it came to a patient dispute which was regarded time-consuming and mentally exhausting.

Some caregivers usually let the women decide. This could provide trust and allow for a better dialogue. These caregivers believed that most women still chose a vaginal birth plan.

> "I usually (say)… that if she insists on a C-section she can have it. There won't be any argument about that. But then there will be a time period where we can work on these issues." L10 Consultant

Midwives highlighted that a forced delivery was a very bad starting point for a birth experience, which again could influence the attachment between mother and child. In some situations, caregivers regarded planned CS to be an appropriate option for the individual woman. A previous traumatic birth experience and severe fear of childbirth were acknowledged as legitimate indications by several obstetricians:

If they haven't made contact with the ground all the way through the pregnancy, just walking around thinking about the birth, are so afraid that they can't be happy about the child. They aren't able to enjoy the pregnancy…For those women, it must be completely OK to have a C-section?" L11 Consultant

Women's views on autonomy were divided. A minority of the women thought the final choice should be taken by the woman herself. Arguments presented were; it was her body and should be her decision, she knows her own body and psyche the best, she was the one bearing the consequences and the outcome of an attempt for VD was uncertain.

> "At the end of the day I believe it should be the woman, I do… But I do not mean that it should be like if you are pregnant you call in and order a planned C-section, I don't mean it should be like that. But I believe there should be a process in advance." G4 Woman, two months postpartum

Most women would prefer a shared process between the woman and caregiver or a conditional autonomous choice depending on reason for the request, where ungrounded requests could be denied. Many emphasized that a good process with information and dialogue was of greater importance than who was to decide. The fact that it was a surgical procedure, with elevated risks for the mother and child, a medical choice, a possibility that women would have CS for reasons of convenience or because it was misunderstood as an "easy way out", were arguments presented for why complete autonomy would be problematic.

> "I don't believe the woman should decide for herself, not exclusively… Either way you need someone to talk to about it. Not necessarily to be allowed to decide completely. " G13 Woman, gestational week 31

Many had felt included in the decision-making, either by being able to make the final choice for themselves or having the opportunity to say no to a vaginal birth plan. Others felt as if they were presented to a judge or committee of doctors evaluating their case, without being present to defend themselves or being able to influence the decision.

> "…that I felt in a way that when I had presented my case then it was totally out of my hands. Then it was like a judge up there who was to decide." G2 Woman, gestational week 34

Discussion

The findings of this study illustrate considerable tensions as well as fruitful interplay, across the five dimensions of access proposed by Levesques' framework of access to patient-centered care, when it comes to birth counseling for cesarean requests among women in Norway. This new insight can facilitate shared reflection on what health care should entail for women requesting CS.

Appropriateness & ability to engage

There were diverging attitudes and practices involved in declining a persistent cesarean request when regarded as inappropriate. Some caregivers emphasized their responsibility for allocating societal goods and providing evidence-based care as an argument for declining requests, whereas others advocated for respecting patient choice after an informed process and avoiding harm by a forced delivery. Patients' potential complaints and litigation were emphasized as an emotional burden and some caregivers did not consider it worth their effort to decline persistent requests. Accordingly, anticipated complaints can influence decisions even in a context that protects against financial and medicolegal consequences for physicians, in line with a Norwegian survey showing a considerable variation in judgment about CS determined by risk of complaints and litigation (Fuglenes et al., 2009).

Tensions in perspectives on CSMR can also be explained by equivocal evidence. CS in the absence of obstetric indications is not expected to provide benefit for the mother or child in terms of physical health and may even cause harm (Sandall et al., 2018). Evidence is scarce concerning whether planned CS improves the mental health of the mother during and after pregnancy (Olieman et al., 2017). Studies have shown that giving birth by planned CS did not significantly improve postpartum mental health of mothers (Adams et al., 2012), but may provide a more positive birth experiences (Wiklund et al., 2007). A mismatch of preference for planned CS and not receiving it was associated with increased risk of posttraumatic stress disorder and depression (Garthus-Niegel et al., 2014). While there is uncertainty in anticipated gain of a planned CS on mental indication, there may be a mental gain of birth counseling and psychosocial therapy during pregnancy for these women (Rouhe et al., 2015, 2013; Saisto et al., 2001, 2006). After all, increasing evidence suggests that mental stress during pregnancy has unfortunate consequences for the behavioral, social and emotional development of children (Korja et al., 2017; Kvalevaag et al., 2015).

Variation in attitudes towards the appropriateness of CSMR has been illustrated among obstetricians across several European countries (Habiba et al., 2006). Our study illustrates diverging opinions and practices even within one hospital in Norway. This intraprofessional tension regarding the appropriateness of CSMR calls for a discussion and development of a more homogenous approach among caregivers. Swedish guidelines have suggested to comply with cesarean requests that are grounded sufficiently serious, when it persists after participation in a counseling program (Wiklund et al., 2012).

Acceptability & ability to seek care

Caregivers revealed a prominent culture for VD, in line with other studies from Scandinavia (Karlstrom et al., 2009; Panda et al., 2018). A prominent culture for VD was also reflected among women. Studies have shown that the vast majority of Norwegian women prefer VD (Fuglenes et al., 2011; 2012), and most women with fear of birth do deliver vaginally (Storksen et al., 2015). The majority of women, as well as caregivers in our study, did not favor maternal choice for CSMR. Hence, the interplay of shared cultural attitudes towards VD among women and caregivers in Norway may partly explain the low prevalence of CSMR.

In line with the central and highly valued role of midwives in pregnancy and delivery care in Norway, midwife-led continuity models of care for pregnancy and childbirth have been shown to increase the likelihood of experiencing a spontaneous VD (Sandall et al., 2016). After crisis-oriented counseling provided by midwife the majority of women (86%) in one study in Norway changed preference to vaginal delivery and remained satisfied

with their choice (Nerum et al., 2006). Our study thus supports the hypothesis that midwife-led pregnancy and delivery care combined with a strong professional culture for VD may help keep national CS rates at reasonable levels (Panda et al., 2018). Counseling provided by midwives was highly appreciated by women as well as obstetricians in this study. Organization of counseling as a maturation process with postponed decision-making to promote women's reflection and changed motivation for VD, increased fear and stress during pregnancy for some women. Early screening and decision-making in pregnancy have been proposed to improve care (Kenyon et al., 2016).

Strengths and limitations

To the best of our knowledge, this is the first study that in order to facilitate improvements in care explores maternally requested CS within a broad framework of access to care. The information power of the study is regarded as high based on the narrow aim and specific recruitment, narrow analysis with application of theory, and high and heterogeneous number of informants representing both parties of the counseling situation; pregnant women and caregivers (Malterud et al., 2015). Four women were interviewed after birth, which could have influenced their perception of the counseling and decision process in light of how the birth was finally experienced. However, we experienced the descriptions to be varied and heterogeneous independent on interview timepoint and mode of delivery.

Some restrictions upon transferability should thus be evaluated before interpreting the results. Women were recruited from specialized care; they had already perceived a need for care and identified that a service existed. Additional challenges in the approachability of service and ability to perceive is expected outside the context of specialized care. Also, the Norwegian health system, which avoids payment and medicolegal barriers, creates a unique context for our findings. Within this legally protected context our study setting is a university hospital that holds a low and recommendable CS rate (12.6%) according to the WHO recommendations. It is especially interesting to investigate women's access to counseling for requested planned CS in such a context where caregivers have the resources to provide CS but aim to limit the use of it. This may have influenced the findings towards a lower or more restrictive access towards *CSMR*, but not necessarily towards patient-centered *counseling* for CSMR. However, even within one hospital with a restrictive provision of CS, we are able to show variation in attitudes and values when it comes to providing and involving women in decisions for CSMR.

This study illustrates how a framework of access to health care can be useful to explore need and provision of care for women when entitlements are unclear. Whether barriers of access to care in certain situations are acceptable or even preferable, is a normative question beyond the scope of this paper. Our approach can be implemented in other contexts to facilitate understanding of local tensions and interplays to improve care for this complex issue.

Conclusion

This is the first study to investigate women's access to patient-centered counseling for maternal cesarean request through a framework of access to patient-centered care. Variations in attitudes towards appropriateness of CSMR and willingness to decline persistent cesarean requests calls for shared reflection on how to provide appropriate patient-centered care for these women. More research is needed on how to organize the counseling process. Midwife-led counseling was highly appreciated by women and caregivers. Few women or caregivers favored complete maternal choice, illustrating the relevance of dialogue-based decision-making to improve satisfaction and avoid future conflicts.

Ethical approval

This study was approved by the regional committee for medical and health research ethics in Norway December 7th 2015 (Ref. 2015/2029REK vest) and the Norwegian Social Science Data Services November 20th 2015 (ref 45158/3/MSS).

Funding

University of Bergen.

Declaration of Competing Interest

None.

Acknowledgements

We would like to thank the informants of this study, those who helped with recruitment and the Global Health Priorities research group for feedback on the manuscript. We would also like to thank Margrethe A. Schaufel for methodological support and Julia C Norman for providing language editing and translation of quotes.

References

Adams, S.S., Eberhard-Gran, M., Sandvik, A.R., Eskild, A., 2012. Mode of delivery and postpartum emotional distress: a cohort study of 55,814 women. BJOG 119, 298–305.
Barry, M.J., Edgman-Levitan, S., 2012. Shared decision making–pinnacle of patient–centered care. N. Engl. J. Med. 366, 780–781.
Boerma, T., Ronsmans, C., Melesse, D.Y., Barros, A.J.D., Barros, F.C., Juan, L., et al., 2018. Global epidemiology of use of and disparities in caesarean sections. Lancet 392, 1341–1348.
D'Souza, R., 2013. Caesarean section on maternal request for non-medical reasons: putting the UK National Institute of Health and Clinical Excellence guidelines in perspective. Best Pract. Res. Clin. Obstet. Gynaecol. 27, 165–177.
D'Souza, R., Arulkumaran, S., 2013. To 'C' or not to 'C'? Caesarean delivery upon maternal request: a review of facts, figures and guidelines. J. Perinat. Med. 41, 5–15.
Eide, K.T., Morken, N.H., Baeroe, K., 2019. Maternal reasons for requesting planned cesarean section in Norway: a qualitative study. BMC Pregnancy Childbirth 19, 102.
Fuglenes, D., Oian, P., Gyrd-Hansen, D., Olsen, J.A., Kristiansen, I.S., 2010. Norwegian obstetricians' opinions about cesarean section on maternal request: should women pay themselves. Acta Obstet. Gynecol. Scand. 89, 1582–1588.
Fuglenes, D., Oian, P., Kristiansen, I.S., 2009. Obstetricians' choice of cesarean delivery in ambiguous cases: is it influenced by risk attitude or fear of complaints and litigation. Am. J. Obstet. Gynecol. 200 (48), e41–e48.
Fuglenes, D., Aas, E., Botten, G., Oian, P., Kristiansen, I.S., 2011. Why do some pregnant women prefer cesarean? The influence of parity, delivery experiences, and fear. Am. J. Obstet. Gynecol. 205 (45), e41–e49.
Fuglenes, D., Aas, E., Botten, G., Oian, P., Kristiansen, I.S., 2012. Maternal preference for cesarean delivery: do women get what they want? Obstet. Gynecol. 120, 252–260.
Garthus-Niegel, S., von Soest, T., Knoph, C., Simonsen, T.B., Torgersen, L., Eberhard-Gran, M., 2014. The influence of women's preferences and actual mode of delivery on post-traumatic stress symptoms following childbirth: a population-based, longitudinal study. BMC Pregnancy Childbirth 14, 191.
Habiba, M., Kaminski, M., Da Fre, M., Marsal, K., Bleker, O., Librero, J., et al., 2006. Caesarean section on request: a comparison of obstetricians' attitudes in eight European countries. BJOG 113, 647–656.
Karlstrom, A., Engstrom-Olofsson, R., Nystedt, A., Thomas, J., Hildingsson, I., 2009. Swedish caregivers' attitudes towards caesarean section on maternal request. Women Birth 22, 57–63.
Kenyon, S.L., Johns, N., Duggal, S., Hewston, R., Gale, N., 2016. Improving the care pathway for women who request Caesarean section: an experience-based co-design study. BMC Pregnancy Childbirth 16, 348.
Korja, R., Nolvi, S., Grant, K.A., McMahon, C., 2017. The relations between maternal prenatal anxiety or stress and child's early negative reactivity or self-regulation: a systematic review. Child Psychiatry Hum. Dev. 48, 851–869.
Kvalevaag, A.L., Ramchandani, P.G., Hove, O., Eberhard-Gran, M., Assmus, J., Havik, O.E., et al., 2015. Parents' prenatal mental health and emotional, behavioral and social development in their children. Child Psychiatry Hum. Dev. 46, 874–883.

Levesque, J.F., Harris, M.F., Russell, G., 2013. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. Int. J. Equity Health 12, 18.

Lovdata. (1999). Lov om pasient- og brukerrettigheter (Law on patient rights).

Malterud, K., 2011. Kvalitative Metoder i Medisinsk forskning; En Innføring (Qualitative Methods in Medical research; an Introduction). Universitetsforlaget AS, Oslo.

Malterud, K., 2012. Systematic text condensation: a strategy for qualitative analysis. Scand. J. Public Health 40, 795–805.

Malterud, K., 2016. Theory and interpretation in qualitative studies from general practice: why and how. Scand. J. Public Health 44, 120–129.

Malterud, K., Siersma, V.D., Guassora, A.D., 2015. Sample size in qualitative interview studies: guided by information power. Qual. Health Res. 26, 1753–1760.

Nerum, H., Halvorsen, L., Sorlie, T., Oian, P., 2006. Maternal request for cesarean section due to fear of birth: can it be changed through crisis-oriented counseling? Birth 33, 221–228.

Nilsson, C., Lundgren, I., 2009. Women's lived experience of fear of childbirth. Midwifery 25, e1–e9.

Norsk Gynekologisk Forening (Norwegian Society for Gynecology and Obstetrics). (2014). Veileder i fødselshjelp. Kapittel 40: keisersnitt (Guideline in obstetric care. Chapter 40: c-section). Norsk Gynekologisk Forening (Norwegian Society for Gynecology and Obstetrics).

Norsk Pasientskadeerstatning (2016) (The Norwegian System of Patient Injury Compensation). Om NPE (About NPE). NPE.

Olieman, R.M., Siemonsma, F., Bartens, M.A., Garthus-Niegel, S., Scheele, F., Honig, A., 2017. The effect of an elective cesarean section on maternal request on peripartum anxiety and depression in women with childbirth fear: a systematic review. BMC Pregnancy Childbirth 17, 195.

Panda, S., Daly, D., Begley, C., Karlstrom, A., Larsson, B., Back, L., et al., 2018. Factors influencing decision-making for caesarean section in Sweden - a qualitative study. BMC Pregnancy Childbirth 18, 377.

Rouhe, H., Salmela-Aro, K., Toivanen, R., Tokola, M., Halmesmaki, E., Ryding, E.L., et al., 2015. Group psychoeducation with relaxation for severe fear of childbirth improves maternal adjustment and childbirth experience–a randomised controlled trial. J. Psychosom. Obstet. Gynaecol. 36, 1–9.

Rouhe, H., Salmela-Aro, K., Toivanen, R., Tokola, M., Halmesmaki, E., Saisto, T., 2013. Obstetric outcome after intervention for severe fear of childbirth in nulliparous women - randomised trial. BJOG 120, 75–84.

Ryding, E.L., Lukasse, M., Kristjansdottir, H., Steingrimsdottir, T., Schei, B.Bidens study group, 2016. Pregnant women's preference for cesarean section and subsequent mode of birth - a six-country cohort study. J. Psychosom. Obstet. Gynaecol. 37, 75–83.

Saisto, T., Salmela-Aro, K., Nurmi, J.E., Kononen, T., Halmesmaki, E., 2001. A randomized controlled trial of intervention in fear of childbirth. Obstet. Gynecol. 98, 820–826.

Saisto, T., Toivanen, R., Salmela-Aro, K., Halmesmaki, E., 2006. Therapeutic group psychoeducation and relaxation in treating fear of childbirth. Acta Obstet. Gynecol. Scand. 85, 1315–1319.

Sandall, J., Soltani, H., Gates, S., Shennan, A., Devane, D., 2016. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database Syst. Rev. 4, CD004667.

Sandall, J., Tribe, R.M., Avery, L., Mola, G., Visser, G.H., Homer, C.S., et al., 2018. Short--term and long-term effects of caesarean section on the health of women and children. Lancet 392, 1349–1357.

Storksen, H.T., Garthus-Niegel, S., Adams, S.S., Vangen, S., Eberhard-Gran, M., 2015. Fear of childbirth and elective caesarean section: a population-based study. BMC Pregnancy Childbirth 15, 221.

Storksen, H.T., Garthus-Niegel, S., Vangen, S., Eberhard-Gran, M., 2013. The impact of previous birth experiences on maternal fear of childbirth. Acta Obstet. Gynecol. Scand. 92, 318–324.

Sydsjo, G., Moller, L., Lilliecreutz, C., Bladh, M., Andolf, E., Josefsson, A., 2015. Psychiatric illness in women requesting caesarean section. BJOG 122, 351–358.

The Norwegian Institute of Public Halth (Folkehelseinstituttet). (2020). The norwegian medical birth registry. The Norwegian Institute of Public Halth (Folkehelseinstituttet).

Wiklund, I., Andolf, E., Lilja, H., Hildingsson, I., 2012. Indications for cesarean section on maternal request–guidelines for counseling and treatment. Sex Reprod. Healthc. 3, 99–106.

Wiklund, I., Edman, G., Andolf, E., 2007. Cesarean section on maternal request: reasons for the request, self-estimated health, expectations, experience of birth and signs of depression among first-time mothers. Acta Obstet. Gynecol. Scand. 86, 451–456.

Wiklund, I., Edman, G., Ryding, E.L., Andolf, E., 2008. Expectation and experiences of childbirth in primiparae with caesarean section. BJOG 115, 324–331.