

**Obstetric professionals' perceptions of cesarean
delivery upon maternal request in Bergen, Norway**

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ABSTRACT

Background: Cesarean delivery rates are increasing worldwide, despite potential evidence of increased medical risk when the procedure is not medically indicated and the negative economic consequences of overtreatment. Greater personal wealth, advanced fetal monitoring, and physician fear of litigation are some of the causes cited for increasing cesarean rates. Cesarean upon maternal request (CDMR) is an additional component – one that is often cited by obstetric professionals, but the rate of occurrence is largely unknown. CDMR requires obstetricians to balance ethical concepts of patient autonomy and beneficence, as well as the implications of increasing hospital and national rates. This project aimed to generate additional information about the experience of obstetric professionals regarding CDMR to supplement the largely normative ethical arguments found in existing literature.

Objectives: To explore obstetric professionals' perceptions of CDMR in Bergen, Norway.

Methods: Eight practicing obstetric professionals in Bergen, Norway were interviewed. The findings were analyzed using thematic analysis.

Results: Resulting analysis found that a confident, self-defined professional identity and a protective workplace culture supported the clinical decision-making process. Additionally, a compassionate perception of women requesting cesarean section and confidence in a normalized birth experience directed patient communication, with the idealized outcome of an empowered, vaginal birth. Informants illustrated a relational understanding of autonomy that attempted to both respect the patients' wishes while maintaining their professional integrity.

LIST OF ABBREVIATIONS

ACOG – *American College of Obstetricians and Gynecologists*

CAQDAS – *computer aided qualitative data analysis software*

CD or **CS** – *cesarean delivery or cesarean section (interchangeable)*

CDMR – *cesarean delivery upon maternal request*

NIH – *National Institute of Health (US)*

NICE – *National Institute for Health and Care Excellence (UK)*

NHS – *National Health System (UK)*

OR – *odds ratio*

REK - *Regional Committee for Medical & Health Research Ethics (Norway)*

GLOSSARY

- Acute or emergency cesarean** – a cesarean section performed after labor has commenced
- Adhesion (surgical)** – the attachment of scarred tissue to the peritoneum
- Assisted vaginal delivery** – a labor requiring the use of vacuum assistance or forceps
- Breech presentation** – a malpresentation in which the buttocks or the feet of the fetus are leading, that is, the portion of the newborn to emerge first
- Cephalopelvic disproportion** – the head of the baby is too large to pass through the pelvis of the woman
- Elective or planned cesarean** – a cesarean section performed before the onset of labor, defined typically >8 hours before labor
- Episiotomy** – an incision in the perineum to facilitate birth
- Hypoxia** – an oxygen deficiency
- Intrapartum** – occurring or provided during labor
- Neonatal** – relating to or affecting the infant during the first 27 days of life
- Perinatal** – relating to or affecting the infant from 22 weeks of gestation to the 7th day following birth
- Placenta previa** – a condition in which the placenta develops over the cervical opening interfering with birth and potentially leading to serious hemorrhage
- Postpartum** – occurring or provided after labor
- Pre-eclampsia** – a serious, progressive condition marked by maternal high blood pressure leading to complications such as kidney damage and seizures
- Macrosomia** – “large body”, here used in reference to a large baby
- Morbidity** – the incidence of disease in a specified population
- Mortality** – the proportion of deaths to the population
- Thromboembolism** – a blood vessel blocked by a portion of a blood clot
-
- Bestemmelse** - determination
- Fylkesmannen** – a division of the county government tasked with supervising and evaluating public services, including health services
- Medbestemmelse** – codetermination
- Norsk Gynekologisk Forening** – Norwegian Gynecological Association
- Norsk pasientskadeerstatning** – Norwegian Patient Injury Compensation
- Pasient- og brukerrettighetsloven** – Norwegian Patient’s Rights Act

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1. INTRODUCTION

Cesarean delivery (CD) has developed from a radical surgery of last resort to a routine procedure occurring at ever-increasing rates worldwide. Its early application before the surgical advances of the 20th century was morally unsound, considered in 1742 by an obstetrician, “Repugnant, not only to all rules of theory or practice, but even of humanity” (2). Cesarean was only rarely applied in the dire phases of a difficult or obstructed labor and resulted in near universal maternal mortality. Harrowing reports of early procedures depict septic, exhausted women with unknown, but likely poor, fetal statuses. Even efforts to save a fetus in instances of maternal demise were unacceptable: “It is, indeed, possible to save a child by the cesarian operation...but what man in his senses would put his character upon this footing” (2).

In 1911 the transverse lower segment procedure, wherein the fibrous lower portion of the uterus is sectioned, was introduced (2). This improvement in technique sought to avoid sectioning the vascular body of the uterus and scarring its musculature. The eventual acceptance of this new procedure shifted obstetricians’ opinions towards surgical interventions during birth. As surgical hygiene and technique improved throughout the 20th century, the procedure has enjoyed a rapid rise to routine – even in instances with questionable medical validation.

Worldwide, cesarean section rates have increased enormously over previous decades, despite potential increased risk associated with the procedure for both the mother and the baby, as well as economic consequences of overtreatment (3-5). More than half the world’s nations experience population-level rates above the debatable WHO recommended rate of 15%, often with large intra-hospital and regional disparities (4). Health system features, such as the capacity for surgical procedures, financing

structure, and composition of health personnel have been identified as important population-level determinants of cesarean rates (6). Additionally, the debate often focuses on the decision-making roles of obstetricians and women, with some obstetricians citing maternal demand as a cause of increasing rates (7). The actual occurrence of cesarean upon maternal request (CDMR) is unknown, but estimates suggest that it is only an indication in 5-8% of cesarean sections, and is more often motivated by significant emotional elements, rather than simple convenience (8-10). Despite its apparently uncommon occurrence, the request of cesarean section was found to be “problematic” to 62% of obstetricians surveyed (11).

1.1 Practicality of normative ethics in clinical decision-making

Ethics is the disciplined study of morality, and in the case of medical care, the obligations that a physician has to his or her patients, to health systems, and to society as professionals (12). The normative ethics of medicine, commonly outlined in four principle concepts: patient autonomy, beneficence, non-maleficence, and justice – hold physicians to a professional code that guides their prominent position in the community (13). Non-medically indicated CD land within an ethical grey area that draws heavily from the principles of autonomy and beneficence. Physicians, practicing in an increasingly non-paternalistic model, must consider the autonomy of the mother to choose, weighing her liberty and agency to act, “...freely in accordance with a self-chosen plan...” (12). Beneficence considers a risk-benefit evaluation weighing the magnitude of harm against the probability of harm. The evidence available regarding the risks of planned cesarean delivery versus a vaginal delivery has provided inconclusive guidance on the whole, but major obstetric organizations advocate vaginal delivery in healthy pregnancies (5, 14, 15). In the context of potentially increased risks, clinicians’ responsibilities to beneficence can conflict with

the patient's autonomy to choose delivery mode. Threats of litigation and economic incentives in many societies add another unfortunate layer to obstetricians' willingness to comply with a CDMR.

Medical ethicists Chervenak and McCullough have approached the topic of CDMR with a professional model that highlights the component of informed consent within patient autonomy as paramount in approaching CDMR with respect. In Chervenak and McCullough's model, complying with a request for cesarean section can be conducted ethically if informed consent is obtained, although the complexity of true informed consent must be respected (13). While the four ethical principles and the prescriptive model provided by Chervenak and McCullough provide some guidance for obstetric practice, clinical decision-making processes is nuanced, idiosyncratic, and prone to human features of error and intuition. The focus on informed decision-making in traditional approaches to autonomy have been criticized for their reductionist understanding of the clinical experience (13). Conflating the arguments surrounding CDMR into whether or not performing the procedure is ethical leads to questions about the practicality of normative ethics in day-to-day clinical practice.

1.2 Problem statement

Obstetric opinions of CDMR have been previously explored in surveys and debates drawing heavily from normative ethical arguments of autonomy (13, 16-20). This literature has attempted to determine the acceptability and morality of granting or refusing a non-medically indicated cesarean section. By directing heavy focus to granting or refusing, however, the data veers towards reductionism that undermines the complex physician-patient relationship. Asking a physician if she would comply

with a cesarean upon maternal request reveals little about the meaning she ascribes to the request, her motivations, or ethical processes that lead to a decision made in good faith.

In light of these considerations, additional qualitative data could better describe the clinical encounter of CDMR. This study aimed to explore obstetric professionals' experiences with CDMR in Bergen, Norway using in-depth interviews. The Norwegian context provided a publicly-funded health system with a protective medico-legal environment. Additionally, the county of Hordaland has maintained one of the lowest cesarean section rates in the country: 13.7% in 2013 (1). These concomitant factors create a unique obstetric setting with little financial or legal motivations to perform non-medically indicated cesarean sections, which could potentially reveal additional challenges or opportunities in approaching this "problematic" clinical experience.

1.2.1 Objectives

- To explore obstetricians' experiences and perceptions of cesarean delivery upon maternal request in Bergen, Norway.

Research questions

- How do obstetricians perceive the ethical principles of patient autonomy and beneficence in cesarean delivery upon maternal request?
- How do obstetricians perceive the risks, benefits, and indications for the two birth modes?
- How do professional conditions and values play a role in determining choices of birth mode?

2. LITERATURE REVIEW

In developing the research question, the review of literature considered the evidence-based context in which obstetric professionals form clinical decisions. The current medical indications and potential risks (and benefits) of cesarean delivery have been explored. It has also considered the clinical guidelines provided by major obstetric organizations regarding requested cesarean deliveries, legal aspects, and previous obstetric opinions provided by debate submissions and survey data.

2.1 Indications for application

A minority of births encounter complications that are indicative of a cesarean delivery. The modern application of the procedure is largely seen as falling along a continuum of medical necessity. On one extreme lies the absolute, life-saving indications for intervention that are, on the whole, non-controversial. Instances of indisputable action include placenta previa, in which the placenta has developed over the cervical opening resulting in potentially fatal maternal hemorrhage during birth. Fetal hypoxia (low blood oxygen) or imminent fetal demise, or cephalopelvic disproportion (the head of the baby is too large to pass through the pelvis of the mother) are also indisputable indications (2).

In the center of the continuum are acceptable instances of application, including previous CD, breech presentation (a position in which the buttocks or the feet of the fetus are leading, that is, the portion of the newborn to emerge first), twin birth, prolonged labor, and fetal distress (2). Some controversies in application exist for these indications, and new evidence can rapidly change the clinical recommendations. For example, following the results of the Term Breech Delivery

Trial, which recommended cesarean delivery for all breech presentations, there were significant decreases in vaginal breech deliveries (as well as perinatal mortality) within eight years of publication (21, 22). Twin births are often cited as an indication for cesarean section, although a review of randomized control trials found no difference between perinatal or maternal outcomes in cesarean or vaginal delivery (23). Previous cesarean delivery is often an indication, as many clinics' policies reflect the century-old maxim, "Once a caesarean, always a caesarean" (24). The primary cesarean section could then potentially affect subsequent pregnancies – creating an echo effect within the population that would maintain higher rates. Repeat cesarean deliveries constitute a varying proportion of cesareans, cited as an indication in 24% of cesareans in Germany and 8.9% in Norway (8, 25).

Of the mentioned indisputable and acceptable indications, the following have been cited as the most common: non-reassuring fetal status (fetal distress), labor arrest disorders (i.e. prolonged labor), multiple gestation (twins), previous cesarean section, breech presentation, suspected macrosomia (large body, here in reference to the baby), and pre-eclampsia (a serious, progressive condition marked by high blood pressure leading to complications such as kidney damage and seizures) in descending order of prevalence (8, 9). These indications accounted for approximately 78% of all cesarean deliveries, although variations in coding practices could lead to misclassifications (8).

A surgical approach in a high-resource setting is considered a conservative, defensive solution to complex birth scenarios. This conservative approach to obstetric practice has developed from the previously mentioned advancements in surgical technique, but also from the physicians' response to expectations for a perfect birth outcome and

reduction of all catastrophic risks. Multiple options for advanced fetal monitoring leaves the parameters of fetal distress to the judgment of the physician, again with the increasing expectation of a perfect outcome.

2.1.1 Elective cesarean versus cesarean upon maternal request

Some confusion has arisen in interpreting the recorded indications for a cesarean section, with elective cesarean deliveries occasionally falsely interpreted as those applied without medical indication (26). Elective cesarean deliveries are commonly defined as cesarean deliveries carried out before the spontaneous onset of labor (27, 28). These cases include *both* medically indicated cesareans (including those indications listed above that could be identified during prenatal screening), or non-medically indicated cesareans. Non-medically indicated cesarean deliveries are often blamed for the increasing cesarean section rate, and are composed of both obstetrician-motivated reasons and maternal indications. Obstetricians practicing in hot medico-legal contexts may be less willing to perform a vaginal delivery with one or more concomitant risk factor involved. The inclusion of private obstetric care in the health system, leading to increased financial compensation for surgical deliveries could also be an unfortunate motivation for some clinicians, as well as desire to control scheduling of patients.

Maternal indications, specifically requested cesarean delivery (CDMR), are a debated topic and are described by Kerr as a marginal indication (2). The phrase “upon maternal request” can indicate a host of soft indicators for electing to have a CD – fear of labor and birth, fear of lower genital tract trauma, perception of safety, uncertainty in scheduling, wishing to have a partner present, or fear of fetal injury during the birthing process (2). The phrase “too posh to push” has infiltrated media

outlets and has potentially shaped the perception of this phenomenon as a concern of celebrity and perhaps created an overestimation of the actual occurrence of CDMR (26). CDMR prevalence is difficult to accurately access, but has been cited as an indication in 5%-8% of cesarean deliveries (8-10).

There have been attempts to explain why women may wish to have a non-medically indicated cesarean. Potential predictors explored in a Norwegian study for the preference of cesarean section included income, education, previous cesarean, assisted fertility use, anxiety and/or depression before pregnancy, fear of birth, and sexual abuse among others. The eventual prediction model argued that those at highest risk for requesting a cesarean section are multiparous women with prior cesarean delivery, a self-described bad birth previous experience, and a high fear of birth (29). An additional Norwegian cohort study found similar results, with fear of childbirth and previous bad experience with childbirth strongly associated with the preference for cesarean delivery (30). These results counter the media-created image of the woman who is concerned about cosmetic changes or convenience and suggest that more complex emotional factors drive the request for the procedure.

2.2 Rising cesarean delivery rates and potential controls

Determining an appropriate population (and thereby facility-level) CD rate has been difficult, and arguably one universal rate does not exist. The minority of births that require surgical intervention should occur consistently, yet the disparity in international CD rates indicates a host of additional motivations at play. In 1985 the WHO attempted to address the varying international CD rates and presented a theoretical 5-15% as the acceptable minimum and maximum rates any region should be experiencing (31). The report was recently revised by reinforcing that 15% is, “not a target to be achieved but rather a

threshold not to be exceeded”, and that rates above 10% improve neither maternal nor neonatal outcomes, but that the priority lies in providing needed cesarean deliveries rather than aiming towards a specific rate (32). The upper threshold has been especially scrutinized, and is not commonly mentioned in literature. Striving towards a universally acceptable rate disregards inevitable variations in obstetric skill and resource availability, for example it can be imagined that an obstetric team without astute assisted vaginal birth abilities would be better served to deliver via cesarean in cases of breech or abnormal lie.

If the 15% upper threshold is respected, however, a shrinking minority of nations is able to maintain it. A 2010 WHO report on CD rates found that of 137 countries included in analysis, approximately 50% reported excessive CD occurrence. When the threshold for over-use was increased to 20%, the excessive CD occurrence drops to 33.5% of analyzed countries. Within the countries reporting higher than recommended CD rates, there are notable extremes; Brazil, China, and the United States together account for 58% of the 6.2 million “unnecessary” CD deliveries in 2008 (4).

However, it is important to consider the usefulness of such national rates. The comparison of one region to another based on a crude rate is a matter of scrutiny. Recognizing that crude rates hold little in terms of meaning, driving forces, or international comparability, the WHO has recently adopted the 10-Group Classification System, or the Robson Classification System (32). This categorization of women based on obstetric characteristics aims to remove confounding factors and create cesarean data that is more comparable across health facilities and nations.

Previous attempts to define the non-medical determinants in increasing/decreasing CD rates identify changes in individual income and amount of publicly funded healthcare as important players. A theoretical model assessing determinants found that doubling the share of publically funded national healthcare could decrease rates an average of 29.8% [9.6%-50.0%] (6). Naturally, a publically funded health care scheme imposes inflexible controls upon overtreatment and would reduce unnecessary procedures, but there are examples of attempted reductions without financial overhauls. Norwegian health authorities recognized an increasing CD rate in the mid-1990s and invited hospitals to participate in the Breakthrough Project in order to better describe cesarean rates and potentially lower the intra-hospital variations (8-16%) in CD delivery rates (33). The Breakthrough working model is based on evaluating factors such as, “ownership of the problem, affection, community, competitive, performance measurement, external pressures and guidance” (33). While the project claimed to have achieved its first objective of better describing the underlying indicators for cesarean delivery in Norway, four years following the project the cesarean delivery rates remained unchanged.

2.3 Cesarean delivery in Norway

Norway's CD rate remains relatively low when compared with nations of similar

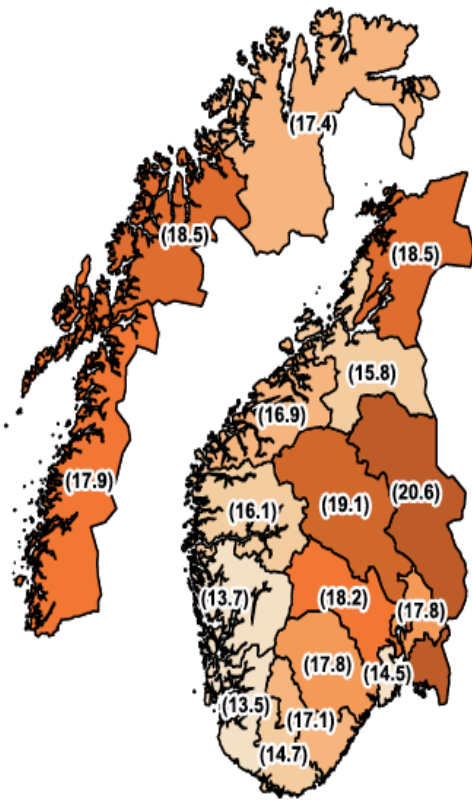


Figure 1: Cesarean rates in Norway 2013 from the Medical Birth Registry (1)

economic development. The crude national rate in 2013 was 16.3%, with considerable variation across the 19 counties (1). The lowest rates were observed in Hordaland and Rogaland (13.7% and 13.5% respectively). Although not as dramatically in other regions of the world, Norway has experienced a similar upwards trend in cesarean delivery rates in recent decades, increasing from 2% in 1967 (the first recorded cases in the Medical Birth Registry) to nearly one fifth of births in some counties (1).

Norway also enjoys a patient compensation scheme that rarely results in individual healthcare workers being held financially responsible for damages in the form of a lawsuit. If a patient wishes to receive financial compensation in the event of damages due to treatment failure that resulted in lost wages, he or she can appeal to the *Norsk pasientskadeerstatning* (Norwegian Patient Injury Compensation) (34). This legal protection, in addition to the support provided to clinicians by the *Pasient- og brukerrettighetsloven* (Norwegian Patient's Rights Act), removes some of the external financial and medico-legal climate factors that have been cited as motivators in obstetric preference for cesarean delivery. Additional information regarding the specific setting of this project will follow in section 3.8 Situating the study site.

2.4 Potential risks, potential benefits, and economic consequences

A review of available evidence weighing the risks and benefits of non-medically indicated cesarean section should be approached with caution. It has been assumed that a cesarean delivery carries an increased risk in maternal morbidity and mortality as compared to a vaginal delivery (35, 36). However, all cesarean deliveries are not comparable, and several distinctions must be considered in comparing the surgical procedure to vaginal delivery. The first that acute and elective cesareans conducted before spontaneous labor carry different risk profiles, with greater risks associated with an intrapartum cesarean delivery (37). The intended mode of delivery is important to consider, as studies that misclassify an intrapartum cesarean delivery could result in additional complications reported within the cesarean group (28).

The planned cesarean section has been shown as acceptable for women, as it is perceived as a low-risk, controllable, and less painful alternative to vaginal birth (38). Medical professionals, however, do not enthusiastically advocate elective cesarean without medical indication as an acceptable alternative (25). The lack of robust data comparing elective cesarean section to vaginal delivery has resulted in hesitation regarding the appropriateness of its application. There have been no randomized controlled trials comparing the outcomes of vaginal birth and non-medically indicated cesarean section in singleton, cephalic births. The failure of a one such trial was attributed to the physicians' reluctance to enroll eligible patients, highlighting the clinicians' uncertainty in exposing participants to perceived risk (39). Obscuring evidence further, the phenomenon of CDMR has not been formally coded or otherwise uniformly recorded in such a manner that would allow review, which is one aim of the introduction of the previous mentioned Robson Classification Model. In the absence of a randomized control trial, current evidence is guided by research

comparing vaginal birth with elective CD, with no respect to whether the CD was planned on the indication of maternal request (14). As previously outlined, an elective CD can occur for a host of medication indications that could have a causal relationship with birth outcomes. Healthy breech and twin trials have been employed as proxy indicators for potential risks of non-medically indicated cesarean delivery (22, 40). The potential risks discussed below have been commonly cited as associated with cesarean delivery.

2.4.1 Maternal

Operative risks

Hemorrhage of $\geq 1000\text{mL}$ was compared in a prospective cohort study of women who planned a cesarean (either upon request or due to breech presentation) or planned a vaginal delivery. No difference was found between the groups, although the authors cite the low validity of measuring obstetric blood loss as a possible factor (28, 41). A population-based cohort study with the power to capture rare outcomes employed hysterectomy resulting from blood loss and transfusion as outcome measures. A hemorrhage leading to hysterectomy was found to be associated with cesarean delivery (adjusted OR 2.1 (1.2-3.8)), as hemorrhage leading to transfusion was found to be associated with vaginal delivery (adjusted OR 0.4 (0.2-0.8)) (36). The association was noted cautiously, however, as the surgical nature of cesarean may cause hysterectomy to be selected as a first-defense against hemorrhage. Additional cohort studies have found a decreased risk of hemorrhage in planned cesarean compared to vaginal deliveries (42, 43).

No significant differences in intraoperative trauma, including lacerations of the bladder, bowel, ureter, were found between planned cesarean and vaginal deliveries

(43). Anesthetic complications were reported to be higher for cesarean delivery (OR 2.3 (2.0-2.6)) (36), however an additional cohort study found no increased risk (44).

Post-operative risks

Infection is a commonly measured adverse outcome, however mixed results on its occurrence have been reported. One large cohort found the risk of infection in elective cesarean to be three-fold higher than that associated with vaginal delivery (36). However, subsequent cohort studies have found no increased risk in either infection nor wound complication to be associated with elective cesarean section (28, 44). This post-operative risk could be reduced by the universal use of prophylactic antibiotics in women undergoing surgical delivery (45).

Surgical adhesions, the attachment of scarred tissue to the peritoneum, are a risk associated singularly with cesarean delivery. It is a leading cause of secondary infertility, intestinal obstruction, and post-operative pain in women, and its risk of occurrence increases with each additional cesarean section (46). A review of adhesion examinations in repeat cesarean deliveries found that nearly half of the cases presented with adhesions of any grade (47). Additionally, 5.7% of women undergoing an abdominal surgery on the uterus were readmitted for additional surgery attributed to adhesion repair (46).

Thromboembolic risks, specifically pulmonary embolism with maternal demise, are incredibly rare events. A review of 1.4 million births in the U.S. identified 7 cases of maternal death due to pulmonary embolism occurring post-cesarean from 2000-2006, a number reduced to a single case from 2007-2013 following implementation of post-surgical compression devices (48). Additionally, the risk of deep vein

thrombosis is not limited to cesarean delivery, but has also been reported in vaginal delivery and is a general risk for sedentary patients (44).

Increased hospital stay appears to be a commonly observed risk factor for cesarean delivery. The length of stay is approximately 1.5 days longer for cesarean deliveries versus vaginal deliveries (28, 36).

Implications for future pregnancies

Uterine rupture is a concern for future pregnancies following primary cesarean section. The risk of uterine rupture during a trial of labor does increase with each subsequent cesarean section, especially for induced labor (49). Although rare, its occurrence is a life-threatening emergency for both the mother and the child. Some clinicians and health facilities avoid this catastrophic outcome by refusing a vaginal trial of labor after a primary cesarean section, but an automatic repeat cesarean is not always necessary (25). In instances where additional pregnancies are expected or planned, however, the increased risk of uterine rupture are sufficient to recommend a cautious approach to a non-medically indicated primary cesarean delivery (3).

Infertility following a cesarean delivery due to tubal injury, adhesions, or emotional factors surrounding the delivery has been cited as a concern. Results from population-based cohort study showed an increased risk of post-cesarean infertility (OR 0.91 (0.87-0.95)) as well as an increased median time to next pregnancy (50). However, the causal relationship of cesarean delivery in these results is suspect. It is crucial to consider the fertility of a woman before pregnancy, as both assisted fertility technology and increasing age of first pregnancy have been noted as risk factors for cesarean delivery. Subsequent infertility would then not be due to the cesarean

delivery, but rather already existing maternal factors. An additional cohort study that did consider self-reported fertility pre-pregnancy found neither increased risk between cesarean section and subsequent infertility nor a difference in time to next pregnancy (51).

Possible medical benefits from non-medically indicated CD

Although there are a host of potential risks associated with cesarean delivery, some perceived benefits have been cited. By the nature of the procedure, perineal and cervical tears are largely avoided (44). Reduced perineal pain has also been reported, but in exchange for increased abdominal pain (5). The procedure is perceived by some to protect against urinary and fecal incontinence. However, the protective nature of cesarean against urinary incontinence is not well-supported (25). A review of evidence found no association between reduced fecal incontinence and cesarean delivery (52). Additionally, there were no differences found in self-reported sexual satisfaction at 6, 12, and 24 weeks post-delivery in women who delivered vaginally with and without episiotomy, instrumental vaginal delivery, elective cesarean, or emergency cesarean (53).

2.4.2 Neonatal

Acute risks

A study comparing planned route of delivery found that neonates delivered via planned cesarean section had a greater risk of NICU admission and respiratory morbidity requiring resuscitation (OR 0.42 (0.27-0.65) and 0.41 (0.24-0.71) respectively) (54). Respiratory difficulties in neonates become especially pronounced in those delivered before 39 weeks, and have lead obstetric organizations to advise against elective cesareans before this point in gestation. An additional cohort study

did not find an association with respiratory morbidity and cesarean delivery specifically, but an association with “any life-threatening complication” for the neonate was found at OR 0.34 (0.12-0.97) (44). Laceration in neonates is also an increased risk associated with cesarean delivery, being the most commonly cited birth injury in cesarean delivery (55). This injury was relatively rare, however, reported in just 0.7% of cases (55).

Long-term risks

Conditions such as diabetes mellitus, asthma, autism, and increased allergies have been explored as possible long-term risks for children born via cesarean section. However, the available evidence has not found a conclusive association (25).

Possible benefits

As the procedure allows the neonate to bypass the birth canal, conditions of obstructed labor (e.g. shoulder dystocia) are largely avoided. Traumatic birth injuries such as brachial plexis and fractures are also reduced via cesarean delivery, although still reported (55). The passage of meconium (and subsequent aspiration) could also be reduced by a cesarean delivery (54).

2.4.3 Economic consequences

Beyond the possible medical risks of CD, the increasing rates worldwide highlight economic disparities. In general terms, under- and overtreatment harm patients and erode the aim of universal coverage by poorly distributing available resources. A 2010 WHO Health Systems Report estimated costs associated with excessive cesarean deliveries at 2.32 billion USD, while costs associated with unmet CD needs were estimated at 432 million USD (4). The aforementioned unequal distribution of

resources is starkly visible when considering the disparity between hospitals in regions that serve the same geographic area, and, in fact, a facility-level comparison of rates (public versus private) can better clarify inequities than population-level comparison.

In absolute terms a cesarean delivery is simply more costly and resource-demanding than a vaginal delivery (56).

2.4.4 Summary of risks and benefits

Despite being one of the most commonly applied surgical procedures worldwide, the available evidence has not supported a conclusive consensus on whether or not a planned cesarean delivery carries significantly more risks than a vaginal delivery for either the mother or the neonate. In addition to potential medical risks, excessive use of the procedure has economic considerations.

2.5 Clinical recommendations and the law

In an attempt to provide guidance to evidence-based practice for obstetric professionals, available literature has been compiled and reviewed by various major organizations. The National Institute of Health (NIH), following three-day conference in which eighteen health professionals reviewed available evidence released a consensus statement that faulted the available evidence as insufficient in determining the risks of elective cesarean delivery when compared to vaginal delivery. In the instance of CDMR, the committee recommended that, “Until quality evidence becomes available, any decision to perform a cesarean delivery on maternal request should be carefully individualized and consistent with ethical principles”(3).

The most recent committee opinion from the American College of Obstetricians and Gynecologists (ACOG) drew heavily from the 2006 NIH conference conclusions and recommended that a plan for vaginal delivery is safe and appropriate. However, it also included provisions for CDMR to ensure the safest possible outcome in the light of current evidence. The process for selecting appropriate CDMR cases is not addressed, nor are any clinical practice recommendations in regards to directional counseling, i.e. encouraging a vaginal delivery (14).

The National Institute for Health and Clinical Evidence (NICE), an executive body within the UK National Health System (NHS) tasked with evaluating and guiding practices within the NHS, published its cesarean guidelines in 2011. The department determined a similar lack of sufficient evidence to recommend either delivery route. The guideline states that physicians encountering CDMR should explore the reasons behind the request, provide an overview of risks and benefits of delivery routes, and refer the patient to a professional providing perinatal mental health support. If the woman, following these recommendations, continues to request a cesarean, she must be provided with the procedure. If a physician cannot respect this request, he or she must refer the woman to a willing colleague (5).

In its most recent publication on birth guidelines, the *Norsk Gynekologisk Forening* (The Norwegian Gynecological Association) used the NICE and ACOG findings, as well as additional evidence to recommend against a cesarean on pure maternal request in the absence of medical indications. The association further states that directional counseling be offered within the maternity wards, and that a vaginal birth plan is preferable to a planned cesarean section. Taking a stronger stance than either

NICE or ACOG, however, the final decision on birth route in Norway lies with the physician, not the patient (15).

This position is supported by *Pasient- og brukerrettighetsloven* (Norwegian Patient's Rights Act), which states that, "The patient is entitled to participate in the implementation of his or her health care. This includes the patient's right to participate in choosing between available and medically sound methods of examination and treatment" (57). The patient's rights in decision-making extend to *medbestemmelse* (codetermination), not *bestemmelse* (determination), which provides a unique legal support to physicians' clinical practices. The extent to which the patient's values are considered is unclear and rests within individual consultations, but the law supports the physician's eventual decision over a patient's preference.

2.6 Opinions of obstetric professionals

CDMR is a highly discussed topic in obstetrics. To summarize the two positions in an arguably oversimplified manner, in other words, to explore the opinions of those clinicians who comply with the request and those who do not, is unfortunately a result of the available evidence on the topic. In a 2015 debate submission to the *British Journal of Obstetrics and Gynecology*, Dr. Robert Silver argued against CDMR with the support of available evidence. He states the justifications for CDMR as similar to those that justify the performance of cosmetic surgery, but that in the case of cosmetic surgery there is, "...a clear perceived benefit", and that the risks of cesarean for both mother and child are too great to comply with a non-medically indicated request (17). His position appears heavily clinical, supported by risk ratios rather than theoretical ethical frameworks. The opponent submission, from medical ethicists Chervenak and McCullough, argues for CDMR within the ethical

framework of the previously mentioned professional responsibility model. Within this model, the rights of both the mother and fetus are balanced (to the extent that fetus rights can be reasonably considered), and in the case of CDMR directive counseling (for a vaginal delivery) should be carefully attempted and an eventual cesarean delivery offered if necessary (16). Both authors of the opponent submission cite negative evidence and reviews with insufficient findings to support their beliefs of the possibility of an ethical non-medical cesarean delivery.

Within this journal debate, in a matter of words, the issue straddles the medical ethicists who attempt to define rights in a non-reductionist manner, and the physicians who are ultimately performing the procedure and who potentially will be held responsible professionally, personally, and perhaps financially, for the outcome.

Additional literature on the opinions and experiences of obstetric professionals on CDMR have used national and conference surveys to expose elements of the phenomenon. Surveys assessing the obstetric perception of CDMR are largely focused on the physicians' personal experience with the procedure and their opinions of a woman's right to decide. A national obstetric survey performed in Denmark found that 37% were willing to perform a CDMR, although just over 1% would chose the procedure for themselves or a partner (18). An Israeli survey found similar disparities, with 46% willing to perform, yet only 9% willing to undergo (19). These findings suggest a prioritization of patient autonomy over best-perceived care. A survey performed in Turkey, a nation with a 37% cesarean rate, found differing experiences, with 53% willing to perform and more than 60% reporting that they themselves had actually undergone a cesarean delivery (20). The main reason cited that nearly two-thirds of obstetricians had personal experience (either a partner or themselves) was the avoidance of potential perineal trauma. These results suggest a differing standard

of care for the physicians and the patients they are treating, with cesarean actually preferred.

A Norwegian study found that 62% of responding physicians found CDMR to be problematic to their practices, and approximately half of obstetricians would comply with a CDMR (11). Interestingly, the Norwegian survey also considered a financial component, specifically asking if there should be an economic consequence for CDMR in the form of a co-pay. A significant portion (40%) were in favor of a co-pay, presumably to introduce a financial control mechanism to de-incentivize requests for the procedure (11).

These national and conference surveys suggest vast contextual differences in biomedical interventions; clearly the culture, legal climate, financing structure, or additional factors render the situations incomparable. Additionally, surveys as a method perhaps do not sufficiently explore social, cultural, or personal elements as much as potentially expose them. These results also create an unfortunate oversimplification of the clinical situation, in which a woman requesting a cesarean brings with her a host of emotional and experiential factors, as well as borderline medical indications (such as breech presentation). Survey results also appear to divide clinicians into yes-doctors and no-doctors, without sufficiently identifying motivations, fears, or context in which they practice. This simplistic division of obstetricians into yes-doctors and no-doctors is an example of rights-based reductionism that the previous discussed professional responsibility model of obstetric ethics seeks to avoid (13).

Qualitative results could afford more nuances to the clinical experience of CDMR. One such study performed in Iran identified many professional motivations of complying with a request for cesarean: ease of application, frustration with the nuances of vaginal delivery,

and clinical norms (58). In addition, the Iranian study identified a unique socio-cultural theme of patient gratitude whereby the mother and family expressed increased quality of care following cesarean delivery when compared to support through a lengthy labor and vaginal delivery. The obstetricians expressed greater professional respect, with one reporting, “The patient and her family are more respectful after caesarean. They feel you have done some valuable thing for them. I don’t know why. When you have a normal delivery, there is no such gratefulness. It is hurtful because normal delivery takes a long time” (58).

A similar study employing focus group discussions among Swedish obstetricians and midwives identified changing maternal demographics as a key player in CDMR. The professionals perceived the mothers to be likely older, independent, and desire control over the birth process. The professionals interviewed also indicated that better postpartum follow-up to identify traumatic birth experiences (thereby proactively addressing the potential for a second birth to occur via CD) and better psychological preparation for vaginal birth as possible measures to reduce unnecessary cesarean deliveries (59).

Patient autonomy was highlighted in a Norwegian narrative study concerning women who opted for CD but eventually delivered vaginally due to physician direction (60). The resulting interviews revealed women who felt discredited and uninvolved from the decision-making process of their healthcare professionals. As previously mentioned, a bad birth experience was found to be strongly associated with a request for cesarean in subsequent pregnancies.

The experience of CDMR in clinical practice has been presented as complex and emotional, requiring additional professional aptitudes far beyond performing the procedure.

Professional opinions regarding the procedure are mixed, and previously performed surveys do not sufficiently address the motivations and experiences of obstetric professionals. Additional qualitative findings regarding the perceptions of cesarean section amongst obstetricians could serve to illuminate the clinical experience of CDMR and decision-making processes in patient care.

3. METHODOLOGY

3.1 Research Design

The study employed a qualitative design with interview data collected from purposively selected informants and external documents providing additional contextual insights. The data was thematically analyzed using a realist approach.

3.2 Participant Selection

Through an initial contact with reception at the obstetric department at Haukeland University Hospital, I determined roles of the healthcare providers employed by the clinic. I simultaneously listed potential informants by identifying those clinicians who had publically expressed opinions about this topic previously, either in newspaper articles or professional publications. The eventual goal was to purposively select initial informants and continue a chain selection of subsequent informants. I therefore used two points of access, as I feared that a single chain selection of informants would lead to contacting only those colleagues with similar attitudes or practices. The first access point was through leadership, the second through the media-friendly clinicians. From these access points, the informants recommended additional contacts with relevant colleagues.

Potential informants were contacted by email, in which I briefly explained the aims of the study and what participation involved. All informants required several follow-up emails, but the difficulty of scheduling one-hour interviews with practicing physicians was to be anticipated. Once some interviews had been conducted, however, mentioning that peers had already participated helped to secure additional appointments.

The selection of informants was adjusted throughout data collection as new contextual information emerged. I found that clinicians willing to participate were highly experienced, mid-career professionals. This proved helpful for discussing trends and the development of the clinic's practices. However, it became clear that clinicians beginning their careers could provide fresher insight to the difficulties of patient communication, although junior doctors cannot autonomously agree to a cesarean. Additionally, consulting midwives were approached and included in a later stage of collection. Informants also disclosed that private practitioners (general practitioners and psychologists) in the region played an important role in shaping a women's attitudes regarding birth mode. Those who mentioned the influence of private practitioners, however, were hesitant to provide contact information for specific clinics, expressing that the professional relationship between the practitioners and the clinic was not a positive one. I subsequently contacted private gynecological clinics, general practice clinics who staffed midwives, and privately practicing midwives in the region, but with no response.

3.3 Description of Participants

Six obstetricians and two midwives agreed to participate. All informants were career-long public practitioners in Norway, except one obstetrician who had first practiced some years as a private general practitioner. Their years of experience ranged from 6 to 36 years as obstetric professionals. One of the informants had had personal experience with cesarean section. Direct quotes from the participants are differentiated in the findings chapter by years of experience. Two of the participants had fifteen years of experience, therefore they are differentiated by the titles Obstetrician A and Obstetrician B.

3.4 Interviews as a research instrument

The initial interview guide was developed and reviewed with the help of two clinicians (neither practicing in Norway) prior to beginning data collection. However, the guide was adjusted following the first interviews as the local context became clearer. The final version of the interview guide is included (Appendix B).

As a research tool, the guide proved to be helpful for the first interviews. Once the context, protocols, and recent history of the clinic were established, however, the interviews took a more semi-structured form. The guide then ensured that I addressed the main points and that the interview took a logical progression.

3.5 Data Collection

I conducted the interviews from October 2015 – February 2016 in Bergen, Norway. Participants who expressed interest in the project provided one-hour appointments at their private offices for the meetings. All of the offices had closed doors, but three of the interviews were interrupted by clinical pages and follow-up phone calls. The interruptions did not appear to influence the interviews, as the participants continued consistently with the previous questions.

All but one of the interviews were audio recorded following a short introduction and written consent. The refusal on the basis of insecurity with English rather than concerns about confidentiality. The use of English did not appear to excessively burden the remaining participants. Participants were encouraged to simply use any Norwegian phrases that they found difficult to translate, in addition to using the appropriate terms for local governing bodies or laws for clarity (e.g. *Fylkesmannen*

rather than county governor or health authority). Extensive notes were taken and expanded immediately following the unrecorded interview. Recorded interviews and notes were transcribed within days by the researcher. Any unfamiliar Norwegian phrases were checked with native speakers.

In addition to an emergent selection of participants, the project entertained a flexible data collection technique, as informants led me to additional documents that became relevant to understand the context in which they work. These articles, reports, and patient communication tools exist as naturally occurring data. Collection of naturally occurring data, a term used by David Silverman to describe data that exists without being created by a researcher (e.g. newspaper articles, meeting notes, marketing documents, advertisements, etc.), took place concurrently with the collection of interview data (61).

Included in the analysis is an external audit of the department from March 2013 performed by the Fylkesmannen (a division of the county government tasked with supervising and evaluating public services, including health services), as well as a follow-up report. Articles about the clinic published in the local newspaper in recent years, as well as opinion editorials authored by medical professionals were considered.

3.6 Data Analysis

After considering the aims of the project, my position as a student researcher, and reviewing the major analytic traditions, I found that thematic analysis methods as outlined by Braun and Clarke provided the best functionality and potential for flexibility (62). The process of thematizing data according to reoccurring patterns

across a data set is a common thread throughout many analytic methods. However, positioning thematic analysis as a method in its own right (as Braun and Clarke have argued) provides the novice researcher with a practical analytical tool that is divorced from presupposed theoretical and epistemological foundations.

This method does not excuse the researcher from establishing the theoretical assumptions upon which the thematic analysis was performed, rather it provides the opportunity for critical reflection regarding each decision reached during analysis. Transparency and exposition of analytical methods in qualitative research is essential in attempts to maintain credibility, and in the spirit of Braun and Clarke's argument of an active researcher who must acknowledge analytical decisions as such – choices made by an individual – the following outlines the theoretical assumptions and analysis procedure that I applied to the data.

Accepting an ontological realism with an epistemological relativist view is a stance posited as common sense, or even implicit, within social sciences and qualitative research (63). This view acknowledges that entities and objects exist separate of our perceptions (or that a true world exists regardless of our ability or inability to observe it), yet our experiences and values are equally significant as they represent our attempts to understand this real world (63). An important common feature of realism in its many forms is its rejection of a singular, objective truth due to the assumed fallibility of knowledge. This view respects the possibility of multiple realities through expressed experiences, which supports the aims of qualitative research. Inclusion of naturally occurring data, including quantitative data on the clinic, did not serve to illustrate a 'Truth' to which the informants' understandings were compared, but rather to explore alternate explanations of their responses.

Braun and Clarke also mandate that researchers position their analysis approach of the text along the epistemological spectrum between constructivism and essentialism, I have followed the realist approach that is often implicitly accepted in qualitative research, as this paradigm assumes that the language used is capable of expressing experience accurately (62).

An additional question to be addressed during analysis is from which direction the data will be approached – inductively or deductively. A deductive approach searches from the “top-down” for predetermined themes derived from the research question, or from a theory. Coding schemes are structured before analysis and applied to the data. An inductive approach, or data-driven approach, allows the researcher to develop codes from the data itself. I have applied a largely data-driven approach to my analysis to avoid narrowing the data into oversimplified themes, although the research questions served to inform a loose structure.

The level at which data is analyzed must also be considered. A researcher may approach the data either at an explicit level or a latent level of analysis. An explicit level considers what the informant has said to directly develop themes, whereas latent analysis seeks to uncover ideas and assumptions beyond the words the informant has used (62). As the previously adopted realist approach accepts the language as accurate expression of experience, I’ve employed an explicit level analysis.

This form of thematic analysis, with a realist approach and an explicit level analysis, proceeds from a descriptive summarization of data into themes to an interpretive

discussion about connections and interactions between these themes. It does not fulfil a further commitment to developing theories or theorizing beyond the data at point at which themes are created, a feature of more constructivist analyses (62).

The six-phase thematic analysis process outlined by Braun and Clarke provided a semi-systematic guideline with some adjustments as noted. These phases were not approached as clearly defined, chronological achievements; it was typical to return to previous phases and to ‘jump’ to later phases as the iterative process of returning to the data revealed holes, seemingly forced categories, and inadequate representation.

Phase 1: Getting acquainted with the data

Verbatim transcription of the recorded interviews took place within days following each meeting. Personally transcribing the interview data proved to be a valuable foray into analysis, as I would argue that transcription is not simply an automated processing of audio data into written data, but an interpretive activity. Active choices regarding punctuation and style, the inclusion of inflections, and physical motions that occurred during the interviews profoundly affected the final raw transcripts. For example, the following response was initially transcribed as, “Of course, to be given a warning that you are a bad doctor, or you're not doing your job well. Or your license, that's...” Upon rereading and returning the audio recording, I rewrote the transcription to better reflect the response, “ – of course, to be given a warning that you are a *bad* doctor, or you're not doing your job well, or...your license...[sigh]...that's...[trailing].” Returning to the audio recordings throughout the analysis was essential in retaining the expressions of each interview.

Following transcription, each interview was printed onto hardcopies and manually sifted for initial impressions. This was an opportunity for pre-coding, as described by Saldaña as identifying, “rich or significant participant quotes or passages that strike you” (64). Any potential categories or themes of interest could also be noted and acknowledged during pre-coding.

Phase 2: Generating codes

The process of pre-coding assisted the transition into applying first cycle codes. Heeding Saldaña’s advice to novice researchers, I coded the transcripts manually and extensively using both descriptive and In Vivo codes (64). Descriptive codes are a basic type of code that summarizes the topic (not the content) of a meaning unit. In Vivo codes use short quotes pulled directly from the data to capture the voice of the participant in particularly salient meaning units. For second cycle coding, I moved the transcripts into NVIVO, a CAQDAS (computer assisted qualitative data analysis software) to better facilitate the collation process. The first cycle codes were condensed and revised into a final list of 45 descriptive codes. The table below provides a small overview of code development from excerpted data (table 1).

Text excerpt	Pre-coding	Codes	Eventual (sub)category
“[...] we also have to discuss all the time in our clinic. Should we do breech deliveries, for instance? Should we do twins in this way? We always have to look at our own results, all the time. It's not like we have a perfect solution. If we get more complications then we really have to think what are we doing?”	“we” department communication indications for CD breech twins self-reflection humility flexibility	<i>plenum</i> <i>department policy</i>	<i>Operating within a clinic, operating within a community: Clinic culture</i>
“I’ve been contacted by the midwives to come and talk to them [patients who had recently given birth], because they were frightened, and they think that this was something that was more serious than it was. It wasn’t serious at all, but they thought that it was.”	teamwork referral fear perception of women medicalization of birth misconception/perception	<i>perceptions of birth</i>	<i>Normalizing the birth experience: The ideal birth</i>

Table 1: Development of codes from excerpted text

Phase 3: Collating into categories and searching for themes

Although Braun and Clarke’s analysis procedure suggests collating codes followed by an immediate search for potential themes, I found the intermediary step of creating categories helpful in determining the effectiveness of my coding techniques. Similar codes were compiled into categories that were compared against the data. Categories were largely determined over data items, or individual interviews, then subsequently compared to the data set to determine how substantially (or unsubstantially) the potential categories were supported. This phase considered the iterative process of comparison, re-coding, and compiling data extracts of each category.

Phase 4: Reviewing the themes

After the categories were defined, several potential themes had become clear. Keeping in mind Braun and Clarke's definition of a theme as, "...a patterned response or meaning across the data set," I tested the themes against the whole data set considering the appearance of its component categories in NVIVO, however a 'percent representativeness' or another numerical measure was not strictly observed.

A thematic structure that I found myself quite attached to – the various roles that physicians play – fell apart as I tested it against the data. It was a clear exercise in how a 'clean' and imposed thematic structure, while very attractive in imagining how easily the results could be reported, does not originate from the data itself. This phase of analysis was most defined by throwing out all preliminary themes and returning to basic questions. What is really going on here? Why was it important that the informant said this? How would this be different in a different context? Stepping back and answering these questions was very helpful in shaping the eventual thematic structure.

The use of mapping also proved helpful in developing a structure to be compared to the data. Below is the final thematic mind-map that guided the definition of four themes with their associated sub-themes.

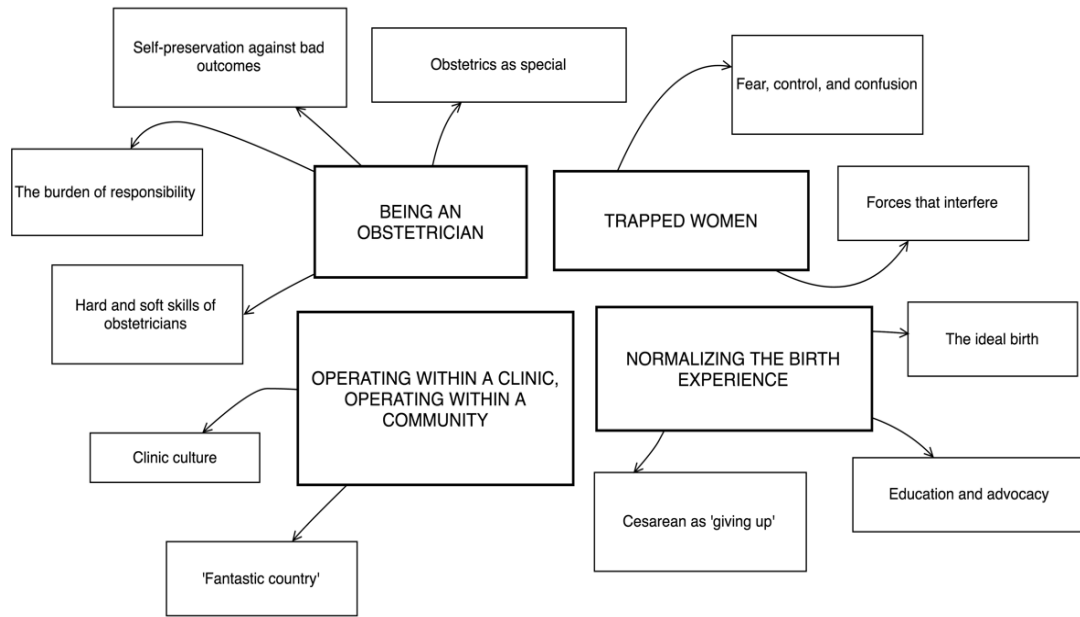


Figure 2: Mind-map of final themes and sub-themes

Phases 5-6: Defining and describing the themes

The final two phases of Braun and Clarke’s are here condensed, as the sixth phase is performed in the write-up of the findings. The fifth phase serves as the final definition and naming of the themes. During this phase I was guided by Braun and Clarke’s advice to not only define what the themes are (preferably within a couple of sentences), but to also determine what they are not. I would further describe this process as finding the edges of each theme, as well as their core features.

During the write-up of the findings, I initially structured the themes and sub-themes exclusively with quotes from the data. This allowed the subsequent descriptions of each theme to be driven by the data itself, rather than selecting the most supportive and anecdotal quotes, to the exclusion of negative cases and conflicting responses.

3.7 Ethical Considerations

The study protocol was submitted to the Regional Committee for Medical & Health Research Ethics (REK) and a decision was received following the June 11th, 2015 meeting. The committee relayed that, “The Regional Committee for Medical & Health Research Ethics, Section C, South East Norway, found the Research Project to be outside the remit of the Act on Medical and Health Research (2008) and therefore can be implemented without its approval” (Appendix C). Written consent was obtained from participants following a discussion of the project’s aims and the goal of anonymous recorded interviews (Appendix A). One participant declined to be recorded for reasons outlined above in data collection section.

Due to the small participant pool and the identifiable context, careful consideration to anonymity was given. The interview guide was designed to collect impressions, experiences, and ideas. No directly identifiable data (e.g. name, age, contact information) was collected on the interview guide nor within the recorded data. Care was taken to avoid indirectly identifiable data appearing in the recorded interview (e.g. facility name, names of colleagues). The participants found this agreeable and largely maintained anonymity. Transcripts and recordings were maintained on password-protected devices.

3.8 Situating the study site

The following interview data are best presented following an overview of the background and recent developments of the clinic studied. The obstetrics unit at Haukeland University Hospital is one of two available to women residing in the area served by Helse Bergen. The clinic experiences approximately 5 000 births annually (5 138 reported in 2014), which represents 1/12 of the approximately 59 000 (59

182 reported in 2014) total annual births in Norway (1). Nationally, the neonatal mortality, defined as death within the first 27 days of birth, stood at 1,8/1000 in 2014. Haukeland reported a rate of 3,7 in the same period, however comparison to similarly sized obstetric facilities reveals facility variation from 2009-2014 (figure 4) (1).

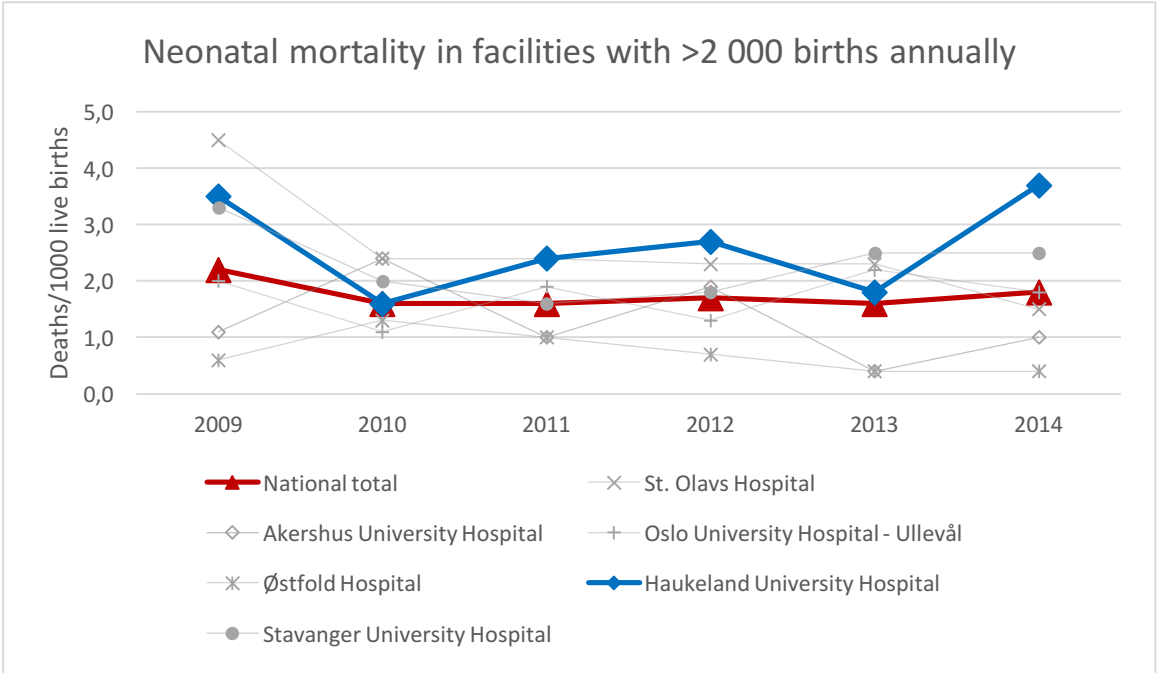


Figure 3: Neonatal mortality in facilities with >2000 births annually (1)

Haukeland University Hospital also reported consistently lower cesarean section rates than the national average. The difference appears most notably in the fewer number of planned procedures at Haukeland (figure 3).

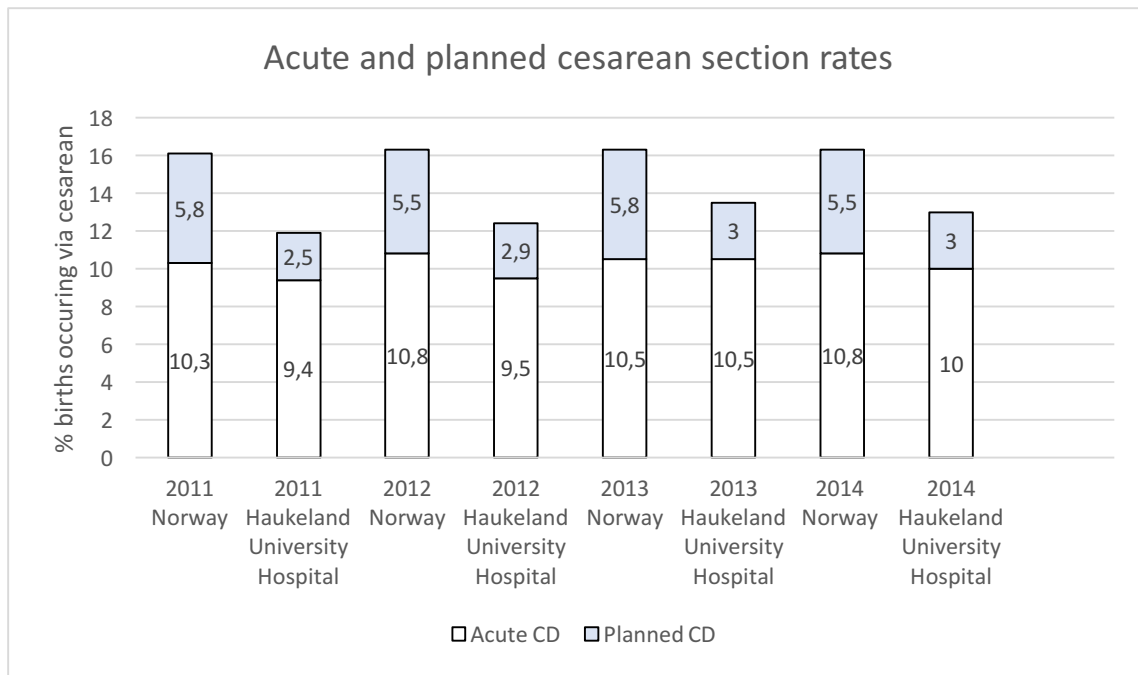


Figure 4: Acute and planned cesarean sections conducted nationally and at Haukeland University Hospital from 2011-2014 (1)

Following a series of patient complaints, an external audit of the obstetric unit at Haukeland was conducted in March 2013 by Fylkesmannen i Hordaland, a division of the county government tasked with supervising and evaluating public services, including health services (65). Their review considered clinic statistics on neonatal mortality, cesarean section, applications of assisted birth techniques, correspondences with the department, and a review of twenty cases from 2010-2011. In terms of neonatal mortality and perinatal mortality, the reviewers found that Haukeland, “does not stand out in a way that causes concern.” The audit found a nearly five-fold greater application of forceps at Haukeland, expressing concern about increased perineal tears, but also acknowledging that the clinic, “has a long tradition and high competence for redeeming births using forceps.” The reported cites the usage of vacuum extraction and forceps as an important and continuing discussion in the field of obstetrics.

Despite a largely acceptable review of the outcome data on the clinic, the audit cited five points of deviation that could reduce patient safety, with three of the points specifically mentioning either patient participation in birth choice or the cesarean section behavior of the clinic:

- 1. Management has not adequately ensured that women are allowed to participate in choices about their births.*
- 2. Management has not adequately considered the critical viewpoints expressed by their own employees, especially when it comes to the threshold for performing cesarean.*
- 3. Management does not always follow professional guidelines regarding cesarean section. The threshold for intervention during birth has been too high in several cases.*
- 4. Follow-up in individual cases are not addressed in a trustworthy manner. It appears that there is resistance within the leadership to acknowledging failures and making necessary adjustments.*
- 5. Management has failed to use statistics, serious incident reports, feedback from authorities and national guidelines to analyze and adjust their operations so that patient safety is ensured in a satisfactory manner.*

The audit was released in the midst of a series of articles in the local newspaper, Bergens Tidende, discussing the obstetric clinic. Bergens Tidende is reported to have the largest readership share of local news in Hordaland, and between late 2012 and 2015 I have identified numerous articles that directly report on the clinic, profiles of families who had negative birth outcomes, and defensive opinion editorials (66).

The first case narrative from 2012 draws on a patient birth experience that resulted in an intensive care stay for the newborn, with accusations of cesarean delay (67). The same case was again addressed in 2014, reporting a ‘mild punishment’ for the attending obstetrician and providing details on the child’s continued struggle with

birth injuries (68). In 2013 the case of a stillbirth in an overdue pregnancy grabbed attention with the headline, “Babydød fikk KK til å endre regler” (Stillbirth got the obstetric clinic to change rules), although leadership from the clinic explained that the case had actually led to a clarification of already standing policies (69). An additional case in 2014 describes a couple’s ‘shock’ after a prenatal appointment revealed low amniotic levels, but the mother ultimately carried the baby to 27 weeks. The article, “Birk er sta. Han valgte å leve” (Birk is stubborn. He chose to live), details the medical care in passive voice, with the clinic’s representation quoted in a later article that offering the couple the option of terminating the pregnancy followed clinic procedure (70, 71). These cases are driven by the patient narratives, with healthcare workers (if quoted at all) relegated to explaining policy.

Several articles in this time period also discuss financial strains at the clinic and closures, with midwives voicing particular concern about staffing, and one article suggesting the nearby clinic in Voss as a viable alternative (72-78). Allegations of the clinic ‘cheating’ on coding practices for financial gain (over-reporting the number of newborns with malabsorption of nutrients) came in 2014 (79). A burglary at the clinic, as well as the arrest of a father threatening healthcare workers (demanding a cesarean section for his laboring wife, no less) followed (80, 81).

Beyond the newspaper’s annual features of New Year’s babies, positive profiles of the clinic do appear in the form of opinion editorials. “En annen historie fra KK” (Another story from the obstetric clinic) was submitted by a mother who had experienced a good birth at the clinic, despite “...an extra sense of concern in the days before birth” due to the public criticism (82). Both a medical student and a practicing obstetrician published their opinions that the newspaper “scares women” and that

the reports on the clinic are “simplified” and fail to illustrate the range of the services and world-class treatment that the clinic provides (83, 84).

Articles about the obstetric clinic continued to be published throughout data collection for this project. As recently as February 2016, Fylkesmannen i Hordaland opened a new audit concerning inadequate staffing procedures (85). The 2013 audit, as well as media attention profoundly affected the informants’ responses, and the following interview findings would be incomplete without considering the recent context in which they were obtained.

4. FINDINGS

Within the interview data I identified four main themes: *Being an obstetrician*, *Operating within a clinic*, *operating within a community*, *Trapped women*, and *Normalizing the birth experience*. These themes and associated sub-themes are supported by quotes that have been edited for content.

4.1 BEING AN OBSTETRICIAN

In exploring their encounters with CDMR, the informants returned to core features and values of obstetrics, anchoring their practices and beliefs within an honored profession – described as a unique field within medicine. ‘*Being an obstetrician*’ expresses not only the difficulties in discussing birth modes with patients, but the overall challenges and meanings they ascribed to their daily practice and their identities as professionals. Practical abilities, self-awareness and the need for constant personal reflection upon practices were the foundations upon which patient care could move forward, and the sources of confirmation that a clinical decision was made in good faith, with direct and honest patient communication.

4.1.1 Obstetrics as special

Informants identified obstetrics as a special part of medicine, different from other medical fields, with additional challenges and directives. Obstetrics was seen as an assistive practice with unknowable outcomes, as one that brings a natural process to a healthy conclusion with the potential of a very positive outcome for the patient. Their role in the labor process was not posited as crucial or necessary in absolute terms, but rather as an observer or an assistant.

“Yes, it is special in the way that it is healthy. It is doing something natural. If you have a broken leg then you are not healthy. We are working with the future, and this is special.”

Obstetrician, 36 years of experience

“In other fields of medicine, the way we are doing things are much more –the same, we do the same things when it comes to surgeries. Appendicitis. I don't think there are so many – controversies about what to do. But, when it comes to cesarean sections and labor and women, there are huge controversies. This is not about medicine.”

Obstetrician A, 15 years of experience

“We are still very fond of this work. It is an enormous pleasure. That is a tremendous gift to be so close to a woman in the most perfect moment in her life. It is challenging. If you reflect on yourself and what you do, you go in and out of fantastic situations. It is sometimes that we find cancer when a woman is pregnant. But you also have the healthy outcomes. It is sometimes so fantastic you could cry.”

Obstetrician, 36 years of experience

In addition to assisting healthy patients, the observation of poor outcomes was differentiated from other fields of medicine. The overall trajectory of patients in labor was expressed as unknowable, and sometimes uncontrollable.

“I think obstetrics is somehow different from other fields of medicine, in that way, that you have a mother coming in who is, not always but many times,

healthy and normal in every way. Everything is okay. A baby comes in which was healthy and normal and everything okay. Then you follow both of them down. But when somebody is coming into a surgical department with a traffic accident or something – they have already fallen. You are not watching that fall. Also if you come to the internal department with a heart attack, you are already down. You help them up. We are watching them fall without being able to stop it sometimes. I'm not going to make it very special, but I think this is a very special case somehow.”

Obstetrician A, 15 years of experience

4.1.2 Self-preservation against bad outcomes

Poor outcomes and difficult labors were described as a devastating and integral component to their experiences as professionals. Informants expressed a level of sympathy with those who practiced obstetrics with a self-protective element, but were cautious in fully endorsing this self-preservation when it affected patient care or obstetric skill.

“When you stand there between the legs of the woman, looking her into the eyes, watching the baby die between her legs, without you being able to save the baby –that's such a big trauma for the obstetrician, as well. That few of us are saying that, "No, I don't want this. No –". But when you are doing the operation, the mother is covered, they're not seeing anything, they don't see you struggling to get the baby out. I think it's more easy in a way. And, again, nobody will – tell you afterwards that you didn't do everything you could, because you did. You did the cesarean section, even if you did it the baby was not to be saved.”

Obstetrician A, 15 years of experience

“Sometimes it's very difficult to get an overweight patient with diabetes and big baby. The labor is slow. It's like, ‘Ahh, why am I in this situation as a doctor?’ But is it better to do a cesarean? [...] If I'm a coward then I will just solve every problem like that, with a cesarean. That's not a good solution for her. So if we did that to our population, we give them not so good healthcare.”

Obstetrician, 17 years of experience

“My first impression when I started working here was that the doctors were actually very skilled. That they were also – I didn't know how it affect[s] them if something goes wrong. Because that's something that they think about for a long, long time. For years. And everybody's very much afraid, all the time, to make mistakes. Because it has a huge impact on someone's life.”

Obstetrician, 6 years of experience

“Protect yourself from – this is, of course, a big, emotional trauma for the mother and the father who are sitting there. Maybe when the baby is born prematurely it can be that they have never had a baby to term. It can be that they don't have any baby alive. It can be the second or third time that this happens in week 26. And you don't want to – join them, in this fall. So. They [obstetric professionals] wouldn't say that. They wouldn't say it aloud. But I think that it's there.”

Obstetrician A, 15 years of experience

4.1.3 The burden of responsibility

Although losses were described as a frightening, sometimes uncontrollable reality within the field, informants described a concurrent responsibility to take full blame for a poor outcome. The burden of blame was expressed as the natural consequence of taking the burden of the decision. Informants explained that taking choices from the women was not necessarily restricting their rights, but rather relieving them of the guilt and blame that could result from a poor outcome. The weight of blame and the responsibility of making consequent decisions were positioned securely upon the physician, as a compulsory requirement of the profession.

“Where something happens – and it wasn't necessary – it would be harder for us. Because we can't just say that you chose this, so it's now your responsibility that you got an infection. If something went wrong, and they – the clinical indication wasn't there to begin with, as a doctor it doesn't feel good.”

Obstetrician, 6 years of experience

“I let myself tell the patient, ‘I'm going to fix this. I'm going to take care of you. It's going to be all right.’ Even though I know, in the back of my head, everything could be a catastrophe. That's my problem. It shouldn't be the patient's problem.”

Obstetrician, 17 years of experience

“But, if you chose, it's like, if you need to blame anything afterwards you're on your own. So I think that sometimes these women are very vulnerable,

and they need us to take the blame. When you chose it yourself – so choice is not always a good thing. It's difficult for the patient to understand what they are asking for, and also to live with the consequences of that choice. I think it's good to blame the doctor.”

Midwife, 20 years of experience

“This baby had to come out, and she was afraid of both ways. She didn't know how to get the baby out, and I was just, ‘Okay, tell me what to do. We'll do that! Which is better, which is best?’ And then she couldn't decide. She couldn't decide. And then at last, I had to just tell her, ‘Okay, back off. I will decide, and this is going to be my responsibility. So you just have to accept it.”

Obstetrician B, 15 years of experience

The additional responsibility of holding the cesarean section rate low was expressed in mixed, general terms. Informants viewed the determination of an appropriate cesarean section rate with skepticism, and none held any convictions to a specific rate, but a preference for ‘holding the rates low’ was expressed. No informant revealed an annual workplace goal or any incentives to maintain a certain rate. The quality of individual care, doing what was best for the patient in the moment she seeks care, was paramount to holding a particular rate.

“There's been a discussion that it's – a little bit too high. And that there are big differences between different regions and different hospitals. The number 15, or 12, or 10 doesn't mean anything, really. What means something is the kind of help that the women get. [...] Every time I make a decision that's like

one individual decision. But say, say I do something in public or if I have opinions, then it's more with policy and where the rates should be. So I do have feelings we, the obstetricians, should be out there and take some of that responsibility. In that way."

Obstetrician, 17 years of experience

"As long as we manage to stay here, I'm happy. But I think it's very, very important that we have a focus on this. That we discuss this, and we are trying to have the cesarean section rate as low as possible."

Obstetrician A, 15 years of experience

"There has been an opinion here that we are soldiers in this war about keeping cesarean rate low."

Obstetrician B, 15 years of experience

"I wouldn't want it to go further down, I think. If it goes up – if it goes up a little, I wouldn't be worried about it."

Obstetrician, 6 years of experience

"I think it's important that we try to keep it the number as low as we can. I don't think it's the same all over Norway. It's a little bit different from the different cities, but I'm not sure where to – what's the best percentage."

Midwife, 22 years of experience

4.1.4 Hard and soft skills of obstetricians

The practical skills of an obstetrician to mechanically assist birth were discussed as integral to professional identity. The rise of cesarean section rates inversely impacts the field's experience with complex vaginal births, leading to deteriorated ability to perform assisted birth techniques, such as forceps delivery and vacuum-assisted delivery. This deterioration was perceived as a threat to the foundation of obstetrics, and maintaining the skills confidently as respecting the field.

“We use like 5% vacuum and 5% forceps. But we use forceps frequently, and everybody, even the resident would be confident in using the forceps.”

Obstetrician A, 15 years of experience

“I am really happy that I know these tools. I know that I can use them, and I know that I can evaluate when to use the different tools. It's sometimes a very difficult decision, and I don't do proper decisions every time, but I'm really happy that I can offer this to the women. If it's possible, I will do a forceps delivery for the women, and it will be fine. I've done it a hundred times. But if I - if I thought it would be a different situation, I think the whole obstetric field would be kind of destroyed. Because that's a real danger. If you take, if it's easier and easier to do cesarean, to have that solution to every problem. Then I don't have any skills left. I don't even have the skills to give you the best advice. I can't solve the problem. I cannot solve the problem, if I need to do a vaginal delivery. That's a really stupid way of being an obstetrician, I think.”

Obstetrician, 17 years of experience

“The longer we are holding those rates so high, and they are going higher and higher, the lower it's going to be our experience with vaginal delivery, and how we have to monitor and help them. As doctors, our anxiety for having women in labor is going to be higher, and then we just want it to do what is safest, maybe, for us.”

Obstetrician B, 15 years of experience

The practical ability to resolve a complex vaginal birth was balanced with the obstetrician's role as an empathetic communicator, in fact, in the specific case of CDMR, it was identified as the singular quality of an obstetric professional that could be applied with any success. *Medmenneske*, a term deemed difficult to translate by one informant and confirmed through informal member-checking in subsequent interviews, translates directly as “with person” and perhaps more helpfully as “fellow human”. Early career difficulties in patient communication were widely expressed, with personal reflection as a key element in overcoming those difficulties. The development from novice physician to experienced professional was most noted in the informant's growing confidence in patient communication.

“When I was younger, maybe I was little bit more like, “Well, you know, maybe this could happen...maybe that, I don't know.” I kind of wanted to inform them, in a very formal, precise -. The doctor feels more mature, more –I am able to make a decision. I don't not know what I'm going to do, if you know what I mean. [...] When you're younger as a doctor, it's sometimes difficult to know what opinion do I have? What should we do here? And that could be difficult for me, as well, of course. But –it makes me kind of more – it makes me feel more safe, that I probably land on a good decision.”

Obstetrician, 17 years of experience

“I was a trainee doctor, and I found it very hard to sit and have those conversations with those women, because they were afraid of giving birth, and it was for them serious. I began to reflect on it, on a very high level, because it was like hell for me - those days at polyklinikk, and having those patients come in. It was more and more of them that came. So I had to develop a strategy how. The very unique thing about being a doctor is that when a patient comes inside your door, and you just shake their hands, and they come inside to your office. You have maybe just ten seconds to give the the trust that they need to share with you their most intimate part of their bodies, and, at the same time, share with you their thoughts, their darkest thoughts, and their secrets. And everything. So, maybe experience, but also your own personality will appear here. How do you appear to a patient to put their lives in your hands? That's actually what you do as a doctor. And you have just ten seconds. That's a handshake. That's the look. That's the smile. And nothing more. So you have to have a strategy when they come here to you, so you just have to open up.”

Obstetrician B, 15 years of experience

4.2 OPERATING WITHIN A CLINIC, OPERATING WITHIN A COMMUNITY

Features of the community and the workplace established the context in which the informants could perform their work. The overall positive view of working in Norway and the financial protections afforded to physicians practicing in Norway were identified, with a particular emphasis on the lack of litigation. The influence of the

Patient Right's Act in clinical decision-making was expressed in mixed terms. The Norwegian patient population, as discussed in broad terms, was understood as increasingly demanding. The clinic's evolving policies and culture in response to CDMR were described as supportive, largely well-received by patients, yet requiring careful observation and revision. The 2013 audit performed by the Fylkesmannen was seen as an opportunity to reflect on practices, yet not a final and accurate reflection of the clinic's situation.

The understanding of clinic and the community were shaped by comparison to the informant's understanding of and experience with the obstetric situation internationally. This was expressed anecdotally in ball-park estimations of national rates and assessments of obstetric practice abroad through colleagues and friends. While informants formed their contexts by comparison, curiously, the importance of self-reflection rather than comparison was simultaneously advocated.

4.2.1 'Fantastic country'

The In Vivo title of this sub-theme, '*Fantastic country*' was pulled from two informants' descriptions of working in Norway. The use of superlative descriptions, namely 'best' was applied on a national level to the available healthcare, maternal care, and working conditions. The informants reflected some on the poorer conditions in other regions of the world, although none had international work experience. The certainty of their positive perception was also contrasted with a perceived unawareness in the Norwegian population they're serving – not to the extent that patients were ungrateful, but perhaps unreflective and demanding.

“We live in a fantastic country. You operate and take my baby out, and it will be all right, because it’s true. We have the best care in the world, we aren’t perfect, but we are not reflecting on what we have here.”

Obstetrician, 36 years of experience

“It’s always a reference point. What are you comparing it with? And, of course, when you’re comparing us with the rest of world then we are actually, we have a very low rate of cesarean section. And this is something that, actually, I am really proud of, when I’m outside of Norway, because, at the same time we have the lowest perineal tears, breaks in Norway, and it’s the best country to be a mother in. We have very low perinatal mortality and morbidity. So I think that we are doing something right in Norway.”

Obstetrician B, 15 years of experience

“I think generally that the Norwegian people are quite demanding when it comes to health offers, and then I don’t talk about the obstetrician field, I talk about all of the hospital, because – people know that they state has a lot of money, and they want to have their part of – like their rights. So when I was in general practice, and also in general medicine I feel that people are very much – ja. Standing on their rights.”

Obstetrician, 6 years of experience

“[...] we know that women have experienced much worse conditions, and still do in the rest of world. Even though it’s like that, it’s in our populations where they do get very good medical care that we see this anxiety, the way we do, in our society. So I think that’s very interesting. Why is it like that?”

Obstetrician, 17 years of experience

Legal consequences of bad outcomes were perceived as highly unlikely in the Norwegian health system, in some cases nearly impossible without intent to harm. The lack of personal financial responsibility for potential lawsuits freed physicians from defensive practices that they observed informally in their international colleagues. This defensive medicine, providing medical services to protect oneself against potential litigation, was expressed as a driving force in increasing cesarean section rates.

“We will never get sued like where you have to personally compensate, because that's not how the system in Norway works. A patient can sue you personally, but I don't know any case where that has been successful on behalf of the patient, and where he or she has won a big amount of money. You nearly need to shoot somebody, I think. Or do direct harm to the mother or to the child. To have your license taken away. It's very rare.”

Obstetrician A, 15 years of experience

“Our system is easier – the way we carry out our practice is different. You will never be punished financially unless you directly murder the patient.”

Obstetrician, 32 years of experience

“If you read American literature, they would section everything [in cases of premature breech labor]. 100%. I read an article where American obstetricians were asked why? So they would say that they don't have

evidence from the literature to do this, but 60% would state medico-legal things is a reason for doing this. Because you are afraid of being sued.”

Obstetrician A, 15 years of experience

[In response to the question, “Do you feel protected against litigation?”] “Ja, actually I do. I feel that, of course, it's my responsibility, but I feel that the department has the highest responsibility, as long as I do what is the routine of the department. Then it's not my responsibility; it's actually theirs.”

Obstetrician B, 15 years of experience

Discussion of the Norwegian Patient Right's Act as a legally supported method of justifying clinical decisions was mixed. Informants understood that the physicians hold the final decision, sometimes expressed in absolute terms. The initial use of the phrase 'maternal request cesarean' was corrected by some informants to reflect that patients do not drive the final decision, in fact, with one informant dismissing maternal request as an acceptable indicator at all. Informants were aware that they held the power to refuse requests, even on a repeated basis.

“[...] the woman, by law, doesn't have the right to decide that, ‘I will have the operation’. That's on me.”

Obstetrician A, 15 years of experience

“They have what's called medbestemmelse, I don't know the term in English. But they are supposed to be listened to, at least. Of course, sometimes we can say no to someone who still continues saying, ‘I do not want this [vaginal delivery].’”

Obstetrician, 17 years of experience

When asked to imagine a policy change in which patients were afforded legal *bestemmelse*, or determination of care, informants viewed this hypothetical change negatively, and hypothesized that the cesarean rate may become higher.

“Well, if the political changes, if they decide that women can chose for it, then it will increase. But not very much. Not very much at all.”

Obstetrician, 32 years of experience

“I will do as I'm told, but in my heart I will think that it's maybe a little bit sad.”

Midwife, 20 years of experience

“I think that the women would be much happier. I would feel that, in some cases, it was wrong, and at least in the cases where something happens, and it wasn't necessary.”

Obstetrician, 6 years of experience

However, upon further discussion, the absolute decision-making power provided by a national law broke down into more pragmatic and flexible application on the ground. This was expressed in the informants' perceptions of the women who were requesting the procedure, and will be further considered in the section *‘Trapped women’*.

Much of the general perceptions of working in a ‘fantastic country’ with a low cesarean section rate were formed by comparisons to international practices and

expressed with vivid anecdotes. Informants were unsettled by and critical of some of the 'bad' and 'unethical' practices that they observed in fellow colleagues abroad, with some conceding that the legal climate or working conditions are perhaps not as ideal as in Norway (as mentioned above).

“I remember reading that about private hospitals in the States that time where they do most cesarean sections is between 3 and 5 in the afternoon. And that's not because the uterus is less willing to give birth between 3 and 5[pm] - it's because they want to go home. For sure. We don't have this system here.”

Obstetrician A, 15 years of experience

“For instance, in Brazil, when you see some hospitals and regions they have like 75% cesarean, then the opponent is, of course, the attitudes that the doctors have. They don't care. They don't care.”

Obstetrician, 17 years of experience

“Actually I've heard about in Spain that the doctors they aren't treating. They are just doing cesarean if they see that this is gonna drag out all night, and there might be some complications. They just do a cesarean so that they can go to bed. Which I think is malpractice.”

Obstetrician, 6 years of experience

“A friend of mine, who lives in Rome, told me a story which made me almost want to cry. She gave birth to her first baby, then came in with her second one, which they knew was a bit bigger. It was maybe a kilo bigger. She came

in with maybe 6/7 centimeters, but didn't progress. She begged the obstetrician to break the water, because that's a standard procedure to have progression in labor. They refused. They said, 'No, this would make the cesarean section more difficult.' And they had this big quarrel going on until she phoned her mother, and in the end she just gave up, because there were too many people trying to convince her to have the cesarean section. We [in Bergen] have this meeting in the morning where we present what we have done the night before. If somebody here had said that a woman who had already had a baby, it's her second baby, we didn't want to break the water – he would be shot dead at the – it's not understandable at all.”

Obstetrician A, 15 years of experience

“[...] when I hear lots of reason indication for a cesarean section in other countries, for me, it is more like the doctor wanted to have a cesarean section for his patients, and not the other way. They say that the patient is too old, the patient is too little, her pelvis is not right for giving birth to a child – without any reasonable indication for not having a vaginal delivery. We don't want to go there.”

Obstetrician B, 15 years of experience

“It's like they just want the reason for the cesarean section. Or no reason. No reason. They just want to do it. If that's the way they are handling Italy, I can understand why they have 40% cesarean section rate.”

Obstetrician A, 15 years of experience

4.2.2 Clinic culture

Within the broader national environment, the clinic in which the professionals practiced was also highly discussed. Informants detailed the process in which women requesting cesarean section encountered the clinic and the collaborative nature of case reviewing.

The request of cesarean section was described as a constant topic of discussion within the clinic and confirmed as a challenge in daily practice. Informants expressed that its magnitude of attention was much larger than the group of patients would suggest. A process, or as one informant described, ‘a package’, is provided to women who requested cesarean section for seemingly marginal reasons. A woman requesting a cesarean section was most commonly identified at initial appointments with her primary care provider and occasionally identified at appointments directly with an obstetrician. She was subsequently referred to the clinic’s Rådgivingscenter for mor og barn (Counseling center for mothers and children) for additional support. This support is provided by a staff of three midwives who have received additional counseling training, but were explicitly described by informants as non-psychologists. The center has been operating since 2011, and serves approximately 400 women annually. Two obstetric informants estimated that the counseling process managed to convince 75-80% of these women to attempt a vaginal delivery. The center was mostly perceived positively, as a good resource for women, and as a relief of additional consulting burden on the obstetricians.

“We have some midwives, first of all. If they are referred to us early in pregnancy they will consult them. One or two or three times. Depending on

what's the problem and how much time they need. Most of them are, how to say that, convinced or happy with going – opting for normal birth.”

Obstetrician A, 15 years of experience

“The most consultation is coming from midwives, there is follow-up and individualized care. It depends on what she needs. The midwives determine yes or no, and the decision is discussed with the physician, if this is a good decision or not.”

Obstetrician, 32 years of experience

While the center was frequently cited as a supportive tool for the obstetricians, some issues with the counseling ‘package’ were expressed. One informant relayed perceived patient irritation with the process.

“[...] the women have to go many rounds at the advice center. Also many conversations with the doctor. I meet some women who, they don't understand, and they get quite upset, because they say that it's not gonna happen that they give birth vaginally. Especially when it comes to breech position, and then they feel that having to go to the advice center and to speak to a doctor more than once is – not something that they are motivated for. I think by making it more difficult, dragging it – it gets dragged out, in some kind of way. Maybe then we decide.”

Obstetrician, 6 years of experience

Midwives operating the center described their services as different from those of physicians. Appointments were less constrained by time and little medical

information was shared in initial meetings. The counseling rooms were also simple and located below the clinic in a designated area that could be accessed directly from outside.

An initial meeting was described as an opportunity for the woman to speak, to explain, and for the counselor to listen. It was emphasized to the women that no hard and fast decisions were made in the center, let alone on the initial consultation.

“When they are here, we inform that there will be taken no decisions today. I just want to hear what your story is, what you want to tell me, and we have to go through a doctor to make a decision.”

Midwife, 22 years of experience

“They have always been possible to do that [have a discussion about fears], but then in a doctor's perspective. And we might have a bit different view. We have a set off a good time for them. So we never look at the watch. So when they are here, it's their time. They can talk about what they want to talk about. I think that us listening is the most important thing. More than they need an explanation, they need to tell us what they have felt and what they have experienced. When they are done, you know, they've like emptied themselves, maybe we could try to put up small things. Follow-ups. Could we talk a little bit more about that [choice of delivery]? Then they feel like they've been heard, I think. And that might be the most important thing about this center.

Midwife, 20 years of experience

Once a woman had gone ‘the rounds’ with the counseling center, her case was reviewed by the consulting midwives and relevant obstetricians to come to an acceptable conclusion. The collaborative nature of this review was often mentioned, as was the general importance of implementing a birth plan. This birth plan was described as a ‘negotiation’ and a ‘promise’ with the women that helped to shape some of the unknowns of vaginal birth.

“We make a deal on the birth before. We try to make it acceptable to the woman. We promise to take care of pain and we promise normal progress of labor, those are the most important. Some other factors like music and things – soft care.”

Obstetrician, 32 years of experience

“We also make a kind of a plan, in their journal, that we try to put words on what they're most afraid of. When they come to the hospital, we as worker, we read the plan and try to make them feel seen and heard. But we do this together, it's not that I do this to you. We're in this together, you know?”

Midwife, 20 years of experience

The written birth plan was not an absolute solution, however, as the unpredictability of labor could place a fellow clinician in a bind.

“I don't feel that there's a big problem with the policy that we have, and I do feel that the planning ahead for those with anxiety is a good thing. It's really something that helps a lot of women, but I think it could put the doctor on-call in some serious dilemmas.”

Obstetrician, 17 years of experience

Dilemmas during labor were addressed with an ‘acute’ birth plan. Informants described re-addressing fears and implementing short term goals using direct, honest communication – techniques that did not differ greatly from the development of the original birth plans.

4.3 TRAPPED WOMEN

In the previous theme, ‘*Fantastic country*’, some informants described the general Norwegian patient population as demanding and somewhat unreflective. As discussion turned to the specific women they serve, however, the tone became more sympathetic. Informants saw a group of women with previous trauma, abusive backgrounds, anxiety, and depression. In contrast to dismissing pure ‘maternal request’ as an acceptable indicator while discussing the Patient Right’s Act in general terms, informants conceded that ‘there’s always a reason’ why a woman asks for a surgical delivery, and for some patients, a cesarean section was an acceptable solution that the informants were willing to grant.

This sympathetic tone extended to identifying what had caused a woman to seek a cesarean section. Informants noted external forces that they perceived to be driving the women’s fears, without consistently placing any form of blame on the women themselves.

4.3.1 Fear, control, and confusion

Fear and lack of control were cited as the overwhelming motivating factors for women to request cesarean section. The women were described as ‘trapped’ in

pregnancy, often without an acceptable alternative as the baby must ‘come out one way or another’. Interestingly, one midwife informant working directly with the advice center conceded that ‘80%’ of the women referred for counseling were not giving birth for the first time, indicating a traumatic previous experience. This perception was not as well represented in the obstetric informants.

“I think some of the women's fear is more general. They don't know what they are afraid of. They're just really afraid when they're in that situation. They don't like to be in that situation. Loss of control, and the possibility of a lot of different things that can happen. It's not necessarily that they know everything that can happen, it's just – very uncomfortable to be in that situation.”

Obstetrician, 17 years of experience

[In response to the question, ‘Do you think that women are demanding?'] No, no. I think that the women are brave. They want to do what they think is right, but sometimes the fear takes over. They are scared not to be heard, seen. But that's very seldom that they want us to just fix it for them. They know that they have to do a job themselves.

Midwife, 20 years of experience

“It's difficult to explain the procedure [cesarean section] to the young. There is pain and fear. They see the cesarean section as control, and these are women who are used to making all the decisions in their lives. Suddenly they are in a situation with no control.”

Obstetrician 36 years of experience

“It could also be that they've experienced something like rape. Lack of control that makes the situation more difficult for them than maybe for others. I find that the women have good reasons for why they think as they do.”

Midwife, 22 years of experience

“Women don't want to hear. They don't want to hear, it's difficult for them to hear. Women have difficulty to communicate. They don't have the words, they don't want to say the words. These women require more than one consultation. They take more time.”

Obstetrician, 32 years of experience

“I have to follow her way of thinking, and she's really, really trapped in this situation where she's pregnant. We need to find a solution where she can feel safe.”

Obstetrician, 17 years of experience

These compassionate views were pervasive in the informants' understanding of their patients. Descriptions of patient motivations for cesarean delivery were underlined with acknowledged and legitimate fear, with no evidence of devaluing the patients' 'very real' anxieties, although they were perhaps not medically accurate.

4.3.2 Forces that interfere

If any blame was to be directed for the motivation for cesarean delivery, it was deflected from the women themselves. The source of this seemingly growing motivation was driven by 'modern society' through journalism and social media. As

previously outlined, the clinic had been highlighted in the local media. Informants expressed this as frustrating for the women, as the evidence reported was not necessarily accurate and increased their anxiety about giving birth in an apparently 'colored' facility.

“[In response to the question, ‘Do you experience women coming in and mentioning specific articles they’ve read?'] Yes, yes. They do. I try, if I can, very carefully to tell them that that is not your story. That's a different person's story. But, of course, it makes them anxious.”

Midwife, 20 years of experience

“This situation with the paper in this town, which has written a lot of – not so nice things about it. There are a lot of women who are afraid, and also a lot of women who do not trust this clinic, I think. They come here with a feeling that they have to work for their rights. And also that they can't – trust the decisions that we make. Which makes it harder, for us, every day.”

Obstetrician, 6 years of experience

The media attention was also experienced as a positive force for self-reflection for the clinic. Informants did not express any wishes to censor the information, but accepted the influence of media as an inevitable process that would only increase.

“The internet is tremendous. It influences the change. We have not the chance to stop it, and we shall not. It's not unfair [that the clinic has received attention], but it's unfair that – journalists must give a basic foundation of

results. They must give a general idea of what is expected. But then what is the alternative? Where do we as a community want to go?"

Obstetrician, 36 years of experience

"I have two sides there. In the women's perspective, I think it's very unfortunate. They get more scared, and that's very, very bad for them. But, I think, as a workplace, I think it's very good to hold those glasses on our work. I also think that things change a little bit, just because of the focus that the media put on us. I find that we work very well together, the doctors and us midwives, and I feel that they [obstetricians] are listening to our [midwives'] perspective on things. That might have changed a little bit, and if that's because of the media, I don't know. But that's not all bad. But, for the women, I think it's all bad."

Midwife, 20 years of experience

Interestingly, fellow physicians were cited by some as interfering with women's decision-making processes. Psychologists, general practitioners, and surgeons were mentioned as professionals who occasionally directed women towards cesarean section, creating a situation where women were not sure which medical opinion should take precedence. The importance of in-clinic counseling with midwives who were familiar with labor was again mentioned.

"It was actually yesterday. I had a patient that I read the letter from her GP, and between the lines I could see that this was something that he put in her mind. Then she came, and she confirmed that. It was impossible that this was the best thing for that patient. So if you are just sending your patient to me –

that this is my job, my table, so don't involve yourself in the decision-making. [...] The patient is beginning to trust you, then they go to another doctor, and they say another thing. They are totally confused, and then you have a confused patient. Confused patients are not good patients”

Obstetrician B, 15 years of experience

“In our experience, when psychologists who don't work with labor, when they try to intervene, at least some of them, they are very pro. Like fulfilling her wish to have a cesarean section. [...] our experience with that, during many years, is that they are not really helpful. It's rare that the psychologist shows up with the patient, but it happens.”

Obstetrician A, 15 years of experience

“[Attending a communication course with various surgical professionals] They couldn't understand what was the problem. Why don't we just give them cesarean section? But then I asked them, one of the surgeons, "If your patient comes to you, and said I don't like my appendix – do you just remove that? Do you just put her on the bed and just cut her in her stomach? And just take it out? Just because the patient asked you to?" No, he doesn't. Okay. Then? So? I think many of them – they don't understand why we are taking it so seriously.”

Obstetrician B, 15 years of experience

4.4 NORMALIZING THE BIRTH EXPERIENCE

The fourth and final theme encompasses the perceived gap between what is expected during birth and what is actually experienced. Informants described a healthy vaginal

delivery as the optimal path, with cesarean perceived as a departure, with balanced concerns for both routes. Importantly, several informants mentioned cases in which a woman had experienced a seemingly positive vaginal birth, only to later find that she reported a traumatic experience.

After discussing policies, convictions, communication techniques, and experiences, the eventual conclusion on the question, 'Is it an acceptable solution for some women to have a planned cesarean section?' was a restrained and succinct 'yes' for all informants.

4.4.1 The ideal birth – unknowable outcomes and divergent perceptions

When asked to describe an ideal birth, informants gave a medical overview of a vaginal birth with spontaneous labor, normal progression, adequate pain relief, and a healthy outcome for both the mother and the baby. Delayed cord cutting was also mentioned, with early contact to encourage bonding. Informants also expressed a personally held 'belief' that vaginal delivery is best, without explaining in empirical terms, with one informant (Obstetrician B, 15 years of experience) simply expressing that, '*You don't go and break the window when the door is open*'. Maintaining this conviction was cited as important to consistent practice within a clinic. Those informants who expressed a personal preference for birth mode wished for a vaginal delivery.

"I think also it's important, as a health worker, that we think that what we're doing is the best way to do it. If it was like 50/50 [those professionals maintaining that vaginal is best], why don't we just do this? So I think it's

good that they do - we really believe that it's the best for the mother and the baby.”

Midwife, 20 years of experience

“I had one cesarean section and two vaginal births. My fear is for cesarean section, for myself. I want the same thing for my patients that I want for myself. And if I want to go to another pregnancy and birth, then I would prefer for myself to have a vaginal delivery. And I would love that for my patients, as well.”

Obstetrician B, 15 years of experience

In addition to a medically healthy birth, guiding a woman from ‘trapped’ to ‘empowered’ was expressed as professionally satisfying and a key feature of an ideal birth.

“[...] the ending of the delivery is controlled by the mother herself. That she doesn't need help by a doctor or forceps. Hopefully that the women, after delivery thinks, ‘What have I done? Wow!’ And that we [obstetric professionals] are just a little part in it. She can tell herself that she is amazing, she is strong, she managed it. That's fantastic, you know? I think it's important that she comes to the conclusion within herself that it's not something that we pressure her into. And make that happen. It could be tricky, it's why this is so exciting.”

Midwife, 20 years of experience

“It’s important for women to have a vaginal birth. For these women it’s important to show that they can do it. It’s a fantastic experience to see them do something that they thought they couldn’t do. It’s very important.”

Obstetrician, 32 years of experience

While imagining an ideal birth, however, informants were careful to address the ultimately unknowable progression of labor. Providing patients with birth plans, per clinic policy, was seen as primarily assuaging a woman’s fear, not creating an entirely realistic structure for labor and delivery. Issues can ‘happen at any time’ during labor, and providing ‘guarantees’ or ‘promises’ regarding the final outcome was admittedly a communication technique to calm anxious women in acute situations.

Guiding women towards a vaginal birth before she finds herself in labor, however, was described by one informant as a ‘paradox’, where you’re asking a woman to attempt a vaginal birth that could result in an acute cesarean anyway.

“It’s really, really very interesting philosophical problem, actually, because you ask the patient to do something that they don’t want, but if they get their solution [planned cesarean] you eliminate a lot of the risks that they’re afraid of. You ask the patients to take some of those risks, and even though they follow your advice, then can end up with the same solution [acute cesarean], and with an even more risky situation. It’s kind of like, it’s kind of difficult to understand. It’s difficult to explain to the patient.”

Obstetrician, 17 years of experience

Additionally, a midwife informant described some of her communication techniques as asking the woman to imagine a good outcome, but admitting that the woman must step into the unknown.

“I also tell them that we can't know what's the result is, if you don't try. I can't promise you a happy ending, you know? It's like you have to try and see if it works. Then the answer will be given to us.”

Midwife, 20 years of experience

However, a seemingly ideal birth with a good outcome could be perceived differently by the woman. Several informants expressed surprise at follow-up appointments that despite seemingly normal labor situations, both vaginal and surgical, were perceived as very ‘dangerous’ and terrifying by the women.

“Their observation of going to the O.R. [operating room], because there are so many people there. They're not prepared for it, so they think that it's much more dangerous than it is. We think that this is totally normal – nothing stressful. I've been surprised a couple of times by that. It's struck me that what is normal for us is not normal for them.”

Obstetrician, 6 years of experience

“I've had women who've had normal deliveries, and they're still traumatized. So that's something we have to work with, and be aware of all the time. Because it's too bad, I think, I think that's really, really sad. Some people are very vulnerable, and some are not vulnerable.”

Obstetrician, 17 years of experience

“It's like we sometimes forget that part, because we see it every day [patients undressed]. It's natural to us, but it's not that for the woman. And sometimes they often want to hide for their partners, as well. They want to be like, dressed. The patient is also lying down, and we are standing. So they feel like we are looking down on them.”

Midwife, 20 years of experience

Finally, despite consistent convictions surrounding vaginal birth and clinic policies that attempt to direct women away from cesarean, informants conceded that a planned cesarean is, in some cases, a necessary and appropriate intervention for some women. The final ‘yes’ was not admitted until the consultation procedures, experiences, and personal beliefs about vaginal delivery were addressed during the interview, however. *‘Those who really fight will get it,’* was a sentiment expressed by a consulting midwife. Interestingly, conceding to a request for cesarean section existed within the unacceptable alternative of ‘forcing’ a woman into labor, not necessarily as affirming a women’s wishes for a surgical birth.

“They are uphill with the brakes on [women who are forced into labor]. So they go into the situation with a negativity that is not good for her.”

Midwife, 20 years of experience

“I will do everything in my power if I really have a strong opinion, in this case it's wrong for the woman to have a cesarean section - then I will do anything in my power to bring her to that point that she's agreeing with me. But I cannot make her. I don't have the authority to make a woman do

something that she absolutely doesn't want to. I don't think that I'm able to do that."

Obstetrician B, 15 years of experience

"But, at the end of the day, I will never force anyone. So if she says, 'No!' and everything is kind of crazy, that can happen, then we just have to do a cesarean. I can't do anything about it then."

Obstetrician, 17 years of experience

"So sometimes you try also to say to this particular woman that, 'You should go into labor'. You test out how strong is her fear of birth. Maybe the backlash you get is so strong that you think okay, we just give up."

Obstetrician A, 15 years of experience

4.4.2 Cesarean as 'Giving up'

The cesarean section itself was described as an easy, quick procedure that is misunderstood by patients. The ease of its application lent some informants to deem it the 'easy way out', and, as a medical professional, a quick solution to an issue in labor. Cesarean section was contrasted with the lengthy counseling process and attending to a difficult labor as a quick solution that, by its nature, disrespected the reasons a woman requested a cesarean in the first place. Curing the fear of labor with a knife was expressed as a 'primitive' solution.

"A cesarean section is a very easy thing for me. It only takes a few minutes; I can do them easily. It takes no time. If I say yes, that is unethical. I didn't spend a lot of time with that woman. It could take ten hours to talk with her

and understand why she's feeling this way. That's more difficult. I turn it around and say that it's not ethical to say yes, because that's the easy way."

Obstetrician, 32 years of experience

"It actually uses a lot more resources by watching something that might be something. If you sit and watch a CTG for two hours, and follow it closely. It would be much easier when you start to wonder if this is gonna be something, if you just did cesarean. At the start. But, yes, that would, of course, make the clinician's day much easier."

Obstetrician, 6 years of experience

"Yes, it's much easier. It seems like you've done what the patient needs, because that's what she can imagine."

Obstetrician, 17 years of experience

The women's perception of the procedure was seen as inaccurate. 'They don't know what they're asking for,' was a repeated attitude, with the simultaneous hesitance to provide a clear picture of the procedure for directional counseling. The informants described a balance between a pure informed consent with a clinical description of cesarean section and disclosing too much information to further frighten an already anxious patient.

"[In response to the appropriateness of a systematic informed consent process] Yes, but I don't think that's what the patient needs. Some would need that, but not everyone. [...] I would never say to a woman, 'Look at this, this is what you're asking for. What a stupid thing to do.' But I think we haven't

described really the cesarean situation or scenario well enough for those women. Because, you know, they get strapped to a table. They can't move. They get medication that makes them nauseous. They can't do anything themselves. We take away from them the possibility of the experience of a normal birth, if there is no indication.”

Obstetrician, 17 years of experience

“Some people would like to know, and they'd like to know as much as possible. Some people get scared of information, so you have to find out – it's kind of – what can I tell you, what do you want to know?”

Midwife, 20 years of experience

“[...] all the cesareans are laparotomy, which is a huge surgery. And also, if they need another surgery, later on - that might become complicated by this cesarean scar and adhesions. I don't think they actually realize that.”

Obstetrician, 6 years of experience

“If she's really vulnerable or really anxious it doesn't really help me or her - to describe this in a kind of very violent way, because it is violent.”

Obstetrician, 17 years of experience

4.4.3 Informing the community

Normalizing the public's view of birth seemed to occur on both an individual (consulting pregnant women) and a community level (through journalism and social media). Some expressed a professional responsibility to educate and correct information that is available to the public. This was often expressed in the context of

future implications of increasing cesarean section rates and creating transparency with the local community following the poor press coverage.

“We have to take control over our own presentation. Social media makes this very difficult. There is a communication section at the hospital that gives us support to write pieces, and to help us to correct things that are totally false in the media. I just had a meeting this morning with some media. We discussed something that was published on NRK, and when it came out, I thought, ‘This is not what we were talking about’. But we have to understand the development of the social media. Instead of asking, ‘What is the truth here?’, we find the easiest way out.”

Obstetrician, 36 years of experience

“Women are going to give birth, and women have given birth, and times are changing, and healthcare is changing, and we can't stop that. We have to be where we are. If there are social media, if there are written media, whatever - we have to be there. Just explain, because we know a lot of things, actually. So that's where we have to be.”

Obstetrician, 17 years of experience

5. DISCUSSION

The findings illustrate a cohesive group of medical professionals who drew upon confident, self-defined professional identities and a protective workplace culture that supported the clinical decision-making process. Additionally, a compassionate perception of women requesting cesarean section and convictions surrounding a normalized birth experience directed patient communication, with the idealized outcome of an empowered, vaginal birth. The source of resistance against vaginal delivery was deflected from the women themselves and placed broadly across various interfering players.

As pregnancy itself is a temporal process, the integration and interaction of the four themes can also be conceptualized as a journey. The figure below outlines the actors and influencing factors in a requested cesarean delivery identified by informants (figure 6).

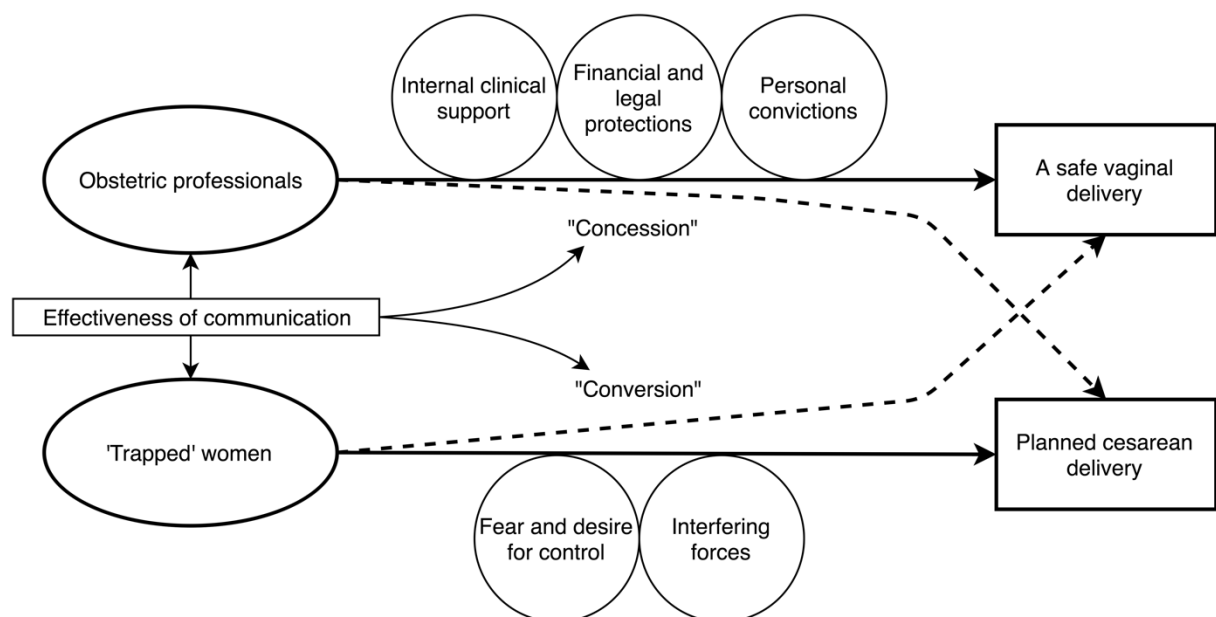


Figure 5: The identified themes as a process from pregnancy to birth mode intention

The situation, as described by informants, was not unlike a trailhead meeting between an experienced guide and novice hikers. The journey from pregnancy to a safe vaginal delivery was a well-worn and systemically supported path that the professionals uniformly advocated for. Women setting out on the path to cesarean were ideally caught in time and persuaded to join the perceived optimal route, but with sufficient resistance could not be forced to a destination that was unimaginable.

The degree and quality of this persuasion brings us back to central questions about patient autonomy and the value of choice in healthcare.

5.1 Risks of paternalism

Returning to Chervenak and McCullough's professional responsibility model, many of the informant's views could be interpreted as bordering paternalistic practice, or the prioritization of beneficence-based practice over patient autonomy (86). Convictions regarding vaginal birth, although current evidence does not conclusively indicate a difference in risk between planned cesarean and vaginal deliveries, potentially put the professionals at risk of over-riding patient wishes. Additionally, the informants' expressions of ultimate decision-making power raised questions about their conceptions of patient autonomy. Women ultimately granted the cesarean section were not permitted the word 'choice' when described, rather they were unconvinced, improperly influenced, and persistent. The cesarean section was provided as no other acceptable alternative seemed possible, not given as a positive right inherent in patient choice. These fears of paternalism appear to have also materialized in the 2013 audit and the clinic's reputation in the community.

I am skeptical of outright accusations of paternalism, however, and speculate that these claims would be better supported if the data contained more conflict and blame directed towards the women. From my analysis the informants' conceptualization of choice and decision-making more closely reflected a relational understanding of patient autonomy rather than an ethical misbalance of beneficence and autonomy.

5.1.2 A relational view of patient autonomy

Autonomy respects an individual's capability to act in their own self-interest as an independent agent, free from undue influence (12). Patient-directed decision making has been particularly emphasized as a measure of autonomy, with tremendous focus on the empowered, informed patient arriving at a self-directed conclusion after being offered all medically reasonable options. Evaluation of an individual's competence to act autonomously is sensitive, as impingement upon autonomy in cases of diminished capacity (appointing a surrogate) has serious implications. A so-called "thin" or "minimalist" approach considers the absence of severe cognitive or emotional impairments to be sufficient in qualifying a person's choice as autonomous (87).

Criticisms of absolute understandings of autonomy are leveled at the absurd situation in which a physician is reduced to a "mere automaton" who, after providing a menu of options to the patient, passively accepts the choice unless significant pathological impairment could erode the patient's capacity (86, 88). Additionally, a minimalist approach to determining a person's cognitive or emotional fitness fails to consider additional, often subtle, social conditions that could diminish her competence to express decisions that are truly her own (87).

Relational approaches attempt to enhance the principle of autonomy by including pervasively influential social conditions in their de-emphasis of independent agency (88). Rather than champion a purportedly empowered choice as the ethical endgame, relational understandings ask clinicians to consider autonomy-supporting/undermining features in the broader environment, including clinical interaction. By de-emphasizing the focus on decision points during care and softening the understanding of an autonomous agent, clinicians can gain an enriched view of autonomy that both respects the patient's self-identity and supports their desires to practice medicine with integrity (88).

The displacement of blame and motivation for a requested cesarean section revealed the informants' awareness of some of the potential autonomy-undermining factors their patients were encountering. Relational understandings of autonomy allow clinicians to explore, alongside patients, the possible motivations of social forces (the 'frightening' newspaper reports) and to develop a supportive space in which patients are empowered to develop their own stories. Descriptions of their communication techniques – trying to follow each woman's rational without undermining her reasoning – also suggested that the informants sought individualized opportunities for empowerment. These time-intensive consultations were broadly described as an attempt to unpack what the women *actually* needed and how the professional team could attend to these needs. Informants did not appear to expressly devalue choice, but developed it in ancillary measures through the birth plans. The value of choice is central to autonomy, but a patient's expression of preference could simply be her only known tool of participation in healthcare. Patients have judged high quality interpersonal relationships and engagement in care that doesn't involve choice as values of participatory healthcare, not merely decision-making power (88). The

gradual cultivation of a trusting, supportive relationship was, for the informants, the turning point in a CDMR case – not the so-called ‘informed’ moment a woman understood the biomedical reasoning and cooperated.

As the clinic’s procedures were largely successful in convincing women to opt for vaginal birth, the ‘choice’ of cesarean section was interpreted as a proxy expression of unfulfilled needs that through careful, compassionate communication could be satisfied without resorting to surgery.

5.2 Protected virtues of moral medicine

Relational understandings of patient autonomy are demanding on clinicians, and would not have been possible without extensive clinical, legal, and systemic support protecting the practices of the informants. Much of the informants’ critical perceptions of international practices could be explained by the absence of these supports and the degradation of the physicians’ roles in their respective communities.

Moral leadership in medicine, as described by Chervenak and McCullough, successfully supports four professional virtues that enable a physician to practice ethical medicine (86, 89). Borrowing from legal lexicon, they further argue that upon this moral foundation the physician acts as an ultimate trustee, or fiduciary to the patient. The first virtue, *self-effacement*, requires a physician to provide care regardless of differences between herself and the patient (e.g. gender, religion, etc.). Providing care while accepting a reasonable risk (such as the potential transmission of infectious diseases), or *self-sacrifice*, is the second. The third virtue of *compassion* prompts a physician to attempt to alleviate pain and stress in her patient. The final virtue requires a physician to act with *integrity*, here defined as imposing intellectual

rigor on judgement: “Clinical judgment is rigorous when it is based on the best available medical information or, when such information is lacking, consensus clinical judgment and on careful thought processes of an individual physician that can withstand peer review” (86). Professional integrity in medicine, then, is not simply exhibiting honest behavior, but allowing transparent evaluation of one’s actions.

When a physician is incentivized to pursue her own interests over those of her patients, these virtues are violated and her role as a fiduciary is degraded. However, a physician operates within a healthcare system and must rely on leadership to cultivate a protective environment. Economic motivations are identified as a major threat to the moral practice of medicine (86). A fee-for-service model incentivizes prioritizing patients who are able to pay and over-treating conditions. Unfavorable medico-legal environments require physicians to accept an unreasonable financial risk to themselves, leading to defensive medical practices. Physicians alone cannot act upon these economic threats without appropriate support from leadership.

The healthcare system in Norway, as previously described, is unique. When discussing the difficulties that existed in their practices, the physicians described core aspects of practicing medicine, loss, and responsibility – not clinical budgets. Economic threats were a non-issue for the informants, and the topic of litigation was quickly dismissed. It comes as no surprise that the legal and economic protections afforded at a national level allowed the professionals to perform medicine as they saw fit, and these results were anticipated.

At a clinical level, however, an interestingly cohesive workplace ethos emerged that appeared to most affect the virtue of *integrity*, per Chervenak and McCullough's obligation of clinical judgement to "withstand peer review" (86). Plenum discussions, daily morning meetings, and the collaborative nature of case reviews were mentioned as tools provided by clinic leadership to guide the healthcare team to a 'good decision'. This description of a functioning team seemed to belie the intra-clinic conflicts outlined in the media, specifically between physicians and midwives, and support a degree of professional transparency amongst colleagues. The intended actions of an individual clinician appeared to be greatly diluted amongst her peers, and indeed, a CDMR case was described as run through a committee before being granted.

Semantically, this workplace cohesion had a peculiar influence on the interview material. Policies and approximated figures were reported by all informants, and subsequent informal member-checking revealed very similar understandings, which seemed to confirm a general knowledge about the magnitude and reception of CDMR cases. While this cohesive understanding may simply suggest good attendance at regular staff meetings, the expressed beliefs (down to the phrases used) were also notably similar. The lack of negative cases, or even subtly divergent cases (i.e. uncertainty about the optimal birth mode), hinted that such a case would meet strong resistance in the daily 'peer review' process the informants described (such as was noted in the 2013 audit). The evaluation of professional integrity within a clinic undoubtedly draws on generally held values, and the data suggests that the informants were integrated into the belief system of their workplace.

Whether this belief system developed inductively or deductively is difficult to determine, and arguably irrelevant to the outcome. The clinic did not have a prescribed goal rate, and informants dismissed any explicit policy about rationing the procedure. Resistance to the belief system was also left unmentioned, but this could simply be due to the inclusion of mostly senior clinicians (median experience at the clinic was 17.5 years). The understanding of ‘vaginal as generally best’ was justified by lack of data to suggest otherwise, as the clinic’s outcomes did not differ significantly from national averages. This pervasive belief could explain the clinic’s reputation as ‘strict’, but was defended by informants through claimed self-reflection and willingness to adjust policies in the face of negative data.

While the belief of ‘vaginal as generally best’ had perhaps brought the clinic additional, particularly negative attention, my interviews suggested an equally ubiquitous belief regarding the patients. The compassionate perception of the women was seemingly ingrained in the clinic’s belief system, and was the starting point in the informants’ reported behaviors and interactions with the patients.

The suggested workplace belief system, comprising of both convictions regarding birth mode and a compassionate perception of women, seemed to represent important values by which a professional in this context could be determined to have integrity, not simply the quality of ‘intellectual rigor’ of judgment as described by Chervenak and McCullough.

5.3 Elite interviewing and reflexivity

A feature of this project that must not be overlooked is that of so-called elite informant interviewing. Elite informants can be defined as those who hold

professional influence within a hierarchy, or in relative terms to the researcher herself (90). While not exclusive to elite informants, this group may hold particular challenges in terms of what they are willing to disclose about their organizations, availability, and motivations for participation. Attempts to control the interview, challenging the interviewer, and skirting direct questions are also conditions to be aware of when pursuing influential subjects (90). Approaching informants with vast professional experience and knowledge required additional precautions and preparation, which, for this project, had both positive and potentially negative effects on the data collected.

In the spirit of Alan Peshkin's reflection upon one's own subjectivity from the conception of the project, as well as Malterud's similar call to identify personal motivations and preconceptions about the study subject, I have reviewed journal entries and post-interview notes to explore how my appearance, behavior, and beliefs have shaped the project (91, 92). The resulting reflections appear to have had particular influence on the interview situation.

As well as piquing informant interest and initiating interviews, two characteristics of mine (non-Norwegian and non-medical) naturally influenced the interviews' progressions. A competent appearance was essential from the outset to avoid wasting time on descriptions of national policy or procedures, and I found myself 'presenting' information within questions for the sole purpose of proving a sort of capability. However, regardless of preparation, the knowledge gap between a graduate student and a mid-career medical professional is insurmountable, and there were near universal examples of simplification and explanation in the data. The trend of international comparison was undoubtedly inspired by an international researcher.

Additionally, vivid accounts of procedures and patient experiences would not, perhaps, be as present in interviews conducted by a fellow physician.

However, the fear of wasting interview time on these explanations was largely unfounded. Through a forced simplification of their practices, informants (perhaps inadvertently) exposed components of the issue that I had relegated or failed to address entirely. The broad question, ‘Why was it important that the informant explained this to me?’ uncovered additional challenges and motivations that are perhaps best illustrated in the theme ‘Being an obstetrician’. Furthermore, the exercise of forming the Norwegian context through international comparison appeared to assist the informants in addressing institutional supports that directly influenced their clinical practices.

Additional elite informant challenges previously mentioned – challenging the interviewer, controlling the interview, skirting questions – were not explicitly encountered. Interviews progressed in a friendly, conversational manner. Some informants gave the impression of testing the waters with prefaces such as, ‘I’m sure you’ve read about this’ or ‘Maybe you’ve heard about this’, but without direct confrontation, as Harvey encountered in his experiences with elite informants (90).

Some apparent inconsistencies were present in the data sets, however, specifically the lack of internal staff conflicts, non-adherence to departmental cesarean thresholds, and clinical budget concerns in the interview data. These issues were widely discussed both in the media and in the 2013 audit, and while I have little evidence that the informants were ‘performing’ on behalf of the clinic, additional informant

sampling from multiple obstetric clinics in Norway could be recommended in future studies of this nature.

5.4 Conclusions

Medical professionals worldwide experience decision-making challenges that are not sufficiently illuminated by a normative ethical framework. Obstetric professionals encountering seemingly non-beneficial requests from patients strive to balance their obligations to beneficence and autonomy, and absolute ethical understandings can lead to absurd and unresolvable stalemates. Relational views of autonomy that seek alternative opportunities for empowerment beyond the informed, decisive, and independent patient offer a more pragmatic approach that guides a patient towards a treatment plan that both respect the woman and the physician's professional integrity.

Appropriate leadership that protects a physician's economic and professional interests is essential to cultivating a clinical environment that can withstand the demands of relational understandings of autonomy. Freeing a medical professional from an unreasonable threat of litigation and removing economic incentives to provide care could not only encourage better support for CDMR cases, but reduce total cesarean section rates.

Potential opportunities for improvement identified by this study included post-natal counseling for women, given the importance of supporting women following a traumatic birth experience and the informants' expressed difficulty in identifying traumatic cases. Compassionate public communication about and ownership of the clinic's belief system could also serve to improve relationships with the community.

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Document of Informed Consent

Obstetric professionals' perceptions of cesarean upon maternal request.

Researcher:

Robin Cole

Supervisor:

Professor David Lackland Sam, Department of Psychosocial Science, University of Bergen

Contact: robin.cole@student.uib.no

Background and purpose of the study

This is a request for you to participate in a small qualitative study that intends to explore obstetricians' perceptions and experiences with cesarean section upon maternal request. The rates at which cesarean section procedures are occurring are increasing worldwide, often being performed without medical indication. There is limited information regarding physicians' personal attitudes regarding this procedure.

What does the study entail?

Following informed consent, data will be collected using semi-structured individual interviews using a prepared guide. Interviews are anticipated to last one hour. Interviews will be performed, recorded, and transcribed individually by the researcher. Data will be coded and kept anonymous.

Potential advantages and disadvantages?

This data collection will assist the researcher in her intended academic project. Data collected could better explain the physician's role in the delivery choice. Potential disadvantages of your participation include the time you will spend on the interview. Interview questions, while not anticipated to cause emotional harm, may be found to be sensitive in nature.

APPENDIX A

What will happen to the information you provide?

The data recorded will only be used in accordance with the study as described above. All the data will be processed without name or any other directly recognizable type of information. De-identified data will be stored for one year after the project is completed and deleted thereafter.

Voluntary participation

Participation in this study is voluntary. You are entitled to withdraw your consent to participate in the study whenever you want to without stating any particular reason. Withdrawal from the study will not have implications in any way.

Additional information

If you have any questions, suggestions, or concerns please ask the researcher before signing this consent form. If anything arises after the interview please contact the individual listed on the top of this form.

I am willing to participate in the study:

(Signed, date)

I confirm that I have given information about the study:

(Signed, date)

APPENDIX B

INTERVIEW GUIDE

My name is Robin Cole, and I would like to talk to you about your personal and professional experiences and perceptions with caesarean sections. The interview should take approximately an hour. If it is okay with you, I will be tape recording our conversation. I assure you that all your comments will remain confidential. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time.

Are there any questions about what I have just explained?

Introduction and demographic information

Years practicing:

Title/position:

In which sector(s) (private/public) have you practiced:

Personal experience with CD (self or partner):

Preliminary: What is your general opinion about the current rate of cesarean delivery observed in Norway?

- How do you observe the choice of cesarean delivery in your practice?
- How do you perceive the support provided to the women who request CD?

Patient perception of childbirth

1. In general terms, would you please describe the woman who requests a cesarean section.
 - What are their main concerns/motivations?
 - Do you feel that women have accurate concerns?

APPENDIX B

Personal and professional experience

2. Can you describe an ideal birth?

3. Do you find it difficult to discuss birth options with women who disagree with your professional opinion?

- What strategies have you developed to cope with this disagreement?

Policy in context

4. Some would argue that a woman has a right to choose her birth method, and it is unethical to deny her this request. How do you react to this?

5. How do you foresee the current cesarean delivery rate changing?

- If you foresee it changing, what are the most important determinants in facilitating this change?

APPENDIX C



**Regional Committee for Medical
& Health Research Ethics**

South East Norway, Section C

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Our ref.: 2015/923

IRB ref: IRB00001870 REK Sør-Øst C

Date: 12th October 2015

To whom it may concern,

Re: REC Letter of Exemption

I am writing in reference to a request from Robin Cole via e-mail dated 30th of September 2015, regarding a Letter of Exemption in English.

Review

The Regional Committee for Medical & Health Research Ethics, Section C, South East Norway, reviewed the Research Project "Obstetric professionals' perceptions of cesarean delivery upon maternal request (*Norwegian title: Obstetrikers oppfatning av keisersnitt når den er ønsket av moren*) at its Committee Review Meeting on the 11th of June 2015. The Project Manager is David Lackland Sam and the Institution Responsible for Research is University of Bergen.

The application was assessed accordance with the Norwegian Research Ethics Act (2006) and Act on Medical and Health Research (2008).

The Committee's Decision

The Regional Committee for Medical & Health Research Ethics, Section C, South East Norway, found the Research Project to be outside the remit of the Act on Medical and Health Research (2008) and therefore can be implemented without its approval.

Ethics Committee System

The Ethics Committee System in Norway consists of seven Independent Regional Committees with authority to either approve or disapprove Medical Research Studies conducted within Norway, or by Norwegian Institutions, in accordance with the Act on Medical and Health Research (2008).

Please do not hesitate to contact the Regional Committee for Medical and Health Research Ethics Section South East C (REK Sør-Øst C) if further information is required, as we are happy to be of assistance.

Yours faithfully,

Britt-Ingjerd Nesheim
Chair of the Regional Committee for Medical
& Health Research Ethics of South East Norway,
Section C

Henriette Snilsberg
Executive Officer