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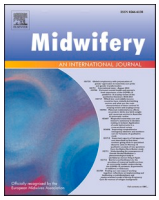

Clinical decision-making during childbirth in health facilities from the perspectives of labouring women, relatives, and health care providers: A scoping review

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ABSTRACT

Problem: For health care providers to ensure appropriate decision-making in clinical settings during childbirth, facilitators and barriers must be identified.
Background: Women who experience a sense of control by participating in the decision-making process, are more likely to have a positive birth experience. However, decision-making may involve hierarchies of close observation and control.
Aim: The aim of the scoping review was to map and summarise existing literature on the process of clinical decision-making during childbirth from the perspective of labouring women, relatives and health care providers.
Methods: We carried out a scoping review in line with Joanna Briggs Institute scoping review methodology. The search identified studies in Scandinavian or English languages from 2010 - Jan 2023 comprising evidence at different levels of the pyramid, resulting in 18.227 hits. Following the PRISMA checklist, the final inclusion comprised 62 papers.
Findings: Four main categories summarized the importance of the following factors: 1) Woman-caregiver relationship, with sub-categories The importance of communication and Midwifery care, 2) Consent and legal issues, 3) Organization, with sub-categories Medicalization, Working atmosphere, and Complexity, and 4) Decision-making tools and models, with sub-categories Shared decision-making, and Other tools and models for decision-making.
Conclusion: Balancing intuition and expertise of caregivers with evidence-based practices, is crucial to ensure women's participation in decision-making. Furthermore, a trusting relationship between the mother, partner, and health care provider is of utmost importance. Shared decision-making, which appeared to be the primary model for clinical decision-making regardless context, requires reflective practice and is a communication strategy.

Problem

Existing facilitators and barriers for appropriate decision-making in childbirth are not well known.

What is Already Known

Women who feel in control during childbirth by participating in the decision-making process, have an increased likelihood of a

Abbreviations: CDSR, Cochrane; CS, Caesarean Section; DM, Decision-making; HCP, Health Care Provider; ICM, International Confederation of Midwives; JBI, Joanna Briggs Institute; OSF, Open Science Framework; RMC, Respectful maternal care; SDM, Shared decision-making; WHO, World Health Organization.

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positive birth experience.

What this Paper Adds

The review identified important factors influencing the decision-making process positively and negatively. Main facilitators for appropriate decision-making are a trustful relationship between the mother, partner and the health care providers, good communication, and midwifery care. Other determining factors are consent and legal issues, medicalization, working atmosphere, complexity, shared decision-making, and other models for decision-making.

Introduction

Decision-making (DM) and women's involvement in maternity care is a focus area for health care providers (HCP). According to International Confederation of Midwives (ICM) and World Health Organization (WHO), midwives should support the right of women to actively participate in decisions about their care (ICM, 2008; World Health Organization, 2018). As stated in a systematic review carried out to inform WHO intrapartum guidelines, women hope for a childbirth in a clinically, culturally and psychologically safe environment where they can experience a sense of control by being a part of the decision-making process (Downe et al., 2018). A metasynthesis about DM and informed choice identified three themes; "uncertainty"; women's concerns about the unknown and the course of pregnancy and childbirth, "bodily autonomy and integrity"; control of her own body, and "performing good motherhood"; understood as the responsibility of giving birth in a hospital setting according to risk assessment. These three factors influence maternal health decision-making. However, the authors found little research on the process of decision-making (Yuill et al., 2020).

DM in midwifery is a process that offers opportunities to engage in discussions that maintain the integrity of all individuals involved. This process is influenced by factors such as available resources, the cultural context and the woman's needs, but always place the woman and her child in the centre of care (Jefford and Jomeen, 2020). An evidence-based model for DM in midwifery acknowledges the physical, legal, political, cultural, and societal context of women and midwives (Menage, 2016). However, a review on midwifery DM in childbirth shows that it involves hierarchies of close observation and control. Existing research does not inform the discipline of the complexity of midwifery clinical DM during childbirth (Jefford et al., 2010).

There is lack of research on the process of multi-professional DM within midwifery and obstetrics (Dowding et al., 2011), and a need for deeper understanding on how DM during childbirth can influence level of patient safety. Multi-professional simulation training in teams can provide health care workers with complex and complicated situations that can help prepare for enhanced efficiency and patient-centred care, and to reduce time stress perception for improved DM (Dekker et al., 2012; Gregory et al., 2017). Training as a team on risk images can lead to increased awareness among participants, ultimately enhancing the DM process (Braut et al., 2012; Dekker et al., 2012).

Contextual factors influencing DM must be identified (Dekker et al., 2012). WHO states that women in low-income countries are less likely to demand participation in DM during childbirth than pregnant women in high-income countries (World Health Organization, 2018). The study presented here is part of a multi-professional simulation training project on decision-making in prolonged labour in Norway and Tanzania Høifødt et al., 2022.

The aim of the scoping review is to map and summarise existing literature and clarify concepts and definitions on clinical decision-making with user involvement during childbirth, in line with Joanna Briggs Institute (JBI) recommendations (Aromataris and Munn, 2020; Munn et al., 2018; Pollock et al., 2023). The objectives, inclusion criteria and methods for this scoping review were specified in the protocol published in Open Science Framework (OSF) 23rd September 2020 Egenberg et al., 2020. Being a part of the multi-professional simulation training project on decision-making in prolonged labour in high- and low-resource settings, the aim of the scoping review is to inform the project by giving a scientific overview on clinical decision-making during childbirth in health facilities, from the perspectives of labouring women, relatives, and health care providers.

Due to the pandemic, the group of co-authors for the protocol was partly replaced by other co-authors for the scoping review.

Methods

Study design

The review is carried out in line with Joanna Briggs Institute scoping reviews' manual (Joanna Briggs Institute, 2022), to map and summarise existing literature and clarify concepts and framework from any type of literature (Munn et al., 2018). We had an inductive approach by developing a coding framework, categories, and subcategories (Pollock et al., 2023). The review was conducted as a preparation for the interventional study: "Enhancing patient safety in high- and low-resource settings: how to improve the process of decision-making in case of prolonged labour?" Høifødt et al., 2022. The scoping review allows inclusion of evidence also from non-research sources – unlike systematic reviews. Critical appraisal is not mandatory for scoping reviews and formal syntheses are generally not performed (Joanna Briggs Institute, 2022).

Research question

A preliminary search was carried out, identifying literature addressing the research question for the scoping review: *How does existing literature present the process of and the reasons for clinical decision-making with user involvement during childbirth, from the perspectives of labouring women, relatives, and health care providers?*

Eligibility criteria

We included papers on childbirth for singleton pregnancies with cephalic presentation, focusing on user perspective in decision-making. We included healthcare providers like registered midwives/nurses and gynaecologists/doctors caring for women during childbirth in health facilities, with the population of mothers, labouring women, fathers, partners, and relatives. "Labour and birth" were understood as "childbirth".

Inclusion criteria

The inclusion criteria are presented according to Population, Concept and Context (PCC) (Joanna Briggs Institute, 2022).

Population. The review comprises studies involving health care providers, pregnant women and women who have given birth, and their partners/relatives. To identify the target population, we used terms like mother, labouring woman, father, partner and relatives (Joanna Briggs Institute, 2022).

Concept. DM within healthcare might be referred to as clinical decision-making as well as shared decision-making (SDM) (Tiffen et al., 2014). Women in labour are active members of the team with definite expectations. The concept of DM during childbirth is understood in this perspective and reported accordingly (Joanna Briggs Institute, 2022).

Context. The scoping review was done in a global context (Joanna Briggs Institute, 2022), focusing on childbirth in health facilities.

Exclusion criteria

Most papers were found to be irrelevant, explained by the wide literature search. We excluded all literature that did not focus primarily on childbirth for singleton pregnancies with cephalic presentation at term. Among the excluded topics: abortion, breastfeeding, breech, family planning, premature birth, twins etc. (see appendix I). An additional, thorough screening process was carried out among the 259 remaining papers to exclude papers not highly relevant to user involvement/DM in childbirth. This exclusion process was mainly comprising papers which did not focus on women's and relatives' involvement in DM, and papers focusing on DM between health care providers only.

Search strategy

While preparing the protocol Egenberg et al., 2020, we verified in Prospero (National Institute for Health Research, 2019), JBI (Joanna Briggs Institute, 2022) and Cochrane Libraries (Library, 2024) by using terms like childbirth, obstetrics, midwife, decision-making and patient participation, that our review question has not yet been thoroughly addressed, see Appendix II. We did an extensive search using the databases Embase, Medline, CINAHL, Web of Science, Cochrane CDSR, SveMed, Google Scholar, JBI Reviews and Protocols, and British Nursing Index to identify studies on this topic. To understand the mechanisms of decision-making in childbirth, we decided to exclude studies focusing on where to give birth, pregnancy and postnatal complications, co-morbidity etc.

The following was our search strategy for Medline database: labour, obstetric, parturition, delivery, obstetric, caesarean section, vaginal birth after caesarean, partus, childbirth, full-term birth, decision making, clinical decision-making, shared decision-making, patient participation, consumer, client, patient, user, mother, maternal, partner, father, family, co-mother, labouring woman, "participat"," involv", "engage", empowerment.

For search strategy, see Appendix II Search strategies systematic reviews and Appendix III Search Strategies Childbirth and Decision-making. In January 2023, we conducted renewed searches to identify relevant published papers covering the period from February 2020 to January 2023.

The search identified studies in Scandinavian or English languages from 2010 - Jan 2023, comprising evidence at different levels of the pyramid (Alper and Haynes, 2016; Aromataris and Munn, 2020).

"Clinical DM" is understood as a "contextual, continuous and evolving process, where data are gathered, interpreted, and evaluated in order to select an evidence-based choice of action" (Tiffen et al., 2014).

Sources of evidence

We used the databases Embase, Medline, CINAHL, Web of Science, Cochrane (CDSR), SveMed+, Google Scholar, Joanna Briggs Institute Reviews and Protocols and British Nursing Index. The searches, carried out by the senior librarians Elisabeth Hundstad Molland at Stavanger University Hospital/University of Stavanger and Pema Gurung at Leiden University Medical Center, resulted in 18,227 hits. After removing 6313 duplicates, we were left with 11,914 hits.

Screening and selection

The first screening process of 18,227 papers for relevance according to childbirth for singleton pregnancies with cephalic presentation, was carried out according to the inclusion criteria. The screening process was done partly manually and partly using Rayyan web application. All papers that were included or labelled as "uncertain", were screened by 3 reviewers independently. We used any source of evidence and were not restricted to any specific design. To map the evidence, we asked "how", "by whom" and "for what purpose" the identified terms were used.

The screening process resulted in 1145 remaining papers. Three reviewers, screening all papers independently, conducted the selection of the remaining 1145 titles and abstracts (Joanna Briggs Institute, 2022; Tricco et al., 2018). Papers that met the inclusion criteria by at least two out of three reviewers, were included. After this screening process, we were left with 259 included papers. The third screening process in combination with data charting was carried out by eight reviewers independently charting data from the included, full text papers. Working in pairs, data extraction was crosschecked by the third reviewer, ensuring that all data were double-checked. The process of including sources of evidence that relate to the review questions and objectives, aligns with the concept mapping for scoping reviews (Aromataris and Munn, 2020). Among the 197 excluded papers, the main reason for exclusion was lack of women's and relatives' involvement in DM, and papers focusing on DM between health care providers only. Among the 197 excluded papers, nearly 50 % were qualitative studies, 25 % quantitative studies and the rest mixed methods design and commentaries.

The final inclusion comprised 62 papers.

The selection was done according to the PRISMA checklist (Tricco et al., 2018), see Appendix IV.

We compiled a tabular form with all the included data according to the review question (Joanna Briggs Institute, 2022), see Table 1 for condensed results. After compiling a tabular form with all the included data, each author read the data, asking "how" (describing the process), "why" (describing the rationale), "who" (the different groups) and looked for "facilitators and barriers" regarding DM to map the results (Waddell et al., 2021).

Data extraction

We extracted study characteristics relevant to answer the review question in line with JBI guidelines (Joanna Briggs Institute, 2022).

1. Authors of the paper/study.
2. Year of publication.
3. Country of origin, indicating the background of the co-author group.
4. Aims defined in the paper.
5. Study design/type of text – quantitative, qualitative, mixed methods, review, commentary, conference presentation.
6. Study population; women experiencing childbirth, and HCPs like nurses/midwives/student midwives, doctors/gynaecologists, or groups of HCPs reflecting a variety of professions within maternity care.
7. Concept; the motivation behind the study, "why this study?"
8. Context; describing the site/place/environment for the actual study population, like a maternity ward, a birthing centre, a district hospital or more generally a region.
9. Key findings/messages; the main findings.
10. Definitions were charted if they contributed to clarity or new knowledge.

During the data extraction process, many of the sources presented facilitators and barriers for decision-making. The author group found it appropriate to list findings also according to facilitators and barriers to understand the perspectives of clinical DM among different cadres (Waddell A et al., 2021), although this was not specified in the protocol (Pollock et al., 2023).

Table 1
Tabular form of results.

Authors	Aims	Study design/type of text	Study population	Concept	Context	Key findings/messages
(Koster et al., 2019), The Netherlands	Theory development	Qualitative exploratory study	Women having given birth in a Dutch birth setting	Experienced care during traumatic childbirth	Dutch birth movement	Three themes caused traumatic birth experiences: lack of information and consent. A feeling of being excluded. Discrepancies between women's expectations and reality
(Attanasio et al., 2018), USA	To examine correlates of SDM in childbirth	Cohort interviews	3006 first time mothers	A calling for attention to SDM as patient-centred care	Hospitals US	Women from marginalized social groups were less likely to experience SDM. This also applied to women who were induced, had CS or other instrumental delivery.
(Vedam et al., 2017), Canada	To develop and validate a new SDM instrument	A cross-sectional quantitative survey	1672 women who met a single type of HCP	Assessment of women's autonomy and role of decision	Primary health care	MADM scale – a reliable instrument for assessing autonomy in decision-making in maternity care
(Fair and Morrison, 2011), USA	To examine maternal control during childbirth	Qualitative design	31 primiparas	Experience of control during labour - a strong predictor of birth satisfaction	Recruited from a prenatal care clinic	important aspects of support; preparation, communication, support from provider, respect for the wish for control
(Johnson et al., 2022), Canada	To develop performance indicators for labour and birth that reflect the patient perspective	A qualitative interview design	11 new mothers within 1 year after childbirth	Policy and protocols have been developed without patients' perspectives	Recruited from midwifery and obstetrical clinics	5 themes emerged: desire for patient-centred care, improved communication, expectations of the birth process, care team support during labour and birth, continuing emotional and physical postpartum care. Good communication and SDM made women describe their labour and birth as a satisfying experience
(Watkins et al., 2022), Australia	To explore childbearing women's preferences for collaboration and control over decision-making	A sequential, mixed-method, multi-site case study	182 postnatal women	Poor interprofessional collaboration and lack of decision-making with women have consequences for quality of care	Postnatal wards in 4 maternity services	Fundamental barriers like lack of time and resources, lack of familiarity with and access to their preferred model of maternity care, hindered women's participation in collaboration. Shared decision-making with childbearing women was not routine practice.
(Mazúchová et al., 2020), Slovakia	To determine the satisfaction of women with their participation in decision-making during childbirth	A quantitative cross-sectional study.	360 women 1-year post- partum with a natural birth	The use of the birth plan sometimes provokes hostile opposition from some health professionals	5 paediatric centres during regular medical check-ups	61.5 % of the women were satisfied with control and participation in decision-making during childbirth. Findings indicate the necessity to respect women's autonomy during childbirth, with care focused on the needs of mothers, their rights as well as their active participation during childbirth.
(Abubakar et al., 2020), Nigeria	To examine the influence of responsibility of health decision on maternal complications	A cross-sectional study	206 women in labour	Women of childbearing age in sub-Saharan countries do not themselves decide whether to seek healthcare	A public hospital	Healthcare decisions were made by the participants' husbands in nearly 90 % of the cases. There was a significant relationship between health decision-making and maternal complications.
(Huschke, 2022), Ireland	To explain involvement in DM: why this is happening and how women's subjective experiences are shaped by organisational	Qualitative design using in-depth interviews	23 women, first year after delivery	Critical feminist research on pregnancy and birth	Hospital units in Ireland	*Technocratic and obstetric focused maternity settings serve as a basis for unequal power dynamics and top-down approach. * Women experienced sanctions and

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Table 1 (*continued*)

Authors	Aims	Study design/type of text	Study population	Concept	Context	Key findings/messages
	cultures and social norms					threats from HCP when they didn't want a procedure or treatment * Some women opted free birth/home birth to make sure to be heard * Fear of litigation •Most women did not expect birth to be a positive experience nor to have a role in decision-making process
(López-Toribio et al., 2021), Spain	Explore women's experiences of participation in shared decision-making/ SDM	Qualitative design using focus groups	Women: 23 first time mothers given birth last year	No studies in Spain which have comprehensively explored women's experiences of participation in SDM throughout childbirth	Large hospital	*Use of a single tool, as the birth plan, is insufficient to promote women`s participation in SDM *Lack of information due to insufficient content and/or inappropriate timing. *Suggestions to improve women's participation in SDM: establish mutually respectful relationships between HCP and women and continuity of coordinated, personal care.
(Schulz and Wirtz, 2022), Germany	To analyse measurement of patient reported outcomes reflecting better outcomes over time	A cross sectional survey	150 women 6–12 months after childbirth	No studies were measuring maternity response shifts regarding consultation, relational empathy and SDM	Women using midwifery services during pregnancy and childbirth	The study gives improved understanding of empathy and SDM in midwifery care. Women perceive empathy of the midwife during birth as weaker than during pregnancy. Interactional-communicative behaviour (two-way process) and nonverbal empathy considered as setting-independent core aspects of midwifery. SDM scored significantly lower during birth compared to pregnancy.
(Deherder et al., 2022), Belgium	To explore autonomy and shared decision making	Survey	617 mothers 2–12 months postpartum	To explore the extent to which involvement in midwifery and obstetric care contributes to the childbirth experience after MeToo	Flemish women's experience with labour and birth after #metoo	Women in Belgium felt lower autonomy in SDM with doctors compared to midwives. However, they felt lower autonomy with midwives in Belgium compared to similar studier on autonomy with midwives in The Netherlands and Canada
(Declercq et al., 2020), USA	To explore experiences of care options and SDM	A national survey	Women 18–45 years in US. Analysis based on 1421 participants	Listening to Mothers in California survey	Vaginal, singleton hospital births attended by obstetricians or midwives	In adjusted analyses, relative to obstetric care, midwifery care was associated with less use of interventions, less pressure to have interventions, and greater encouragement of women's own decision making.
(Molenaar et al., 2018), The Netherlands	To explore experiences and needs of parents and HCPs regarding SDM	Qualitative; 11 Focus Group Discussions (no 71)	Parents, midwives, obstetricians, obstetric nurses, and care assistants	Facilitators and barriers to use Elwyn's three-step model; choice talk, option talk, decision talk	Hospitals, midwifery practices and organizations for maternity care assistants	Parents and professionals recognized the steps of introducing a decision (choice talk) and discussing options (option talk), but most parents did not seem to discuss preferences with professionals before reaching their final decision (decision talk).
(Altaweli et al., 2019), Saudi-Arabia	To understand what influences HCPs decision-making and practices	Ethnographic study	Women in labour, HCPs	medicalization of childbirth	maternity wards of two large hospitals	Three core influences that shaped clinical decision-making were identified: organizational culture, a medical concept of birth,

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Table 1 (*continued*)

Authors	Aims	Study design/type of text	Study population	Concept	Context	Key findings/messages
						and a hierarchical system of control
(Meyer et al., 2019), Switzerland	To increase understanding of decision-making in complex home-like birth settings	Grounded theory approach	20 midwives and 20 women	Unexpected complications require a decision of whether to transfer	Midwives attending births in home-like births centres	Midwives should be aware of the influence of mutual and personal commitments. Need of appropriate information to enable women to accept change to their plans. SDM does not need equality; decision-making is unevenly shared
(Jackson et al., 2017), UK	To explore how women's, partners' and HCPs involvement in decision-making	Conversation analysis of transcribed video films	26 labouring women, their partners and HCP	Few studies on experience of women's, parents', HCPs' interaction during labour	British reality television programme	"We need to", "we are going to" do not provide a space for discussion. It shows HCPs authority and how their authority reduces the women's participation
(Nieuwenhuijze, Low, et al., 2014), The Netherlands	To explore communication between maternity care providers and women during second stage of labour regarding birthing positions	Exploratory, qualitative design	41 nulliparous women in 2nd stage, and their HCPs	Women's involvement in decision making - a profound effect on their birth experiences and satisfaction	A teaching hospital	Maternity care providers used a dynamic process between open, informative approaches and more closed, directive approaches depending on the woman's needs and clinical condition.
(O'Donnell et al., 2014), Malawi	To explore the perceptions of maternity care in a rural setting	27 in-depth interviews and 2 focus group discussions	33 postnatal mothers, 10 HCP	Care unacceptable to the woman although high clinical standard. Care popular with the women but ineffective or harmful	4 major hospitals	The perceptions of quality of care differed substantially. Caregivers perceived that good quality care included availability of resources, while postnatal mothers prioritized good relationships with their caregiver
(Ringqvist et al., 2022), Sweden	To explore the factors behind secondary fear of childbirth among multiparous women	Quality improvement work in two steps: 1. design of a care model for Timeout in prolonged labour based on interviews. 2. implementation of a care model	41 women with secondary fear of childbirth after prolonged labour	The importance of creating woman-centred birthing environments, where women can feel free and secure during birth	A large university hospital	The Time-out as a care model can prevent secondary FOC. Central aspects of the model are to ensure women's involvement, good communication and a documented care plan for women in prolonged labour. Interprofessional teamwork is of importance
(O'Brien et al., 2021), Ireland	To generate greater awareness of the contextual and relational factors that influence SDM	Qualitative; action research	5 postnatal women, 13 midwives	SDM	Large hospital	Multiple organisational and relational factors influence how women can participate in SDM, including the model of care they attend, continuity of carer, power dynamics, hospital policies and trust in self and others. Exercising choice is not only defined by but dependent on the degree of trust in their relationships with maternity care professionals.
(Weiseth et al., 2022), USA	To evaluate the feasibility, acceptability, and safety of TeamBirth	"TeamBirth" interventional study using mixed methods	2669 patients and 375 clinicians	A need for system innovations to close gaps in quality of care	Four high-volume community hospitals	89 % of respondents reported experiencing at least one huddle. 89 % of respondents reported experiencing at least one huddle. TeamBirth was acceptable for both patients and clinicians; HCPs talked about labour in a way the women could understand, and their preferences made a difference. TeamBirth involved and empowered the patients and family in their care

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Table 1 (*continued*)

Authors	Aims	Study design/type of text	Study population	Concept	Context	Key findings/messages
(Skoogh et al., 2019), Sweden	HCPs perceptions of patient safety in connection to childbirth	Descriptive and qualitative design	19 midwives, nursing assistants and physicians	To understand patient safety in intrapartum care	Labour wards in 3 mid-size hospitals	The informants perceived that to listen, avoid unnecessary interventions, value trust and respectful communication for better decision making, learn and reflect after incidents were important factors for patient safety.
(Weltens et al., 2019), The Netherlands	To understand underlying factors for decision-making	A qualitative study	10 Dutch midwives working in midwifery-led care	An increase of intrapartum referrals to obstetric-led care	Rural and mixed areas	Knowledge and intuition is influencing midwives' reasoned decision-making. SDM is practices in non-urgent situations. New form of risk perception, leading to "better safe than sorry" approach
(Rietveld et al., 2018), The Netherlands	To increase understanding of gynaecologists' decision-making during trial of labour	A constructivist grounded theory approach	9 gynaecologists	A broader perspective than focusing only on specific personality traits	9 different hospitals	Patients' opinions, aspects of progress of labour and gynaecologists' personal stances regarding trial of labour played a role in the decision-making process
(Gregory et al., 2017), USA	Describe the relationship between decision-making style and decision quality	Mixed methods; survey and observation	40 delivery nurses, physicians, and allied personnel	Influencing factors of the decision-making process in this context have been understudied.	One labour and delivery unit	There was a relation between analytical and intuitive decision-making and time stress on decision quality in observations of real clinical decisions.
(Daemers et al., 2017), The Netherlands	Explore factors influencing clinical decision-making	Qualitative research	11 Dutch primary care midwives	Midwives' clinical decision-making processes	Intra-partum decision making	Factors influencing clinical decision-making: perception of pregnant women and midwives as whole persons, sources of knowledge, collaboration between maternity care professionals, and organisation of care.
(Melman et al., 2017), The Netherlands	Insight into facilitators and barriers among professionals involved in decision-making	Qualitative study	30 obstetricians/ obstetric residents, 9 midwives	What are facilitators and barriers to adhere to the existing guideline for performing a CS?	Hospitals in different regions	HCPs hesitate to allow women to be part of the decision-making process on mode of birth. Barriers for guideline adherence: insufficient staffing, lack of technical skills, and disagreement with some of the guideline recommendations
(Van Otterloo and Connelly, 2016), USA	To clarify the meaning of risk	Concept analysis	Obstetric nurses	Understanding risk can help nurses identify who is at risk and how to intervene	Coping strategies and previous life experiences	Three defining attributes of risk were identified: chance of injury/loss, cognitive recognition and the decision-making processes
(Litorp et al., 2015), Tanzania	To explore obstetric caregivers' rationales for their hospital's CS rate	Qualitative design	32 obstetric caregivers	A high CS rate	A Tanzanian university hospital	Caregivers' rationale for CS: factors outside their control, private practice, specialist-resident interaction, resident-midwife interaction, fear and blame
(Nieuwenhuijze, Korstjens, et al., 2014), The Netherlands	To identify quality criteria for SDM in maternity care	Three round web-based Delphi study	71 international experts	The emphasis is on the process of coming to a consensus-based decision	Experts on SDM from Europe, North America, and Australia	Open and respectful communication between woman and HCP is essential, and to stimulate women to participate in decision-making. There is a need for preparing women antenatally for unexpected urgent decisions
(Noseworthy et al., 2013), New Zealand	To explore and propose issues of decision-making model for midwifery care	Informal prenatal and postnatal participant interviews	8 midwife – woman pairs in an urban setting	A need for a relational decision-making model within midwifery care	Midwives and self-selected pregnant women	Care decisions were influenced by identity projects, individual practices, the organisation of maternity care, local hospital cultures,

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Table 1 (*continued*)

Authors	Aims	Study design/type of text	Study population	Concept	Context	Key findings/messages
						medicalised childbirth, workforce shortages, funding cuts and poverty
(Kruske et al., 2013), Australia	To examine HCP's attitudes towards women's right to make autonomous decisions	A web-based survey	336 maternity staff	Lack of focus on HCP's perceptions of the ethical-legal principle of autonomy	Midwives and doctors from public and private health sectors	Maternity care professionals have an overall poor understanding of their own legal accountability, and the rights of the woman and her foetus for outcomes experienced in pregnancy and birth.
(Danerek et al., 2011), Sweden	To describe attitudes of midwives towards obstetricians` decision-making regarding a woman`s refusal of an emergency CS	Quantitative cross-sectional design	Midwives at 13 of Sweden's maternity units (no: 259)	Whether to focus on the health of mother or child	Midwives working in labour wards, with competence on fear of birth	89 % of the midwives meant that the obstetrician should try to persuade the woman to undergo a CS in case of foetal distress. 77 % of the midwives responded that the obstetrician should not comply to the women's ''own choice''
(Styles et al., 2011), UK	To explore midwives' intrapartum referral decisions regarding risks factors	Online survey	102 midwives	A better understanding of decision-making and risk, may reduce misjudgements	Maternity units in Scotland	Inconsistency between midwives in their referral decisions was not explained by differences in dispositional risk propensity, personality factors, experience, or location
(Maputle and Hiss, 2010), South Africa	To explore midwives' experiences of relating to women during labour	Qualitative, exploratory, descriptive, contextual, and inductive design	12 midwives in the obstetric unit	The Batho Pele Principles, Patients' Rights Charter, and Millennium Developmental Goals	A tertiary, public hospital	Midwife-centred care rather than woman-centred care. Lack of information-sharing, empowerment, autonomy. Inadequate listening skills of attending midwives. Conflicting expectations and unrealistic choices. Shortage of staff
(Mauadie et al., 2022), Brazil	To analyse the decision-making power of women in childbirth	Qualitive study, using in-depth interviews	11 resident nurses and 12 resident physicians in obstetrics	Professional discourses begin with the professional training	A public maternity hospital	Uncertainty and fear of unfavourable outcomes and complications threatening maternal and foetal well-being, sustain the recurrence of the discursive practice of risk control. Risk control is produced by the knowledge-power of medicalization and determine unequal relations between women and professionals.
(Afulani et al., 2020), Kenya	To bridge the gap between effective communication and women's autonomy	Mixed methods; quantitative and qualitative	32 clinical and 17 non -clinical HCPs	Communication. Women's autonomy		38 % of respondents reported that women are never able to choose birthing position, 33 % reported that they do not always explain exams or procedures. 73 % reported that women were not always asked for permission before these tasks.
(Furr et al., 2021), USA	To promote shared decision-making	Quasi-experimental pre-/post-test design, using the educational communication tool "SUPPORT"	29 nurses recruited from "Labor and Delivery Nurses Rock" Group on Facebook	SDM may improve women's satisfaction with their birth experience	Hospital nurses	*Nurses willingness to advocate women's autonomy increased significantly after education. *SDM with standardized perinatal communication may support women's perinatal education and her satisfaction with labour.

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Table 1 (*continued*)

Authors	Aims	Study design/type of text	Study population	Concept	Context	Key findings/messages
(Nicholls et al., 2022), UK	Views and experiences of the consent process in antenatal and intrapartum care	Qualitative design; semi- structured in-depth interviews	15 doctors and midwives	Determination of high-quality patient consent	Large urban teaching hospital	Results showed that it was challenging to engage women in dialogue; 1) they did not want information or wanted HCP to decide, 2) difficult to assess what was important within a time-limited consultation, required a degree of second-guessing beliefs and values, 3) concerns regarding consent in emergencies
(Feeley et al., 2019), UK	To synthesize and interpret existing qualitative literature on unconventional birth choices	Meta-ethnography	Five studies included	Midwives' views, attitudes, and experience	High-income countries	Midwives can play a crucial role in ensuring respectful maternity care, including supporting women in their birthing decisions. Midwives have various ways of working, from "willingly facilitative" to "reluctantly accepting".
(Begley et al., 2019), Ireland	To describe SDM, discuss its necessary conditions and develop a definition	Discussion paper		The true belief, knowledge, and moral basis of decision-making	Philosophy for practice	SDM in maternity care can be defined as a dialogue between clinicians and expectant women to decide upon a course of care or none, by making available the clinicians' complete knowledge. Informed consent is not shared decision-making.
(Megregian and Nieuwenhuijze, 2018), The Netherlands	Examine how SDM can help reduce potential ethical threats	Case driven literature study		Informed consent, informed refusal, informed choice, SDM	SDM in the context of unclear evidence	The framework of SDM, enhanced by skilled communication, empathy, and acceptance of vulnerability, offers midwives and women the opportunity to engage in meaningful dialogue without compromising professional integrity or a woman's autonomy.
(Stohl, 2018), USA	To determine the competence of the labouring woman regarding her ability to provide informed consent	A doctrine of informed consent to protect patient autonomy	Court cases regarding the right to informed consent by women in labour	Maternal right to informed consent throughout labour and delivery	ACOG	ACOG upholds the maternal right to informed consent and bodily integrity. Interventions during childbirth cannot be performed without her informed consent.
(Kozlowski et al., 2017), Australia	To identify empirical evidence for the role of emotions and emotional intelligence in clinical reasoning	Systematic literature review	Nurses and physicians	Clinical decision making as a rational and cognitive process		Educational preparation must reflect the importance of emotional competence related to decision-making. Both emotions and cognition are engaged in clinical decision-making. Clinical models of clinical decision-making could be more nuanced and valid
(Healy et al., 2016), Ireland	To synthesise how perceptions of risk impact midwives' and obstetricians' care for low-risk women in labour	Integrative review	Midwives, obstetricians	Perceptions of risks	High-resource settings	An assumption of abnormality surrounding birth is contributing to a risk culture, lack of midwifery responsibility, fear of involvement in adverse outcomes, and personal values regarding physiological birth
(Smith, 2016), UK	To consider clinical decision-making within midwifery	Commentary		Applying logical or intuitive decision making		Through combination of intuition and rationality, and the consideration of evidence and individual emotions, values and beliefs, clinicians can

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Table 1 (*continued*)

Authors	Aims	Study design/type of text	Study population	Concept	Context	Key findings/messages
						successfully make shared clinical decisions
(Bolton, 2015), UK	To create attention to the practice of informed consent during obstetric emergencies	Discussion paper		To understand the challenges of performing informed consent during labour		Obtaining proper consent during labour can be problematic and/or impossible. Taking proper consent from women during labour requires skills and judgement, and cannot be standardised
(Griffith, 2015), UK	To consider the impact of the Supreme Court ruling on nursing practice	Literature review		The United Kingdom Supreme Court ruling on nursing practice	Globally	Patients are entitled to information about risks and about alternative treatment that might be available. The paternalistic approach to withhold information that can be frightening, is outdated.
(MirzaeeRabor et al., 2016), Iran	To discover the factors facilitating SDM	A meta-synthesis		A woman's right to participate in decisions should be the cornerstone of all midwifery care.		Midwives have a vital role in preserving the woman's dignity. Respect for dignity is respect for beliefs, attitudes, and principles
(Maputle and Hiss, 2013), South Africa	To study the concept of woman-centred care in childbirth	Concept analysis by an inductive-discovery approach		Woman-centred care		Woman-centred care is mutual participation and responsibility sharing, information sharing and empowering, communication and listening, recognition and honouring of cultural sensitivity and the support of choices
(Lawrence et al., 2012), USA	Call to action in quality patient care in labour and delivery	Discussion paper		Quality measurements and recommendations for patient care in labour and delivery	Professional societies caring for pregnant and labouring women	Mutual respect, patient-centred care, and SDM are essential for providing quality obstetric care. Ensure that patient-centred care and patient safety are organizational priorities that guide decisions for organizational policies and practises.
(Muoni, 2012), UK	To describe from where midwives get information before clinical decision making	Educational paper		Regardless of working conditions, midwives are expected to make quick and accurate decisions		Midwifery clinical decisions should always be evidence-based and follow a systematic continuum which clearly portrays the process of their decisions.
(Lothian, 2012), USA	To explore current understanding of risk and safety in pregnancy and childbirth	Commentary		What is acceptable risk in childbirth?		Informed decision-making requires knowledge and support, and childbirth education can provide both. Develop a deeper understanding of the relationship between evidence-based care and safety
(Oyelese and Vintzileos, 2012), USA	How do we communicate medical evidence to the patients?	Commentary		Not discussing absolute risk, has the potential to cause undue anxiety, misinterpretation, and unrealistic expectations		Appropriate communication of what the evidence really shows, may improve counselling of the patients and lead to more realistic expectations. Important to discuss both the absolute risk and the relative risk
(Simpson, 2011), USA	To promote informed consent	Commentary		Women are lacking essential information on potential risks, benefits, and alternative approaches before procedures		Obtaining informed consent is an ethical requirement to ensure active involvement. Appropriate literacy and language levels are required to understand written materials for

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Table 1 (*continued*)

Authors	Aims	Study design/type of text	Study population	Concept	Context	Key findings/messages
						common obstetrical procedures
(Jefford et al., 2010), Australia	Exploring processes midwives use when engaging in clinical decision-making	Literature review. Four included articles	Midwives in birthing units	Clinical decision-making in midwifery		Clinical decision-making in midwifery differs from medical context because of the woman-midwife partnership. It is socially negotiated by involving hierarchies of close observation and control.
(Jefford and Jomeen, 2020), Australia	To establish midwives' perception of the value of workshops designed to empower their decision-making/DM etc.	A book providing a comprehensive exploration of decision-making for midwives		Medicalisation may lead to silenced midwives and/ or midwifery abdication		*Midwives need to find their voice and develop skills in both clinical reasoning and transformative reflection *Using appreciative inquiry- approaches that focus on reflection and clinical decision-making, may create feelings of reunification in midwives and rejuvenate inherent passion for the profession
(Ballesteros, 2022), Spain	A philosophical exploration of two stigmatizing concepts	A philosophical analysis		The biomedical model of childbirth can lead women who question medical decisions to be perceived and treated as being either irrational or selfish		Uncritical and unqualified acceptance of biomedical model views jeopardizes women's involvement in decision-making
(Kloester et al., 2022), Australia	To critically appraise and synthesize midwives' experiences of facilitating women's informed decision-making	Narrative review	midwives	There is a lack of evidence-based facilitation od informed decision-making for child-bearing women	SDM from high income countries	Midwives were shown to have a strong desire to facilitate informed decision-making yet reported a disparity between philosophy and practice due to multiple barriers.
(Villarmea and Kelly, 2020), UK	To discuss SDM, autonomy and rationality	Theoretical study		Shared decision-making is about sharing the process of decision-making, not the decision itself	SDM in the delivery room	The recent UN report advocating a human rights-based approach to end mistreatment and violence against women in reproductive health services has a particular focus on childbirth and obstetric violence. This paper contributes to the recognition of obstetric violence as a human rights violation. It offers conceptual tools to diagnose the impact of gender stereotypes during childbirth and to eliminate women's discrimination in the field of reproductive health.
(Almorbaty et al., 2023), Australia	To review and evaluate factors related to supportive relationships between women and midwives	integrative review		Understand how supportive relationships between childbearing women and their midwives can improve maternity care	Child-bearing period	Successful relationships require therapeutic communication, trust, respect, partnership, and SDM

Data analysis

The final 62 papers were mapped and categorized in line with basic qualitative content analysis (Pollock et al., 2023), and presented with main categories and sub-categories, see Fig. 1. Facilitators and barriers to clinical decision-making.

Presentation of results

The following PRISMA flow chart details the review decision process, with the results from the search according to identification, screening, eligibility and papers included (Joanna Briggs Institute, 2022), see Fig. 2.

Of the 62 included papers, all published in the period 2010–2023, 26 had a qualitative design. 10 papers had a quantitative design, and 4 papers used mixed methods. Additionally, there were 14 commentaries/

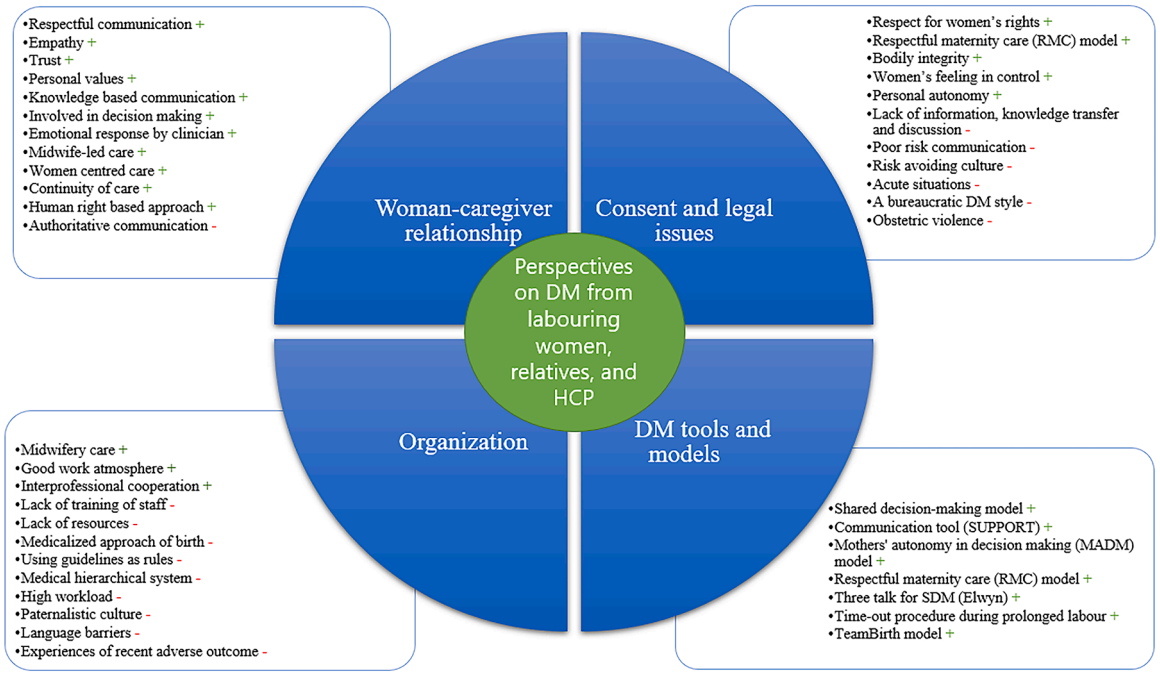

Fig. 1. Facilitators and barriers to clinical decision-making.

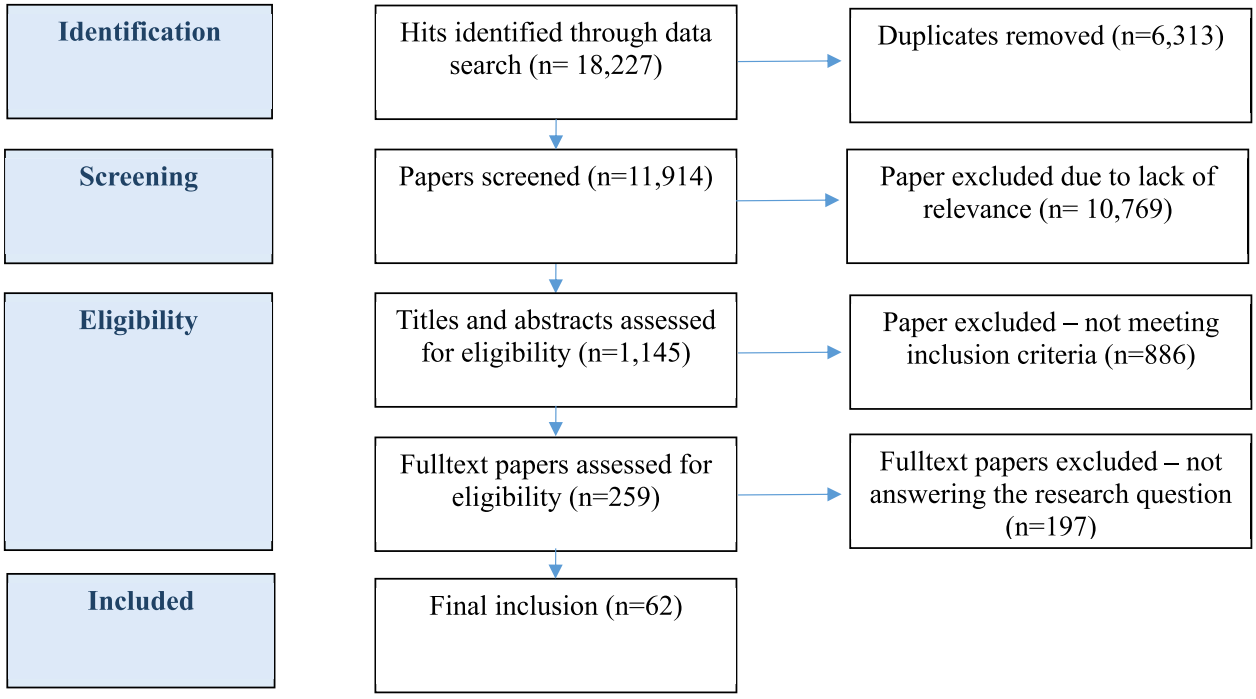

Fig. 2. Prisma flow chart.

discussions/educational papers/concept analysis and theoretical studies, there were 7 systematic reviews, and 1 book.

Geographically, 31 papers originated from Europe, another 14 papers originated from North America.

Eight papers originated from Oceania, another 6 papers came from Africa, two papers originated from Middle East, and finally, 1 paper originated from Brazil, South America.

Results

The following part presents the results organised under the following main categories; 1) Woman-caregiver relationship, 2) Consent and legal issues, 3) Organisation, and 4) Tools and models for decision-making, related to context. The results are also summarized in a diagram (Peters et al., 2021), comprising the main categories of facilitators and barriers, see Fig. 2. Health Care Providers (HCPs), who are reflecting a variety of professions within maternity care, including midwives, doctors, clinicians, nurses and other caregivers, are referred to as HCPs.

Woman-caregiver relationship

"Woman-caregiver relationship" was described as important for clinical DM in 31 papers: (Afulani et al., 2020; Almorbaty et al., 2023; Ballesteros, 2022; Begley et al., 2019; Bolton, 2015; Daemers et al., 2017; Feeley et al., 2019; Huschke, 2022; Jackson et al., 2017; Jefford et al., 2010; Jefford and Jomeen, 2020; Kozlowski et al., 2017; Lawrence et al., 2012; López-Toribio et al., 2021; Lothian, 2012; Maputle and Hiss, 2013; Maputle and Hiss, 2010; Mazúchová et al., 2020; Megregian and Nieuwenhuijze, 2018; MirzaeeRabor et al., 2016; Molenaar et al., 2018; Muoni, 2012; Nicholls et al., 2022; Nieuwenhuijze et al., 2014a; Simpson, 2011; Skoogh et al., 2019; Smith, 2016; Stohl, 2018; Vedam et al., 2017; Weiseth et al., 2022; Weltens et al., 2019).

The main category "Woman-caregiver relationship" has two subcategories: "The importance of communication", and "Midwifery care".

The importance of communication

Communication is of vital importance for the woman-caregiver relationship (Feeley et al., 2019; Jefford and Jomeen, 2020; Lawrence et al., 2012; Maputle and Hiss, 2013; Stohl, 2018). DM can be described as a communication strategy, where a woman and her care team interact as partners to make decisions that are fully informed and based on the best available evidence, and consistent with personal values (Lawrence et al., 2012). DM throughout pregnancy and childbirth is enhanced by skilled communication, empowerment, and mutual respect within midwifery practice (Almorbaty et al., 2023; Begley et al., 2019; Bolton, 2015; Lawrence et al., 2012; Maputle and Hiss, 2013; Megregian and Nieuwenhuijze, 2018; Simpson, 2011; Vedam et al., 2017; Weiseth et al., 2022). Central aspects of communication are trust (Almorbaty et al., 2023; Ballesteros, 2022; Jefford et al., 2010; Lothian, 2012; MirzaeeRabor et al., 2016), safety, responsibility, and mutual and personal commitments (Skoogh et al., 2019). Other aspects of communication facilitating DM are the HCPs communicating in an understandable way with the woman, using evidence-based knowledge, while listening, being open, respectful, empathetic, and supportive towards her values and preferences (Ballesteros, 2022; Molenaar et al., 2018; Muoni, 2012; Nieuwenhuijze, Korstjens, et al., 2014; Weltens et al., 2019).

HCPs must emphasise women's autonomy to participate in clinical DM and having access to evidence-based maternity care (Feeley et al., 2019; Lawrence et al., 2012; Maputle and Hiss, 2013; Mazúchová et al., 2020; Stohl, 2018). A woman's right to participate in decisions regarding her health and care should be the cornerstone of all midwifery care (López-Toribio et al., 2021).

Engaging women's hopes, aspirations, concerns, and fears through a caring approach, is a facilitator for DM, as it helps to build trust (Lothian, 2012). Caregivers who communicate in an authoritative manner like "we need to", "we are going to", or telling women what to do, leave no room for discussion (Huschke, 2022; Jackson et al., 2017)

Clinicians' experienced emotions, although not always acknowledged, will affect DM. Emotional reasoning; the application of emotion and cognition in DM, is important because the emotional reaction is perceived as confirming a truth regardless of evidence (Ballesteros, 2022; Kozlowski et al., 2017; Smith, 2016). Building emotional capabilities in clinicians may be an effective step towards increasing patient safety as well as clinicians feeling of self-efficacy (Kozlowski et al., 2017).

Wrong assumptions about women's knowledge, expectations, and their ability to demand effective communication, are hindering factors for communication. Factors such as dependency and lack of decision-making, lack of information-sharing, and lack of open communication and listening, have implications for woman-centred care, Empowering HCPs to develop effective communication skills, particularly in difficult situations, can improve person-centred maternity care (Afulani et al., 2020; Maputle and Hiss, 2010).

Midwifery care

Midwifery care, defined as midwife-led care (Daemers et al., 2017; Weltens et al., 2019), woman-centred care (Feeley et al., 2019; Maputle and Hiss, 2013; Nicholls et al., 2022; Smith, 2016) and with-woman orientation (Feeley et al., 2019; Smith, 2016) facilitates DM. Midwifery care plays a significant role in DM (Daemers et al., 2017; Weltens et al., 2019).

Key elements of midwifery care include recognizing the pregnant woman and midwife as holistic individuals, integrating theoretical and clinical knowledge, fostering collaboration among maternity care professionals, and considering organizational factors(Daemers et al., 2017; Weltens et al., 2019). The influence of women's needs and wishes should be part of the intra-partum decision-making process (Weltens et al., 2019).

With-woman oriented midwives, or midwives with a woman-centred philosophy, play a significant role in supporting women's decisions, and allow for optimal well-being of mothers and children despite unconventional decisions that are made (Feeley et al., 2019; Smith, 2016).

Woman-centred care means that participation is based on a more collaborative relationship and partnership. Participation includes open communication and the woman's involvement in DM, consultation and collaboration with various HCPs based on mutual respect (Maputle and Hiss, 2013). Woman-centred care and DM are related to midwives' experienced intuition, personal circumstances, and to attitudes about physiological aspects and collaboration with other providers (Daemers et al., 2017). Adopting a woman-centred philosophy and human rights-based approach as endorsed by WHO is central to give women authentic involvement in DM (Nicholls et al., 2022).

Consent and legal issues

"Consent and legal issues" was described as important for clinical DM in 25 papers (Altaweli et al., 2019; Begley et al., 2019; Bolton, 2015; Danerek et al., 2011; Deherder et al., 2022; Fair and Morrison, 2011; Griffith, 2015; Healy et al., 2016; Johnson et al., 2022; Kloester et al., 2022; Koster et al., 2019; Kruske et al., 2013; Lawrence et al., 2012; Maputle and Hiss, 2013; Mazúchová et al., 2020; Megregian and Nieuwenhuijze, 2018; MirzaeeRabor et al., 2016; Nicholls et al., 2022; Nieuwenhuijze, Low, et al., 2014; O'Donnell et al., 2014; Simpson, 2011; Stohl, 2018; Villarmea and Kelly, 2020; Watkins et al., 2022; Weiseth et al., 2022).

The main category "Consent and legal issues" has two sub-categories: "Consent", and "Legal issues".

Consent

The process of consent depends on the women's preferences, values, and a feeling of being met with respect by the HCPs (Begley et al., 2019; Bolton, 2015; Megregian and Nieuwenhuijze, 2018; Simpson, 2011). The respect for women's rights needs active participation, and personal autonomy is fundamental compared to a paternalistic approach (Griffith, 2015; Mazúchová et al., 2020). Respectful maternal care (RMC) emphasises the autonomy of pregnant women to participate in DM (Kloester et al., 2022), and is exemplified by open communication, mutual respect, and honouring of cultural diversity (Maputle and Hiss, 2013).

Women in labour might decline recommended treatment or interventions, or the consent might not be given due to impracticality (Megregian and Nieuwenhuijze, 2018; Stohl, 2018). A pre-printed consent form is not a proof of consent and cannot be standardised (Bolton, 2015; Stohl, 2018). Barriers to a woman's involvement in decision-making include lack of consent and information that exceeds her reading ability (Bolton, 2015; Megregian and Nieuwenhuijze, 2018; Simpson, 2011; Stohl, 2018). Lack of information and DM without involving the woman could lead to a negative birth experience and decreased satisfaction/perceived quality of the care (Deherder et al., 2022; Koster et al., 2019; Weiseth et al., 2022). A bureaucratic style of

DM based upon a dominant discourse of risk avoidance could veto the woman's choice (Watkins et al., 2022), like midwives who found it difficult to respect a woman's refusal for Caesarean Sections (CS) due to concern for the baby's wellbeing (Danerek et al., 2011). However, presenting relative risks (the risk of an outcome between exposed and unexposed groups) without discussing absolute risks (the actual probability of an outcome occurring regardless of any other factors) has the potential to cause undue anxiety, misinterpretation, unrealistic expectations, and problems with clinical DM (MirzaeeRabor et al., 2016). Women feeling in control of informed decisions during maternity care, express positive experiences regardless of their specific circumstances (Fair and Morrison, 2011; Johnson et al., 2022; Kloester et al., 2022). To accommodate women's preferences, a dynamic process between open, informative approaches and more closed, directive approaches is recommended (Nieuwenhuijze et al., 2014b).

Although HCPs believed that the final decision should rest with the woman, they also believed that the women's wishes could be set aside for the safety of the foetus (Kruske et al., 2013). When women were left out of DM in labour, they felt excluded, distant, and estranged from the birth, and powerless (Altaweli et al., 2019; Koster et al., 2019; O'Donnell et al., 2014). Woman-centred care recognises that each woman brings unique knowledge regarding herself (Lawrence et al., 2012). where the woman's moral right to bodily integrity and self-determination, involvement, preferences, and choices should be supported (Begley et al., 2019; Simpson, 2011).

Legal issues

Legal issues influence informed consent (Healy et al., 2016; Kloester et al., 2022; Kruske et al., 2013; Nicholls et al., 2022; Villarmea and Kelly, 2020). Concerns of litigation (lawsuit) and lack of time for discussions can lead to legal challenges and overuse of medical interventions (Kloester et al., 2022). Assumption on abnormality surrounding birth is contributing to a risk culture, like HCPs fear of adverse outcomes, institutional risk management and lack of midwifery responsibility. To enable the woman's involvement in DM, this imbalance must be corrected (Healy et al., 2016). Doctors saw themselves as being legally accountable for all outcomes during childbirth, regardless of the legal position that all health care providers are responsible only for adverse outcomes caused by their own negligent actions (Kruske et al., 2013). Midwives and obstetricians are disquieted by consent practice in the labour ward setting which is often very different from legal and professional guidance (Nicholls et al., 2022). Many HCPs had experienced fast moving situations where they felt that lawful consent according to the Montgomery judgement, had not been obtained (Nicholls et al., 2022). Women experience being powerless and violated due to structured inequality, patriarchy, and discrimination. Obstetric violence is a violation of human rights (Villarmea and Kelly, 2020).

Though emergent interventions may be necessary in the context of childbirth, the pregnant woman retains capacity for DM throughout childbirth. No treatment, even with the best of intentions, should be given to her (or her foetus) without her consent (Kloester et al., 2022).

Organisation

"Organisation" was described as important for clinical DM in 37 papers (Abubakar et al., 2020; Afulani et al., 2020; Altaweli et al., 2019; Attanasio et al., 2018; Ballesteros, 2022; Daemers et al., 2017; Declercq et al., 2020; Deherder et al., 2022; Gregory et al., 2017; Healy et al., 2016; Huschke, 2022; Jackson et al., 2017; Jefford et al., 2010; Jefford and Jomeen, 2020; Kloester et al., 2022; Kruske et al., 2013; Litorp et al., 2015; Lothian, 2012; Maputle and Hiss, 2013; Maputle and Hiss, 2010; Mauadie et al., 2022; Melman et al., 2017; Meyer et al., 2019; MirzaeeRabor et al., 2016; Muoni, 2012; Nicholls et al., 2022; Nieuwenhuijze, Korstjens, et al., 2014; O'Donnell et al., 2014; Rietveld et al., 2018; Ringqvist et al., 2022; Skoogh et al., 2019; Smith, 2016; Stohl, 2018; Styles et al., 2011; Van Otterloo and Connelly, 2016; Watkins et al., 2022; Weltens et al., 2019).

The main category "Organisation" has three sub-categories: "Medicalisation", "Working atmosphere", and "Complexity".

Medicalisation

A medicalised approach can hinder a woman's involvement in DM (Afulani et al., 2020; Altaweli et al., 2019; Ballesteros, 2022; Declercq et al., 2020; Deherder et al., 2022; Healy et al., 2016; Huschke, 2022; Litorp et al., 2015; Maputle and Hiss, 2010; Mauadie et al., 2022; Nicholls et al., 2022; Watkins et al., 2022), and leave women with a feeling of disappointment, lacking empowerment and support (Huschke, 2022). Medicalised care (Altaweli et al., 2019; Mauadie et al., 2022), a bio-medical approach (Mauadie et al., 2022), and a medical concept of birth (Altaweli et al., 2019) where medical interventions are routinely used regardless clinical indication (Altaweli et al., 2019; Mauadie et al., 2022) are barriers for women's involvement in DM, and serves as a basis for unequal balance of power and top-down approach (Huschke, 2022). Interfering in the normal, physiologic process of birth without a clear medical indication with a "better safe than sorry"-approach is considered risky and a barrier to participation in DM (Lothian, 2012). Evidence-based medicine must be balanced to meet the needs of the women and babies. DM in midwifery practice must consider the intuition and expertise of the caregiver, based on scientific rational thinking (Jefford et al., 2010; Muoni, 2012; Smith, 2016). Control and disciplinary power over women's bodies and a medical hierarchical system of control (Altaweli et al., 2019; Mauadie et al., 2022) are hindering factors for women's involvement in DM. Compared to obstetric care, midwifery care is associated with less use of interventions, and greater encouragement of women's own preferences (Declercq et al., 2020). A shift in focus from risk towards health and well-being, is needed (Ballesteros, 2022; Healy et al., 2016).

Working atmosphere

A good working atmosphere, interprofessional cooperation, and resources are needed for women's participation in DM in clinical settings (Altaweli et al., 2019; Ballesteros, 2022; Daemers et al., 2017; Jefford et al., 2010; Jefford and Jomeen, 2020; Mauadie et al., 2022; Melman et al., 2017; O'Donnell et al., 2014; Skoogh et al., 2019). An open and tolerant atmosphere between the HCPs improved DM (Jefford et al., 2010; Skoogh et al., 2019). Barriers to women's participation in DM and quality of care are often related to lack of interprofessional collaboration and high workload (Altaweli et al., 2019; Melman et al., 2017), and lack of autonomy among women (O'Donnell et al., 2014). The fear of being held responsible for professional choices and perceptions of risk, impact cognitive recognition and the DM process (Ringqvist et al., 2022; Van Otterloo and Connelly, 2016; Weltens et al., 2019). Caregivers stated that their fear of blame from colleagues and management in case of poor outcomes made them advocate for, or perform, CS on doubtful indications (Litorp et al., 2015). Hesitation to allow women to be part of the DM process, can be explained by lack of adequately trained personal staff (Ballesteros, 2022; Maputle and Hiss, 2010; Mauadie et al., 2022; Melman et al., 2017), lack of technical equipment (Maputle and Hiss, 2010; Melman et al., 2017), lack of time (Gregory et al., 2017; Nieuwenhuijze, Korstjens, et al., 2014), language barriers, stress, burnout, and inadequate provider knowledge and skills (Afulani et al., 2020). HCPs need support in ways of enabling women to make decisions that are autonomous whatever the circumstances of the consultation (Nicholls et al., 2022).

Complexity

The possible complexity of childbirth and complications have an impact on women's involvement in DM in clinical settings (Abubakar et al., 2020; Declercq et al., 2020; Healy et al., 2016; Jackson et al., 2017; Jefford et al., 2010; Kloester et al., 2022; Kruske et al., 2013; Litorp et al., 2015; Meyer et al., 2019; Nicholls et al., 2022; Rietveld et al., 2018; Ringqvist et al., 2022; Stohl, 2018; Van Otterloo and

Connelly, 2016; Weltens et al., 2019). Midwifery research is needed to explore how DM is carried out in a complex, fast changing work environment (Jefford et al., 2010). HCPs report that they continuously weigh between successful and adverse birth outcomes, women's opinions, aspects of progress of labour and their personal stances regarding trial of labour in the DM process – what are the odds for this birth go well, or not? (Rietveld et al., 2018). Medical emergencies where HCPs emphasised the necessity of treatment to prevent significant harm, were considered a barrier to women's involvement in DM (Stohl, 2018).

Recent, adverse outcomes in a certain geographic area may lead to earlier referral from local HCPs to the obstetric unit within the same area (Styles et al., 2011). A high frequency of CS was rationalised by referring to circumstances outside their control, e.g., driven by economic compensation, maternal demand, and HCP's point of view (Litorp et al., 2015). In paternalistic societies male family members act on the woman's behalf, and women's lacking education may be a barrier to her participation in DM (Abubakar et al., 2020). The contextual, political, cultural, and human factors among HCPs might cause barriers to DM, like the attending midwife exercising control of the woman's involvement (Maputle and Hiss, 2013; MirzaeeRabor et al., 2016). Women's experience of being involved in DM might be negatively influenced by factors like marginalised social class, with an increased risk for CS and epidural (Attanasio et al., 2018). Caregivers must be aware of their responsibility as decision-makers and medical experts, striving to minimize unnecessary CS (Litorp et al., 2015). DM must be related to a societal level where women's needs, autonomy, and health as a human right, need to be strengthened (Mauadie et al., 2022).

Decision-making tools and models

"Decision-making tools and models" was described as important for clinical DM in 27 papers (Aggarwal et al., 2021; Almorbaty et al., 2023; Attanasio et al., 2018; Begley et al., 2019; Daemers et al., 2017; Deherder et al., 2022; Feeley et al., 2019; Furr et al., 2021; Johnson et al., 2022; López-Toribio et al., 2021; Megregian and Nieuwenhuijze, 2018; Meyer et al., 2019; Molenaar et al., 2018; Nieuwenhuijze, Korstjens, et al., 2014; Nieuwenhuijze, Low, et al., 2014; Noseworthy et al., 2013; O'Brien et al., 2021; O'Donnell et al., 2014; Oyelese and Vintzileos, 2012; Rietveld et al., 2018; Ringqvist et al., 2022; Schulz and Wirtz, 2022; Smith, 2016; Vedam et al., 2017; Villarmea and Kelly, 2020; Watkins et al., 2022; Weiseth et al., 2022).

The main category "Decision-making tools and models" has two subcategories: "Shared decision-making", and "Other tools and models for decision-making".

Shared decision-making

Shared decision-making (SDM) was dominating among the different tools and models for DM (Attanasio et al., 2018; Begley et al., 2019; Deherder et al., 2022; Furr et al., 2021; López-Toribio et al., 2021; Megregian and Nieuwenhuijze, 2018; Molenaar et al., 2018; Nieuwenhuijze, Korstjens, et al., 2014; O'Brien et al., 2021; Vedam et al., 2017; Villarmea and Kelly, 2020; Weiseth et al., 2022).

SDM in maternity care is described as a dynamic process that starts in antenatal care, ends after birth, and is facilitated by opportunities to build a relationship (Nieuwenhuijze, Korstjens, et al., 2014). It is necessary that the HCPs make available their complete knowledge (based on all types of evidence) and expertise, encourages the women's involvement, support her choices, and allow her to practise preferences (Begley et al., 2019). The framework of SDM, enhanced by skilled - and therapeutic - communication, empathy, and acceptance of vulnerability, offers midwives and women the opportunity to engage in meaningful dialogue without compromising professional integrity or the woman's autonomy (Almorbaty et al., 2023; Megregian and Nieuwenhuijze, 2018; Schulz and Wirtz, 2022).

Understanding the importance of autonomy and consent in the context of childbirth can promote SDM (Villarmea and Kelly, 2020). This includes a mutually respectful relationship, the support of relatives and continuity of a coordinated, truthful, and personalised care (López-Toribio et al., 2021; Oyelese and Vintzileos, 2012).

Clinical guidelines were in situations of unconventional birth choices, as well as the cultural norm of "the doctor knows best", considered as barriers to SDM, (Begley et al., 2019; Feeley et al., 2019). Women's acquiescence, where she responds in a socially acceptable way instead of providing an honest opinion, is also a barrier to SDM (Begley et al., 2019). Informed choice, collaboration and SDM should be regarded as important indicators of quality of care (Daemers et al., 2017; O'Donnell et al., 2014; Rietveld et al., 2018), and should be evaluated as such (Johnson et al., 2022). HCPs willingness to advocate for women's autonomy increased significantly with a standardised communication tool "SUPPORT" to facilitate SDM (Furr et al., 2021). Organisational and relational factors influence how women can participate in SDM including factors like continuity of care, power dynamics, hospital policies and trust in self and others (O'Brien et al., 2021).

Other tools and models for decision-making

"Mother Autonomy in Decision- Making" is a scale that assesses interactions with HCPs related to a person's ability to lead DM over the course of maternity care (Vedam et al., 2017). Women experienced moderate autonomy in DM both with midwives and doctors in studies where this scale was used (Deherder et al., 2022).

A trusting "relational model" of DM seems relevant within midwifery, because women and midwives have a web of connections in a context influenced by family, culture, and the society (Meyer et al., 2019; Noseworthy et al., 2013). Intuition and rationality, consideration of evidence as well as emotions, values and beliefs can enable HCPs participate in SDM (Smith, 2016). Poor access to midwifery care may act as barriers in DM (Watkins et al., 2022). An intervention to improve SDM needs a supporting partnership based on awareness of roles and responsibilities (Molenaar et al., 2018; Nieuwenhuijze, Low, et al., 2014).

A decision-making tool called "Timeout" has been developed for use in cases of prolonged labour. During Timeout, the HCPs and the woman discuss the current situation, preferences, capacity of the woman and the different options and develop a common plan. It might prevent secondary fear of childbirth (Ringqvist et al., 2022). Currently, a quality improvement project using Timeout to enhance a common understanding and cooperation within the team including the labouring woman, and make a binding plan, is carried out in Tanzania and Norway Høifødt et al., 2022. The impact of this intervention on patient safety and childbirth experiences among mothers, because of shared decision-making, is yet to be determined.

Similar principles to those in Timeout are found in TeamBirth, where teams including HCPs, woman and relatives, 'huddles' from admission, discuss birth preferences and clinical decisions with the help of a shared planning board in the labour room (Weiseth et al., 2022).

To summarize our findings regarding facilitators and barriers of shared decision-making, we present a diagram comprising the main categories with facilitators and barriers, see Fig. 1.

Discussion

The review, guided by the research question *How does existing literature present the process of and the reasons for clinical decision-making with user involvement during childbirth from the perspectives of labouring women, relatives, and health care providers?* resulted in 62 included papers.

The scoping review shows that main categories for DM with user involvement during childbirth are the ***woman-caregiver relationship, consent and legal issues, organisation,*** *and* ***DM tools and models***. Subcategories like communication, legal issues, medicalised care, working atmosphere, aspects related to consent, and complexity around childbirth, are important to DM. WHO and ICM emphasise women's involvement in decision-making. Evidence-based guidelines ensure that

what is known as best practice, is available in maternity health care. The DM process must be balanced to meet the needs of the women and babies by combining the intuition and expertise of the caregiver together with scientific rational thinking.

According to our findings, the ***woman-caregiver relationship*** is a main facilitator for DM. Midwife-led care (Daemers et al., 2017; Weltens et al., 2019) woman-centred care (Feeley et al., 2019; Maputle and Hiss, 2013; Nicholls et al., 2022; Smith, 2016), and with-woman orientation (Feeley et al., 2019; Simpson, 2011) facilitate DM by combining clinical reasoning and intuition. The intuitive reasoning is automatic and based on pattern making from previous experiences (Smith, 2016; Weltens et al., 2019) Woman-centred philosophy comprises respectful maternity care with support of women in their birthing decisions, regardless of preferences. However, HCPs, understood as a variety of professions within maternity care, including midwives, doctors, clinicians, nurses and other caregivers, are reported to sanction and threaten women who do not comply with procedures and/or treatment (Huschke, 2022). This fact challenges the process of DM.

In line with our second category ***Consent and legal issues***, we found that HCPs' concerns of litigation, their lack of resources and lack of time for discussions, can hinder DM and instead lead to legal challenges and overuse of medical interventions. According to our findings, the pregnant woman retains capacity for DM throughout childbirth, and no treatments or therapies, even with the best of intentions, can be given to her (or her foetus) without her consent (Kloester et al., 2022; Stohl, 2018). Violation of human rights due to structured inequality like nonconsensual procedures, neglect and discrimination, is from a feministic and activist perspective described as obstetric violence (van der Waal et al., 2023; Villarmea and Kelly, 2020). However, it is suggested to use the term "substandard and disrespectful care" instead, which might be perceived as less unjust and less offensive (Ayres-de-Campos et al., 2024). Appropriate DM is a strategy to overcome substandard and disrespectful care.

Organisation of the maternity health care comprised facilitators as well as barriers for DM. Our review identified many barriers related to organisation of care, care philosophy, working situation for HCPs as well as legal and societal circumstances. Clinical guidelines and protocols can be perceived as barriers to DM. However, it is not the guidelines as such but the way the guidelines are used in the DM process.

Medicalised care can form a barrier to DM by interfering in the normal, physiologic process of birth without a clear medical indication. The "better safe than sorry"-approach with an assumption of abnormality surrounding birth, might hinder appropriate DM because HCPs fear adverse outcomes and litigations. According to our findings, medical emergencies where HCPs emphasised the necessity of treatment to prevent significant harm, were considered a barrier to women's involvement in DM. In most health facilities, working with standardised protocols for enhanced patient safety is the norm. If protocols and procedures are perceived as a guiding tool instead of a compulsory action, DM can clarify the need for elaboration of evidence-based practice, risk images, and the woman's values and preferences. Her preferences should be documented consecutively for every involved HCP to be aware of her perspectives.

*Among **DM tools and models,*** shared decision-making (SDM) was found to be the dominating model in our scoping review. A main finding throughout the analysis points towards the importance of the relationship between the woman and caregivers to enable SDM. We found that SDM is a communication strategy, where a woman and her care team interact as partners to make decisions that are fully informed and based on the best available evidence, and consistent with personal values. Facilitators to SDM include continuity of care that engages women's hopes, aspirations, concerns, and fears, and in doing so builds trust, so women can focus on wellbeing and avoid harm. SDM is a cornerstone of good midwifery practice (López-Toribio et al., 2021).

Although SDM is perceived by HCPs as challenging, our findings support SDM regardless of context. To achieve SDM, HCPs must master skilled communication, respect the women's values and preferences and help build a mutual trusting relationship with the woman and her relatives. The learning methodology of simulation training in multiprofessional teams can through reflective practice contribute to enhanced common understanding within the team, and appropriate communication among team members including the woman in labour and her relatives (Egenberg et al., 2017; Sonesh et al., 2015).

Strengths and limitations

We have used a team approach to benefit from the varied background of all co-authors, representing clinical and academic midwifery in a global context. This is considered a strength of this study. However, this is also demanding and can be a limitation by requiring a continuous, coordinated working process throughout the co-authorship of the paper.

The process of SDM is depending on context. We identified few papers from low-resource countries. Selecting papers published in English only, is contributing to this limitation. To avoid publication bias, we have identified publications addressing barriers for clinical decision-making as well as facilitators.

Conclusions and recommendations

A main finding is the importance of the relationship between the women and caregivers to enable shared decision-making. HCPs who are communicating in an understandable way with the woman, using evidence-based knowledge, while listening, being open, respectful, empathetic, and supportive towards her values and preferences, are optimising SDM. Our review identified barriers related to organisation of care, care philosophy, working situation for HCPs as well as legal and societal circumstances. Balancing intuition and expertise of caregivers with evidence-based practices, is crucial to ensure women's participation in decision-making. Furthermore, a trusting relationship between the mother, partner, and health care provider is of utmost importance. Shared decision-making, which appeared to be the primary model for clinical decision-making regardless context, requires reflective practice and is a communication strategy.

There is a need for research on the managerial role within the health facility to ensure that the working conditions enable all staff members to engage in SDM during childbirth for enhanced patient safety.

Ethical statement

No ethical approvals were needed for the scoping review.

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CRediT authorship contribution statement

Signe Egenberg: Writing – review & editing, Writing – original draft, Validation, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Data curation, Conceptualization. **Gry Skogheim:** Writing – review & editing, Writing – original draft, Data curation. **Margrethe Tangerud:** Writing – review & editing, Validation, Methodology, Investigation, Data curation. **Anne-Marie Sluijs:** Writing – review & editing, Writing – original draft, Methodology, Data curation. **Yolentha M. Slootweg:** Methodology, Data curation, Writing – review & editing, Visualization. **Heidi Elvemo:** Writing – review & editing, Data curation. **Mariam Barabara:** Writing – review &

editing, Data curation. **Ingela Lundgren:** Writing – review & editing, Writing – original draft, Validation, Supervision, Data curation.

Declaration of competing interest

The authors declare that they have no competing interests.

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Supplementary materials

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References

Abubakar, R., Yohanna, S., Zubairu, H., 2020. Influence of health decision making on maternal complications among women delivered at a general hospital, North-Western Nigeria. Niger. J. Clin. Pract. 23 (5), 675–679. https://doi.org/10.4103/njcp.njcp_659_18.

Afulani, P.A., Buback, L., Kelly, A.M., Kirumbi, L., Cohen, C.R., Lyndon, A., 2020. Providers' perceptions of communication and women's autonomy during childbirth: a mixed methods study in Kenya. Reprod. Health 17 (1), 85. https://doi.org/10.1186/s12978-020-0909-0.

Aggarwal, R., Plough, A., Henrich, N., Galvin, G., Rucker, A., Barnes, C., Berry, W., Golen, T., Shah, N.T., 2021. The design of "TeamBirth": A care process to improve communication and teamwork during labor. Birth 48 (4), 534–540. https://doi.org/10.1111/birt.12566.

Almorbaty, H., Ebert, L., Dowse, E., Chan, S.W., 2023. An integrative review of supportive relationships between child-bearing women and midwives. Nurs. Open. 10 (3), 1327–1339. https://doi.org/10.1002/nop2.1447.

Alper, B.S., Haynes, R.B., 2016. EBHC pyramid 5.0 for accessing preappraised evidence and guidance. Evid. Based. Med. 21 (4), 123–125. https://doi.org/10.1136/ebmed-2016-110447.

Altaweli, R., McCourt, C., Scamell, M., Tyler, K.C., 2019. Ethnographic study of the use of interventions during the second stage of labor in Jeddah, Saudi Arabia. Birth-Issues Perinat. Care 46 (3), 500–508. https://doi.org/10.1111/birt.12395.

Aromataris, E., Munn, Z., 2020. JBI manual for evidence synthesis. JBI. JBI, Adelaide, South Austalia.

Attanasio, L.B., Kozhimannil, K.B., Kjerulff, K.H., 2018. Factors influencing women's perceptions of shared decision making during labor and delivery: Results from a large-scale cohort study of first childbirth. Patient Educ. Counsel. 101 (6), 1130–1136. https://doi.org/10.1016/j.pec.2018.01.002.

Ayres-de-Campos, D., Louwen, F., Vivilaki, V., Benedetto, C., Modi, N., Wielgos, M., Tudose, M.P., Timonen, S., Reyns, M., Yli, B., Stenback, P., Nunes, I., Yurtsal, B., Vayssière, C., Roth, G.E., Jonsson, M., Bakker, P., Lopriore, E., Verlohren, S., Jacobsson, B., 2024. European Association of Perinatal Medicine (EAPM), European Board and College of Obstetricians and Gynaecologists (EBCOG), European Midwives Association (EMA). Joint position statement: Substandard and disrespectful care in labour - because words matter. Eur. J. Obstet. Gynecol. Reprod. Biol. 296, 205–207. https://doi.org/10.1016/j.ejogrb.2024.02.048.

Ballesteros, V., 2022. A stigmatizing dilemma in the labour room: Irrationality or selfishness? J. Eval. Clin. Pract. 28 (5), 875–882. https://doi.org/10.1111/jep.13747.

Begley, K., Daly, D., Panda, S., Begley, C., 2019. Shared decision-making in maternity care: acknowledging and overcoming epistemic defeaters. J. Eval. Clin. Pract. 25 (6), 1113–1120. https://doi.org/10.1111/jep.13243.

Bolton, H., 2015. The perils of taking written consent for operative delivery during labour. BJOG 122 (9), 1251. https://doi.org/10.1111/1471-0528.13496.

Braut, G.S., Rake, E.L., Aanestad, R., Njå, O., 2012. Risk images as basis for decisions related to provision of public services. Risk Manage. 14 (1), 60–76. www.palgrave-journals.com/rm/.

Daemers, D.O.A., van Limbeek, E.B.M., Wijnen, H.A.A., Nieuwenhuijze, M.J., de Vries, R. G., 2017. Factors influencing the clinical decision-making of midwives: a qualitative study. BMC Pregn. ChildBirth 17 (1), 345. https://doi.org/10.1186/s12884-017-1511-5.

Danerek, M., Maršál, K., Cuttini, M., Lingman, G., Nilstun, T., Dykes, A.K., 2011. Attitudes of midwives in Sweden toward a woman's refusal of an emergency cesarean section or a cesarean section on request. Birth 38 (1), 71–79. https://doi.org/10.1111/j.1523-536X.2010.00440.x.

Declercq, E.R., Belanoff, C., Sakala, C., 2020. Intrapartum care and experiences of women with midwives versus obstetricians in the listening to mothers in California survey. J. Midwifery. Womens Health 65 (1), 45–55. https://doi.org/10.1111/jmwh.13027.

Deherder, E., Delbaere, I., Macedo, A., Nieuwenhuijze, M.J., Van Laere, S., Beeckman, K., 2022. Women's view on shared decision making and autonomy in childbirth: cohort study of Belgian women. BMC Pregn. ChildBirth 22 (1), 551. https://doi.org/10.1186/s12884-022-04890-x.

Dekker, S., Bergstrøm, J., Amer-Wåhlin, I., Cilliers, P., 2012. Complicated, complex, and compliant: best practice in obstetrics. Cognit. Technol. Work (2), 15. https://doi.org/10.1007/s10111-011-0211-6.

Dowding, D.W., Cheyne, H.L., Hundley, V., 2011. Complex interventions in midwifery care: reflections on the design and evaluation of an algorithm for the diagnosis of labour. Midwifery 27 (5), 654–659. https://doi.org/10.1016/j.midw.2009.11.001.

Downe, S., Finlayson, K., Oladapo, O., Bonet, M., Gulmezoglu, A.M., 2018. What matters to women during childbirth: A systematic qualitative review. PLoS One 13 (4), e0194906. https://doi.org/10.1371/journal.pone.0194906.

Egenberg, S., Karlsen, B., Massay, D., Kimaro, H., Bru, L.E., 2017. No patient should die of PPH just for the lack of training!" Experiences from multi-professional simulation training on postpartum hemorrhage in northern Tanzania: a qualitative study. BMC Med. Educ. 17 (1), 119. https://doi.org/10.1186/s12909-017-0957-5.

Egenberg S, Tangerud M, Lindtjørn E, Mchome B, Mushi C, Slootweg Y, & Sluijs, A.-M. (2020). *Clinical decision-making with user involvement during childbirth; a scoping review protocol [Internet]*. OSF. osf.io/9nvrc.

Fair, C., Morrison, T., 2011. I felt part of the decision-making process " : A qualitative study on techniques used to enhance maternal control during labor and delivery. Int. J. Childbirth Educ.: Off. Publ. Int. Childbirth Educ. Assoc. 26 (21), 21–25. In: https://www.researchgate.net/publication/279530875_I_felt_part_of_the_decision-making_process_A_Qualitative_Study_on_Techniques_Used_to_Enhance_Maternal_Control_During_Labor_and_Delivery.

Feeley, C., Thomson, G., Downe, S., 2019. Caring for women making unconventional birth choices: A meta-ethnography exploring the views, attitudes, and experiences of midwives. Midwifery 72, 50–59. https://doi.org/10.1016/j.midw.2019.02.009.

Furr, A., Brackney, D.E., Turpin, R.L., 2021. Perinatal nurses respond to shared decision-making education: a quasi-experimental study. J. Perinat. Educ. 30 (3), 168–176. https://doi.org/10.1891/j-pe-d-20-00039.

Gregory, M.E., Sonesh, S.C., Feitosa, J., Benishek, L.E., Hughes, A.M., Salas, E., 2017. Decision making on the labor and delivery unit: an investigation of influencing factors. Hum. Factors, 18720817703740. https://doi.org/10.1177/0018720817703740.

Griffith, R., 2015. Duty to warn of risks moves to a prudent patient approach. Br. J. Nurs. 24 (7), 408–409. https://doi.org/10.12968/bjon.2015.24.7.408.

Høifødt, A.I., Huurnink, J.M.E., Egenberg, S., Massay, D.A., McHome, B., Eri, T.S., 2022. The perspectives of nurse-midwives and doctors on clinical challenges of prolonged labor: A qualitative study from Tanzania. Eur J Midwifery 6, 61. https://doi.org/10.18332/ejm/152747.

Healy, S., Humphreys, E., Kennedy, C., 2016. Midwives' and obstetricians' perceptions of risk and its impact on clinical practice and decision-making in labour: An integrative review. Women. Birth 29 (2), 107–116. https://doi.org/10.1016/j.wombi.2015.08.010.

Huschke, S., 2022. The System is Not Set up for the Benefit of Women': Women's Experiences of Decision-Making During Pregnancy and Birth in Ireland. Qual. Health Res. 32 (2), 330–344. https://doi.org/10.1177/10497323211055461.

ICM, 2008. International Code of Ethics for Midwives. ICM. Retrieved 20.04.22 from. https://internationalmidwives.org/assets/files/definitions-files/2018/06/eng-international-code-of-ethics-for-midwives.pdf.

Jackson, C., Land, V., Holmes, E.J., 2017. Healthcare professionals' assertions and women's responses during labour: A conversation analytic study of data from One born every minute. Patient. Educ. Couns. 100 (3), 465–472. https://doi.org/10.1016/j.pec.2016.10.004.

Jefford, E., Jomeen, J., 2020. Empowering Decision-Making in Midwifery. A Global Perspective. Routledge.

Jefford, E., Fahy, K., Sundin, D., 2010. A review of the literature: midwifery decision-making and birth. Women. Birth 23 (4), 127–134. https://doi.org/10.1016/j.wombi.2010.02.001.

Joanna Briggs Institute, 2017. Critical Appraisal Checklist For Systematic Reviews and Research Syntheses, 13.08.20). JBI. Retrieved 07.01.20 from. https://joannabriggs.org/sites/default/files/2019-05/JBI_Critical_Appraisal-Checklist_for_Systematic_Reviews2017_0.pdf.

Joanna Briggs Institute, 2022. JBI Manual for Evidence Synthesis. Joanna Briggs Institute. Retrieved 12.08.24 from. https://jbi-global-wiki.refined.site/space/MANUAL/4687342/Chapter+11%3A+Scoping+reviews.

Johnson, G.E., Kan, L., Nguyen, J., Campbell, K., Ralph, L., Koenig, N., Sanaee, M., Maher, C., Cundiff, G.W., 2022. Development of patient-centered outcomes for labour and birth: a qualitative study. Clin. Exp. Obstet. Gynecol. (21), 49. https://doi.org/10.31083/j.ceog4901021.

Kloester, J., Willey, S., Hall, H., Brand, G., 2022. Midwives' experiences of facilitating informed decision-making - a narrative literature review. Midwifery 109, 103322. https://doi.org/10.1016/j.midw.2022.103322.

Koster, D., Romijn, C., Sakko, E., Stam, C., Steenhuis, N., de Vries, D., van Willigen, I., Fontein-Kuipers, Y., 2019. Traumatic childbirth experiences: practice-based implications for maternity care professionals from the woman's perspective. Scand. J. Caring Sci. https://doi.org/10.1111/scs.12786.

Kozlowski, D., Hutchinson, M., Hurley, J., Rowley, J., Sutherland, J., 2017. The role of emotion in clinical decision making: an integrative literature review. BMC Med. Educ. 17 (1), 255. https://doi.org/10.1186/s12909-017-1089-7.

Kruske, S., Young, K., Jenkinson, B., Catchlove, A., 2013. Maternity care providers' perceptions of women's autonomy and the law. BMC Pregn. ChildBirth 13, 84. https://doi.org/10.1186/1471-2393-13-84.

López-Toribio, M., Bravo, P., Llupià, A., 2021. Exploring women's experiences of participation in shared decision-making during childbirth: a qualitative study at a reference hospital in Spain. BMC Pregn. ChildBirth 21 (1), 631. https://doi.org/10.1186/s12884-021-04070-3.

Lawrence 3rd, H.C., Copel, J.A., O'Keeffe, D.F., Bradford, W.C., Scarrow, P.K., Kennedy, H.P., Grobman, W., Johnson, M.C., Simpson, K.R., Lyndon, A., Wade, K., Peddicord, K., Bingham, D., Olden, C.R., 2012. Quality patient care in labor and delivery: a call to action. Am. J. Obstet. Gynecol. 207 (3), 147–148. https://doi.org/10.1016/j.ajog.2012.07.018.

Library, C., 2024. Cochrane Reviews. Cochrane. Retrieved 21.08.24 from. https://www.cochranelibrary.com/.

Litorp, H., Mgaya, A., Mbekenga, C.K., Kidanto, H.L., Johnsdotter, S., Essén, B., 2015. Fear, blame and transparency: Obstetric caregivers' rationales for high caesarean section rates in a low-resource setting. Soc. Sci. Med. 143, 232–240. https://doi.org/10.1016/j.socscimed.2015.09.003.

Lothian, J., 2012. Risk, safety, and choice in childbirth. J. Perinat. Educ. 21, 45–47. https://doi.org/10.1891/1058-1243.21.1.45.

Maputle, S.M., Hiss, D.C., 2010. Midwives' experiences of managing women in labour in the Limpopo Province of South Africa. Curationis 33 (3), 5–14. https://doi.org/10.4102/curationis.v33i3.2.

Maputle, M.S., Hiss, D., 2013. Woman-centred care in childbirth: A concept analysis (Part 1). Curationis 36 (1), E1–E8. https://doi.org/10.4102/curationis.v36i1.49.

Mauadie, R.A., Pereira, A.L., Prata, J.A., Mouta, R.J., 2022. Discursive practices about the decision-making power of women in childbirth. Interface-Comunicacao Saude Educacao. https://www.scielo.br/j/icse/a/RJGMKWVBrcbDGJswgXBgypr/?format=pdf&lang=en.

Mazúchová, L., Kelcíkova, S., Štofaníková, L., Malinovska, N., 2020. Women's control and participation in decision-making during childbirth in relation to satisfaction. Central Eur. J. Nurs. Midwifery 11, 136–142. https://doi.org/10.15452/cejnm.2020.11.0021.

Megregian, M., Nieuwenhuijze, M., 2018. Choosing to decline: finding common ground through the perspective of shared decision making. J. Midwifery Womens Health 63 (3), 340–346. https://doi.org/10.1111/jmwh.12747.

Melman, S., Schreurs, R.H.P., Dirksen, C.D., Kwee, A., Nijhuis, J.G., Smeets, N.A.C., Scheepers, H.C.J., Hermens, R., 2017. Identification of barriers and facilitators for optimal cesarean section care: perspective of professionals. BMC Pregn. ChildBirth 17 (1), 230. https://doi.org/10.1186/s12884-017-1416-3.

Menage, D., 2016. Part 2: A model for evidence-based decision-making in midwifery. Br. J. Midwifery (2), 24. https://www.britishjournalofmidwifery.com/content/professional/part-2-a-model-for-evidence-based-decision-making-in-midwifery-care.

Meyer, Y., Pehlke-Milde, J., Muntwyler, F.S., Fleming, V., 2019. Integrative power in Swiss home-like childbirths: a qualitative multiple case study. Midwifery 78, 97–103. https://doi.org/10.1016/j.midw.2019.08.005.

MirzaeeRabor, F., Mirzaee, F., MirzaiiNajmabadi, K., Taghipour, A., 2016. Respect for woman's decision-making in spontaneous birth: a thematic synthesis study. Iran. J. Nurs. Midwifery. Res. 21 (5), 449–457. https://doi.org/10.4103/1735-9066.193389.

Molenaar, J., Korstjens, I., Hendrix, M., de Vries, R., Nieuwenhuijze, M., 2018. Needs of parents and professionals to improve shared decision-making in interprofessional maternity care practice: A qualitative study. Birth-Issues Perinat. Care 45 (3), 245–254. https://doi.org/10.1111/birt.12379.

Munn, Z., Peters, M.D.J., Stern, C., Tufanaru, C., McArthur, A., Aromataris, E., 2018. Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. BMC Med. Res. Methodol. 18 (1), 143. https://doi.org/10.1186/s12874-018-0611-x.

Muoni, T., 2012. Decision-making, intuition, and the midwife: Understanding heuristics. Br. J. Midwifery 20 (1), 52–56. https://doi.org/10.12968/bjom.2012.20.1.52.

National Institute for Health Research, 2019. Prospero. NIHR. Retrieved 01.10.19 from. https://www.crd.york.ac.uk/PROSPERO/.

Nicholls, J., David, A.L., Iskaros, J., Lanceley, A., 2022. Patient-centred consent in women's health: does it really work in antenatal and intra-partum care? BMC Pregn. ChildBirth 22 (1), 156. https://doi.org/10.1186/s12884-022-04493-6.

Nieuwenhuijze, M.J., Korstjens, I., de Jonge, A., de Vries, R., Lagro-Janssen, A., 2014a. On speaking terms: a Delphi study on shared decision-making in maternity care. BMC Pregn. ChildBirth 14, 223. https://doi.org/10.1186/1471-2393-14-223.

Nieuwenhuijze, M.J., Low, L.K., Korstjens, I., Lagro-Janssen, T., 2014b. The role of maternity care providers in promoting shared decision making regarding birthing positions during the second stage of labor. J. Midwifery Womens Health 59 (3), 277–285. https://doi.org/10.1111/jmwh.12187.

Noseworthy, D.A., Phibbs, S.R., Benn, C.A., 2013. Towards a relational model of decision-making in midwifery care. Midwifery 29 (7), e42–e48. https://doi.org/10.1016/j.midw.2012.06.022.

O'Brien, D., Butler, M.M., Casey, M., 2021. The importance of nurturing trusting relationships to embed shared decision-making during pregnancy and childbirth. Midwifery 98, 102987. https://doi.org/10.1016/j.midw.2021.102987.

O'Donnell, E., Utz, B., Khonje, D., van den Broek, N, 2014. At the right time, in the right way, with the right resources': perceptions of the quality of care provided during childbirth in Malawi. BMC Pregn. Childbirth 14 (1), 248. https://doi.org/10.1186/1471-2393-14-248.

World Health Organization, 2018. *WHO recommendations; Intrapartum Care For a Positive Childbirth Experience* (ISBN: 978-92-4-155021-5). (Sexual and Reproductive health, Issue. WHO. https://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/.

Oyelese, Y., Vintzileos, A., 2012. Interpretation and communication of medical evidence: room for improvement. Obstet. Gynecol. 120 (3), 650–654. https://doi.org/10.1097/AOG.0b013e318265f377.

Peters, M.D.J., Marnie, C., Tricco, A.C., Pollock, D., Munn, Z., Alexander, L., McInerney, P., Godfrey, C.M., Khalil, H., 2021. Updated methodological guidance for the conduct of scoping reviews. JBI Evid. Implement. 19 (1), 3–10. https://doi.org/10.1097/xeb.0000000000000277.

Pollock, D., Peters, M.D.J., Khalil, H., McInerney, P., Alexander, L., Tricco, A.C., Evans, C., de Moraes É, B., Godfrey, C.M., Pieper, D., Saran, A., Stern, C., Munn, Z, 2023. Recommendations for the extraction, analysis, and presentation of results in scoping reviews. JBI Evid. Synth. 21 (3), 520–532. https://doi.org/10.11124/jbies-22-00123.

Rietveld, A.L., de Groot, C.J.M., Teunissen, P.W., 2018. Decision-making during trial of labour after caesarean; a qualitative study with gynaecologists. PLoS One 13 (7), e0199887. https://doi.org/10.1371/journal.pone.0199887.

Ringqvist, A.K., Bergqvist, L., Brezicka, T., Lundgren, I., 2022. Time-out in prolonged labour: development of a care model to prevent secondary fear of childbirth. BMJ Open. Qual. 11 (4). https://doi.org/10.1136/bmjoq-2022-001853.

Schulz, A.A., Wirtz, M.A., 2022. Midwives' empathy and shared decision making from women's perspective - sensitivity of an assessment to compare quality of care in prenatal and obstetric care. BMC Pregn. ChildBirth 22 (1), 717. https://doi.org/10.1186/s12884-022-05041-y.

Simpson, K.R., 2011. Informed consent in the perinatal setting. MCN Am. J. Matern. Child Nurs. 36 (3), 208. https://doi.org/10.1097/NMC.0b013e31820fafde.

Skoogh, A., Baath, C., Bojo, A.-K.S., Hall-Lord, M.L., 2019. Healthcare professionals' perceptions of patient safety for the woman in childbirth in Sweden - An interview study. Nurs. Open. https://doi.org/10.1002/nop2.435.

Smith, J., 2016. Decision-making in midwifery: A tripartite clinical decision. Br. J. Midwifery 24, 574–580. https://doi.org/10.12968/bjom.2016.24.8.574.

Sonesh, S.C., Gregory, M.E., Hughes, A.M., Feitosa, J., Benishek, L.E., Verhoeven, D., Patzer, B., Salazar, M., Gonzalez, L., Salas, E., 2015. Team training in obstetrics: A multi-level evaluation. Fam. Syst. Health 33 (3), 250–261. https://doi.org/10.1037/fsh0000148.

Stohl, H., 2018. Childbirth is not a medical emergency: maternal right to informed consent throughout labor and delivery. J. Leg. Med. 38 (3-4), 329–353. https://doi.org/10.1080/01947648.2018.1482243.

Styles, M., Cheyne, H., O'Carroll, R., Greig, F., Dagge-Bell, F., Niven, C., 2011. The Scottish trial of refer or keep (the STORK study): midwives' intrapartum decision making. Midwifery 27 (1), 104–111. https://doi.org/10.1016/j.midw.2009.12.003.

Tiffen, J., Corbridge, S.J., Slimmer, L., 2014. Enhancing clinical decision making: development of a contiguous definition and conceptual framework. J. Prof. Nurs. 30 (5), 399–405. https://doi.org/10.1016/j.profnurs.2014.01.006.

Tricco, A.C., Lillie, E., Zarin, W., O'Brien, K.K., Colquhoun, H., Levac, D., Moher, D., Peters, M.D.J., Horsley, T., Weeks, L., Hempel, S., Akl, E.A., Chang, C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M.G., Garritty, C., Straus, S.E., 2018. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. Ann. Intern. Med. 169 (7), 467–473. https://doi.org/10.7326/m18-0850.

van der Waal, R., Mayra, K., Horn, A., Chadwick, R., 2023. Obstetric violence: an intersectional refraction through abolition feminism. Feminist Anthropol. 4 (1), 91–114. https://doi.org/10.1002/fea2.12097.

Van Otterloo, L.R., Connelly, C.D., 2016. Maternal risk during pregnancy: a concept analysis. J. Clin. Nurs. 25 (17-18), 2393–2401. https://doi.org/10.1111/jocn.13294.

Vedam, S., Stoll, K., Martin, K., Rubashkin, N., Partridge, S., Thordarson, D., Jolicoeur, G., 2017. The Mother's Autonomy in Decision Making (MADM) scale: Patient-led development and psychometric testing of a new instrument to evaluate experience of maternity care. PLoS One 12 (2), e0171804. https://doi.org/10.1371/journal.pone.0171804.

Villarmea, S., Kelly, B., 2020. Barriers to establishing shared decision-making in childbirth: Unveiling epistemic stereotypes about women in labour. J. Eval. Clin. Pract. 26 (2), 515–519. https://doi.org/10.1111/jep.13375.

Waddell, A, Lennox, A, Spassova, G, P, B, 2021. Barriers and facilitators to shared decision making in hospitals from policy to practice: a systematic review. Implement. Sci. 16, 23. https://doi.org/10.1186/s13012-021-01142-y.

Watkins, V., Nagle, C., Kent, B., Street, M., Hutchinson, A.M., 2022. Labouring Together: Women's experiences of "Getting the care that I want and need" in maternity care. Midwifery 113, 103420. https://doi.org/10.1016/j.midw.2022.103420.

Weiseth, A., Plough, A., Aggarwal, R., Galvin, G., Rucker, A., Henrich, N., Miller, K., Subramanian, L., Hawrusik, R., Berry, W., Gullo, S., Spigel, L., Dever, K., Loveless, D., Graham, K., Paek, B., Shah, N.T., 2022. Improving communication and teamwork during labor: A feasibility, acceptability, and safety study. Birth 49 (4), 637–647. https://doi.org/10.1111/birt.12630.

Weltens, M., de Nooijer, J., Nieuwenhuijze, M.J., 2019. Influencing factors in midwives' decision-making during childbirth: A qualitative study in the Netherlands. Women and Birth 32 (2), E197–E203. https://doi.org/10.1016/j.wombi.2018.06.009.

Yuill, C., McCourt, C., Cheyne, H., Leister, N., 2020. Women's experiences of decision-making and informed choice about pregnancy and birth care: a systematic review and meta-synthesis of qualitative research. BMC Pregn. ChildBirth 20 (1), 343. https://doi.org/10.1186/s12884-020-03023-6.