

# **Caesarean section as an informed choice in the UK: A systematic review of qualitative studies on women's narratives using thematic synthesis.**

## **Abstract**

*Background:* Despite the steady increase in women giving birth via caesarean section in the UK, little is understood about how shared decision making is implemented in obstetrics or what this means for women that have given birth surgically via caesarean. The aim of this systematic review is to assess qualitative literature exploring narratives surrounding women's experiences of caesarean birth as an informed choice and their perceptions of involvement in this process. *Methods:* MEDLINE via EBSCO (MEDLINE, CINAHL, PsychNFO, AMED), EMBASE via OVID, MIDIRS via OVID, Scopus, Wiley Online Library, Google Scholar, Ethos as well as reference sections of included studies were searched. English language primary studies published between 1990-2020 were included in the search. Quality was assessed using the CASP tool in order to consider methodological rigour across individual studies. Findings were analysed using thematic synthesis framework for eliciting higher order interpretations. *Results:* Eleven studies were included in the final review, quality assessment indicated studies were generally of good quality with main limitations in methodology quality indicators. Thematic synthesis identified eight sub-themes related to three overarching themes of 'Patient-clinician' relationships', 'Decision making as an emotional journey' and 'Caesarean not really an informed 'choice''. Themes and sub-themes had interconnecting relationships; the role of health care providers in promoting women's sense of agency via a process of patient centred care was a prominent theme in women's narratives. *Conclusion:* Women's decision making over consent to undergo caesarean births is a complex, emotionally driven process that can have a significant, long-term psychological impact.

## 1. Introduction

The continual increase in Caesarean Section (CS) rates in the UK has been recognised as a public health issue due to a lack of evidence that CS generates better (or at least equitable) mother-infant outcomes compared to vaginal delivery (Wise, 2018; D'Souza R and Arulkumaran, 2013; D'Souza, 2013). The World Health Organisation emphasises that CS rates over 15% such as in the UK (currently at 26.2%) is indicative of unnecessary and therefore unethical surgical intervention (Wise, 2018; Betrán *et al*, 2016). In this regard, the National Institute for Health and Care Excellence (NICE, 2013) guidelines state informed choice/consent as the pinnacle in enabling women to act as equal partners in deciding their mode of birth in a clinical environment. It is reported that informed choice is achieved via maternity care providers supplying women with impartial, evidence-based information (Moore, 2016; D'Souza, 2013; NICE, 2013). The long-term benefits of shared decision making in obstetrics are widely recognised and include increased equity in care, decreased litigation due to improved patient satisfaction and better patient outcomes resulting in reduced post-care complications (Gee and Corry, 2012). Results from international studies identify that UK providers score highly in indicators of supporting women's rights to CS as an informed choice (Betrán *et al*, 2016; Habiba *et al*, 2006). However, shared decision making and informed choice are misunderstood by healthcare providers and is mostly comprised of a shallow process of decanting knowledge to lay persons in order to obtain a consent signature.(Begley *et al*, 2019).

Overall, there is a current lack of understanding regarding women's decision making with respect to CS and if women are genuinely undergoing CS as part of an informed procedure. The present review therefore aimed to shed light on women's decision making experiences of

scheduled and unscheduled CS (in the UK) that are embedded in women's narratives. **More specifically, the aims of this systematic review are two-fold:**

1. To systematically synthesise qualitative data surrounding women's viewpoints and experiences of shared decision making in undergoing CS surgery, both scheduled and unscheduled.
2. To investigate women's satisfaction and needs associated with their decision making process of CS as an informed procedure.

## **2. Methods**

The following databases were systematically searched for peer reviewed, full text, primary research articles published between 1990 and 2020: MEDLINE via EBSCO (MEDLINE, CINAHL, PsychNFO, AMED), EMBASE via OVID, Maternity and Infant Care Database (MIDIRS via OVID), Scopus, Wiley Online Library. In addition, a grey literature search was conducted by searching Google Scholar, Ethos as well as reference sections of included studies. The first author developed an initial search strategy consisting of a combination of keywords and MeSH terms (see appendix 1). **Search strategies were adapted for use in accordance to the different databases as listed above, and was configured according to the PICO framework surrounding the following six concepts that were connected using appropriate Boolean operators and truncation: 1. Cesarean OR Caesarean Section, 2. Mothers OR Postnatal OR women, etc, 3. Decision-making OR Authoritative Knowledge, etc, 4. Psychosocial outcomes OR Satisfaction, etc, 5. UK, 6. Qualitative method OR interview, etc.** Only English language journals published after 1990 were included for synthesis. The lower limitation was set to 1990, as the patient centred care approach was first adapted in the UK in the 90's stemming from the US Chronic Care Model (The Health Foundation, 2014).

Maternal choice in obstetric care policies were first implemented in the UK in 1993 (Kingdon *et al*, 2009; Paranjothy, 2004).

Qualitative studies including women who have given birth via CS delivery in a UK healthcare facility were considered for analysis. Mixed methods studies were also included if findings from the qualitative component could be extracted. There were no restrictions on CS intervention type; however, it was decided that studies on pregnant women's decision making regarding mode of birth with a focus on vaginal birth after a previous Caesarean (VBAC) diverted from the review question and were therefore excluded. In addition, studies focusing on the views or experiences of the non-maternity population (i.e. partner, health professional) were excluded. Studies were selected for inclusion via a purpose-designed data extraction form (see appendix 2).

The PRISMA flow chart was followed in processing and recording study selection outcomes (Moher *et al*, 2009). The first stage consisted of the first author (CD) reviewing all studies at title and abstract level, the second author (JL) reviewed 10% of the studies in order to check for consistency in approach of inclusion and exclusion criteria. Though the authors acknowledge full dual-reviewer screening as best practice, single-reviewer screening is recognised as an acceptable method in lieu of time limitations (Cochrane Information Retrieval Methods Group, 2019).

Thematic synthesis was employed in order to amalgamate descriptive themes as to arrive at a novel interpretation of the existing literature surrounding women's experiences of CS. Three steps were followed in using thematic synthesis in order to tabulate qualitative data<sup>0</sup>. This process consisted of: 1. Extrapolation of primary qualitative data obtained from the findings sections into the NVivo 12 software, followed by line by line coding of free codes that emerge from the text, 2. Aggregating of the free codes into related areas of descriptive themes using an inductive process of cross-comparison until no new concepts could be coded

into pre-existing ones 3. Development of analytical themes or higher-order themes that go beyond primary results in offering new understanding of the primary results. The aim to investigate CS as informed patient choice dovetails with the epistemological positioning of thematic synthesis in investigating viewpoints and experiences in order to answer questions regarding suitability and acceptability of an intervention (Thomas and Harden, 2008).

### 3. Results

The search strategy yielded 6404 studies for potential inclusion. Following removal of 603 duplicates and elimination of 5739 studies at title and abstract stage, 62 studies were identified for full text review resulting in 11 studies included in the final analysis (see figure 1).

Studies included the results from 242 multiparous and primiparous women that were interviewed individually or in focus groups (Weckesser *et al*, 2019; Kenyon *et al*, 2016; van Griensven *et al*, 2016; Mason, 2015; Tully and Ball, 2013; Fenwick *et al*, 2009; Baston, 2006; York *et al*, 2005; Murphy *et al*, 2003), as well as the open-ended survey responses of 1203 women (Redshaw and Hockley, 2010; Porter *et al*, 2007). Nearly half of the studies (N=5) were mixed method design (van Griensven *et al*, 2016; Baston, 2006) or part of a larger quantitative study (Redshaw and Hockley, 2010; Porter *et al*, 2007; Murphy *et al*, 2003). Qualitative data components were analysed using: thematic analysis (Weckesser *et al*, 2019; York *et al*, 2005; Murphy *et al*, 2003), content analysis (Tully and Ball, 2013; Redshaw and Hockley, 2010; Porter *et al*, 2007), narrative analysis (Mason, 2019), framework analysis (van Griensven *et al*, 2016; Kenyon *et al*, 2016) and grounded theory (Fenwick *et al*, 2009; Baston, 2006). Data were collected from a day to 20 years postpartum, only one study considered recollection bias in their study design by piloting the study on women who had given birth more recently (Murphy *et al*, 2003). Studies that reported

participant ethnicity (N=7) identified that 75% or more of participants were White (Kenyon *et al*, 2016; Tully and Ball, 2013; Redshaw and Hockley, 2010; Fenwick *et al*, 2009; Murphy *et al*, 2003), or White British (Weckesser *et al*, 2019; York *et al*, 2005). Moreover, most studies that did not publish participants' ethnicities discussed lack of representativeness as a limitation. (van Griensven *et al*, 2016; Mason, 2015; Baston, 2006; see **Error! Reference source not found.**table 1 for a summary of included studies).

Using the CASP (2020) checklist, quality of studies were shown to be high in regards to clarity of research aims, appropriate use of qualitative design, credible reporting of findings and implications for practice (see table 2). Studies that emerged from larger quantitative surveys were more likely to score lower in regards to methodological quality indicators. The two un-published studies were of high quality overall in comparison to some peer reviewed studies, this could be explained by less restriction on word count allowing for better reflexivity and in-depth description of the analytical process.

Thematic synthesis of the studies identified three key themes: 'patient-clinician relationships'; 'decision making as an emotional journey' and 'caesarean not really an informed choice'. Eight sub-themes were derived from the overarching themes including: 'women versus clinicians as decision makers', 'clinicians role in facilitating agency', 'touchpoints' in decision making', 'meaning of caesarean birth', 'information seeking', 'birth preparedness', 'recovery preparedness' and 'closure' (see theme table 3).

### 3.1 Patient-clinician relationships

#### 3.1.1. Women versus clinicians as decision makers

The phrase 'jumping through hoops' would best describe the experiences of women in the studies that had decided to elect CS as their mode of birth (Mason, 2015 p.223). Women reported feeling infantilised and undermined as they circumnavigated their way through

maternity care structures that were perceived as unsupportive of their decisions due to ulterior motives or did not offer comprehensive continuity of care systems, resulting in women continually feeling like they had to justify their decisions throughout (Kenyon *et al*, 2016; Mason, 2015; York *et al*, 2005). For some women, the wish to have a CS stemmed from a sense of regaining control after a lack of perceived agency during previous childbirth. These narratives illustrated the power struggle and frustration of being dismissed by maternity care providers (Kenyon *et al*, 2016; Tully and Ball, 2013; Fenwick *et al*, 2009; York *et al*, 2005; Murphy *et al*, 2003). In contrast, women who underwent an unscheduled CS reported having very little or no control over the decision to have a CS. Women used threatening medical terminology to explain the urgency of the situation, and how there was no scope to make decisions during the emergency circumstances (Tully and Ball, 2013; Redshaw and Hockley, 2010; Fenwick *et al*, 2009; Porter *et al*, 2007; Baston, 2006; Murphy *et al*, 2003):

*“We didn’t have opportunity to discuss it (CS) really. They said (the situation) was life or death and a threat to me as well”* (First time mother, 28 yrs)(Tully and Ball, 2013, p.107)

The theme ‘in safe hands’ illustrates how some women felt acceptance and even relief in handing over the reins to clinicians to make the decision for them to have a CS (Baston, 2006 p.120).

Contrastingly, ‘illusion of choice’ highlighted the concept of maternal choice as a tick-box exercise for clinicians (Kenyon *et al*, 2016; Tully and Ball, 2013; Baston, 2006; Murphy *et al*, 2003).

### 3.1.2 Clinicians’ role in facilitating agency

Clinician communication style was a key narrative in distinguishing perceptions of control and agency; particularly in unscheduled CS situations. Women’s needs and preferences in regards to clinician care varied widely, for example, some women found confidence in their clinicians’ speed and finality in performing surgery:

“I don’t think anybody introduced themselves to me... But that didn’t bother me, ‘cos they just seemed to work really well as a team.. and I just felt really happy that I was in good hands really” (1375) (Baston, 2006 p.167)

Clinical staff banter and informal approach were found to be re-assuring and normalising of a situation that was unexpected and frightening (Fenwick *et al*, 2009; Baston, 2006). However, for some women the rush, casualness or lack of communication only made women more anxious or served in de-humanising women who expressed themselves as feeling like “meat on slabs” (Porter *et al*, 2007 p.151) or next in a “production line” (Baston, 2006 p 170; Redshaw and Hockley, 2010). Overall, staff were described as ‘too busy’ or caught up in their workflow to offer more personalised care. Simple gestures, such as reassuring touches or having staff members talk through the process made women feel more involved in and satisfied with their CS births (Mason, 2015; Redshaw and Hockley, 2010; Fenwick *et al*, 2009, Porter *et al*, 2007; Baston, 2006).

This theme demonstrates how care provider communication, both direct and indirect, can impact the relative power balance of women’s decision making process and overall experience of birth. This has implications for practice in terms of staff training needs (i.e. basic counselling skills). In particular, how clinicians can best prepare women for medical situations where the notion of agency is subjugated by factors such as patient safety.

## 3.2 Decision making as an emotional journey

### 3.2.1 Touchpoints in decision making

Generally, women across the studies recognised vaginal delivery as the best option for themselves and their babies as deemed by society of what constitutes a ‘good mother’ (Mason, 2015). Therefore, the decision to undergo a CS was described as a melting pot of emotions ranging from guilt, sadness, disappointment, self-blame, anger and relief (Mason,



2015; Tully and Ball, 2013; Redshaw and Hockley, 2010; Fenwick *et al*, 2009; Baston, 2006; York *et al*, 2005). Touchpoints or situations of emotive saliency in the decision making process was named in three of the studies as important in the women's subjective journey towards accepting or finalising the decision to give birth via CS, and consequently how women remember their childbirth (Kenyon *et al*, 2016; Mason, 2015; Baston, 2006). For some women who had undergone unplanned CS, these touchpoints were defining moments usually signalling a loss of control over childbirth (Redshaw and Hockley, 2010; Baston, 2006). For women facing the possibility of a CS, the decision process was marred with anxiety related to the stigma of giving birth via CS. Women reported feeling relief once that decision was taken out of their hands, and felt like clinicians had a responsibility in aiding women manage the emotional aspects of going through this process (Baston, 2006; Tully and Ball, 2013; Mason, 2015). While others looked back at touchpoints with resentment, as this bookmarked how women failed to prevent an unwanted situation (i.e. unscheduled CS): *"I believe if they had done scans they would have seen that the baby was big and breech and a C-section would have been planned"* (5051 UP) (Redshaw and Hockley, 2010, p.155)

### *3.2.2. Meaning of Caesarean birth*

The subjective meaning women placed on CS as a mode of birth related to women's acceptance and postnatal adjustment. Women's accounts can be categorised into two separate entities: women who see mode of birth as a 'gateway' or meaningful transition into motherhood, in which CS is seen as aberration to this process. On the other hand, some women perceive CS as a means to an end, or a procedure that is necessary in order for them to receive their goal- a safe delivery and healthy baby (Mason, 2015; Fenwick *et al*, 2009; Baston, 2006; York *et al*, 2005).

*“It was just a really positive experience but to me the delivery was never important in a rite of passage sense” (Sarah)(Mason, 2015, p.142)*

Women described configuring meaning to CS births as a fluid process of internal negotiation. For example, some women compromised CS as a sacrifice they have to go through for the sake of their baby (Baston, 2006; Tully and Ball, 2013). Additionally, some women reflected on how the final decision to undergo a CS should have been facilitated earlier in order to allow re-framing of birth expectations (Kenyon *et al*, 2016; Mason, 2015; Redshaw and Hockley, 2010). Themes like ‘just another new mother’ exemplifies how clinician’s perception of CS is more in line with the viewpoint of surgical birth as a routine medical procedure (Redshaw and Hockley, 2010 p.155).

Overall, this theme illuminates the incongruity between clinical decision making models adapted by staff and the decision making journey undertaken by women in reframing their childbirth ideologies. It can be observed that women’s decisions or acceptance of CS are shaped by larger constructs that go beyond institutional influence, such as societal pressures over what is defined as normative births.

### **3. Caesarean not really an informed choice**

#### *3.3.1 Information seeking*

Women’s accounts reflected information seeking as emotionally driven and multifactorial, whereby different information sources were consulted according to women’s perception of needs. **There was a sense from women’s narratives that standardised, institution-level information did not cater to women’s needs.** Furthermore, women often felt clinician’s information was conflicting, biased or led by wider organisational priorities in promoting natural births (Weckesser *et al*, 2019; van Griensven *et al*, 2016; Kenyon *et al*, 2016; Mason, 2015; Tully and Ball, 2013; Fenwick *et al*, 2009; Baston, 2006; York *et al*, 2005; Murphy *et*

al, 2003). Overall, women who underwent both scheduled and un-scheduled CS questioned if the timing, quantity, quality and format of formal information given truly enabled informed decision-making (van Griensven *et al*, 2016; Redshaw and Hockley, 2010; York *et al*, 2005): “My Mum had a hysterectomy and the level of information she got for a fairly similar surgery was mountains and mountains. And we just like, don’t have anything” (Focus Group A)(Weckesser *et al*, 2019 p.6)

Women highlighted the importance of lay information sources such as the media and other women’s “birth stories” in order to build their own narrative in regards to the meaning and realities of CS (Mason, 2015 p.67).

These women described cognitive bias in selecting information in order to preserve pre-existing beliefs or to validate their feelings:

“My friends who have had emergencies and then electives, I wanted their opinion, just to reassure myself really” (Heather, bank clerk, 31 yrs)(York *et al*, 2005 p.443)

### 3.3.2 Birth preparedness

Overall, women’s sense of preparedness in undergoing a CS was linked to women’s feelings of agency over their childbirth. Women who felt inadequately prepared for their Caesarean birth, reported more negative association surrounding the emotional and physical consequence of CS. Words such as ‘shock’ were frequently used to illuminate how a CS birth was not expected and in dissonance to what women were taught and encouraged to practice at antenatal classes (i.e. birth plan)( Weckesser *et al*, 2019; Redshaw and Hockley, 2010; Porter *et al*, 2007; Baston, 2006; Murphy *et al*, 2003). Lack of preparedness was also connoted with women feeling distress and fear during the CS surgery, or associated operational procedures such as anaesthesia and even the operative room environment (Mason, 2015; Tully and Ball, 2013; Redshaw and Hockley, 2010; Porter *et al*, 2007):

*“The spinal injection and the sensation of hands working inside my body- I’ve always described it as ‘gutting a fish’” (0319)(Porter et al, 2007 p.150)*

For some women, this sense of detachment was transferred towards their infants with women reporting feeling “numb” (Baston, 2006 p.558) and unable to bond immediately after birth (Fenwick et al, 2009; Porter et al, 2007; Baston, 2006).

*“I actually said ‘yes take him (baby) away’. Because I hadn’t really felt as though I’d given birth or anything” (305; Baston, 2006 p.131).*

### *3.3.3 Recovery preparedness*

Both scheduled and unscheduled CS first time mothers reported lack of knowledge regarding what to expect after CS births, both in the short term and longer term. Women’s vulnerability and dependence on clinicians during the surgery was further compounded by women’s feelings of helplessness after surgery (Weckesser et al, 2019; Mason, 2015; Tully and Ball, 2013; Fenwick et al, 2009; Porter et al, 2007; Baston, 2006). Some of the women contrasted their experience of having decisions made for them by a panel of experts during birth, to being left with inadequate knowledge and tools to make postnatal decisions or having little awareness of how CS could affect other maternal decisions (breastfeeding) (Mason, 2015; Redshaw and Hockley, 2010; Baston, 2006). Furthermore, women reported not factoring in the emotional and physical toll of balancing motherhood with postoperative recovery, and not being aware of the recovery duration as well as all the risks associated with caesarean surgery (Weckesser et al, 2019; van Griensven et al, 2016; Porter et al, 2007; York et al, 2005).

*“I don’t feel as if anyone’s ever informed fully of, one, how major an operation it is, and two, how long it’s going to take to heal externally, but also internally, and the sort of pains and afterpains you get” (32)(van Griensven et al, 2016 p.13)*

### *3.3.4 Closure*

Debrief was a key construct identified throughout the studies as women mentioned a lack of opportunity to discuss and regain closure following their CS births. Women explained debrief as more involving than giving out postnatal recovery information (Mason, 2015; Redshaw and Hockley, 2010; Fenwick *et al*, 2009; Baston, 2006; Murphy *et al*, 2003):

*“I can’t remember anyone actually talking to me about post-caesarean, and how I might feel about it. I think it was all at the physical end, not at the mental end”* (1343) (Baston, 2006 p.123)<sup>0</sup>

Women in the studies highlighted the important yet unfulfilled need of debriefing in order to make sense of or normalise their CS experience. Clinicians’ lack of acknowledgement over how women were left feeling about their CS births served to reinforce feelings of lack of ownership over the birth:

*“But that got me nowhere (crying). That didn’t get anybody to say ‘Oh, I’m really sorry about that’ or ‘why do you feel angry’. It didn’t even get anybody to say, ‘Explain to me why you feel like this’”* (1375)(Baston, 2006 p.135)

This theme encapsulates women’s unmet needs in regards to practical information and emotional support. Misalignment between caregivers perception of CS as a routine event wherein clinical input ceases when the goal of successful delivery is achieved, versus CS as an important beginning to motherhood is again illustrated by the postsurgical care precipice and lack of opportunity for debriefing.

#### **4. Discussion**

This review synthesised the qualitative findings of 11 studies; themes were interlinked and highlight patient-clinician dynamics as a key factor underlying how women feel about their

birthing decisions. Accounts echo previous findings that mode of birth does not solely influence maternal satisfaction or outcomes (Bell & Andersson, 2016; Spaich, 2013). The complex interplay of intrapartum experiences such as institution led care pathways and inaccessibility of equitable information leading to discrepancy in expectations can better explain women's processing of CS births.

Current UK guidelines promote the golden standard of CS as maternal choice as long as the woman is adequately informed and accurately aware of risks and benefits, the role of the clinician placed as expediter of this process (NICE, 2013). Findings from this review indicate that there is minimal evidence of CS births, either scheduled or unscheduled, as the product of a shared decision making process. The theme 'patient-clinician relationships' illustrates the unbalance of influence between women and clinician in the studies. Findings resonate with results indicating that women's involvement preferences vary widely; these variations in findings can perhaps be explained by the difference between the *what* and *how* in provider communication (Patterson et al, 2019 p78-79). Women who experienced empathic, personalised care from their providers were more likely to perceive their experience favourably; even in scenarios where women had low levels of control over what was happening to them.

A lack of preparation was identified as a prominent narrative and key indicator that women do not undergo CS as an informed procedure. Women who underwent unscheduled CS reported that they were not expecting to give birth surgically and did not fully understand the reasons or implications surrounding their childbirth. Even women who expected their CS births reported not fully anticipating the postsurgical **physical** and psychological debilities. Moreover, women were not fully aware of the risks or potential complications of surgical

birth; further putting into question ethical issues surrounding consent and informed choice. For some women, the dissociation experienced in the theatre carried over to parturition with women reporting numbness or loss of attachment to their babies. These findings are comparable with what is already known in literature; post-CS emotional difficulties ranging from mood disturbances to PTSD are more marked in women who experience unscheduled CS. Furthermore, this can be explained by the interlinked triad of loss of control over birth decisions, mismatch in expectations of a momentous occasion and poor woman-provider interrelationships (Benton *et al*, 2019; Kjerulff and Brubaker, 2017; Puia, 2013; Lobel and DeLuca, 2007).

Findings from this review have important implications for practice in that provider discourse and standard antenatal education packages with a heavy focus on natural births as the norm are not discouraging surgical births, but are impacting on how women feel about their decision or experience of CS births. With 1 in 4 women giving birth via CS currently in the UK (Paranjothy, 2004), there is a responsibility to include CS births as part of routine conversation in obstetric care and the antenatal curriculum offered to expecting women and families. In this regards, increasing the quantity and quality of impartial information regarding all birth modes could not only aid shared decision making, but also promote acceptance for those that had not planned their caesarean section.

#### **4.1 Limitations and recommendations for further research**

There are a number of caveats to this systematic review. Firstly, almost half of the studies included (N= 5) were published more than 10 years ago (Fenwick *et al*, 2009; Porter *et al*, 2007; Baston, 2006; York *et al*, 2005; Murphy *et al*, 2003). Current research is therefore needed in order to extrapolate how (or if) changes in care practice (i.e. skin-to-skin initiatives) has impacted on women's feeling of agency in the decision making process and general CS birth experiences.

Secondly, a disproportionate number of women who participated in the studies were of White British ethnicity, employed and in a relationship at the time of birth. Evidence indicates that immigrant women and women of Black ethnicities are more likely to experience birth complications resulting in surgical intervention (RCOG, 2001). Moreover, there is evidence that women's faith related needs are not well understood by care providers (Firdous, 2020). Further research is therefore necessary to explore the decision making experiences of BAME women that are statistically more likely to go through unscheduled CS births (RCOG, 2001), and likely to have additional needs due to cultural and language barriers. Findings from this review illustrate that women are not passive receivers of information; rather decision making or decision reviewing consists of complex mental heuristics that are often situational. It remains unclear how medically trained clinicians working within limited capacity can best support women that are more vulnerable, despite the increase in prevalence of women with additional needs (i.e. refugee women) accessing NHS maternity services (Higginbottom *et al*, 2019).

Quality appraisal of studies indicated methodological flaws can be addressed in future studies. Of note, most studies did not explain authors' process or rationale in purposively sampling participants that originated from larger quantitative studies; putting into question breadth of accounts and qualitative research rigour (Meyrick, 2006). Overall, high quality qualitative and quantitative research with a focus on improving diversity of accounts are needed to gain a better understanding of patient experiences for service improvement.

## **4.2 Conclusion**

Women assign meaning to birth mode with some women rejecting the concept of surgical births more than others do. The promise of choice and informed decision making in obstetrics can be misleading, as this connotes an element of control over a natural or surgical situation that can be unpredictable and often uncontrollable. It is clear from women's accounts that



maternity care providers have a role in preparing women towards the realities of birth and facilitating agency in situations that are outside women's control. As the number of CS births is predicted to increase (Betrán et al, 2016), it is important that women's decision making requirements are met in order to foster healthier mother-infant outcomes.

#### 4.3 Practice recommendations

- Standardisation of maternity care policy and practice that endorse shared decision making, including clinician skills training or upskilling in emotional aspects of birth.
- Shift towards antenatal education programmes that de-stigmatises CS as a common birth procedure and de-mystifies birth aspects in general.
- Availability of timely ante- and post- natal information that is objective and accessible.
- Opportunity to debrief in a way that is mindful and empowering.

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