



“Real decision-making is hard to find” - Swiss perinatal care providers’ perceptions of and attitudes towards decision-making in birth: A qualitative study

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ABSTRACT

Purpose: Ineffective communication and limited autonomy frequently lie at the core of negative birth experiences. Numerous studies indicate a need to improve decision-making with a deliberate shift towards person-centered care. Thus, it is imperative to study the determinants of autonomy-depriving decision-making and ineffective communication through both provider and birthing people perspectives. Our study explores providers’ perceptions of and attitudes towards decision-making in birth, particularly regarding person-centeredness, autonomy, informed consent, and decision-making capacity. We conducted a qualitative interview study and employed reflexive thematic analysis. In total, 15 Swiss providers from birth hospitals and birth centers participated.

Results: Analysis resulted in the development of three themes and eight subthemes. First, the “otherness of birth” encompasses providers’ perception of birth as a clinical situation that is fundamentally different from other clinical situations. Second, the otherness of birth goes along with an “ethical fading”, that is ethical dimensions – to some extent – fade into the background as they are obscured by various circumstances that are related to birth, birthing people, and providers. Third, the “physiology-pathology-dichotomy” describes the permeative power of this dichotomy with respect to providers’ decision-making approaches and their normative weighing of ethical principles.

Conclusions: Decision-making in birth is a critical factor in the actualization of autonomy and characterized by bioethical complexity. Our study reveals important insights into how autonomy-depriving decision-making and ineffective communication unfolds in birth. Our findings provide a framework for future research and yield points of leverage for enhancing decision-making in birth.

1. Introduction

During birth, birthing people, their companions, and providers are confronted with the challenge of decision-making,² in which these parties share decisions and actively work together to answer questions related to issues such as examinations, interventions, or pain management. For the concept of shared decision-making, however, numerous versions with varying levels of paternalism and choice exist (Sandman & Munthe, 2010), it is not transparent how it is related to (different aspects

of) autonomy (Sandman & Munthe, 2009), and it has been argued that, particularly in birth, an inherent power imbalance between patients and providers can reduce the former’s autonomy and, in contrast, a more person-centered approach can enhance their autonomy (Nieuwenhuijze, Korstjens, de Jonge, de Vries, & Lagro-Janssen, 2014; Vedam, Stoll, McRae, et al., 2019). As such, the espoused ideal of person-centered decision-making (PC-DM) prioritizes patients’ needs and preferences over those of providers and includes consideration of the best evidence to lead to optimal care for each individual person. Hence, PC-DM

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² Throughout this article the term “decision-making in birth” refers to all instances of decision-making between providers and service users in birth and, thus, represents a neutral expression which does not encompass any particular conceptual underpinning or operational practice as opposed to the concepts of shared or person-centered decision-making.

synthesizes these two vital aspects: centering a patient's needs and incorporating evidence based care principles into decision-making (Vedam, Stoll, McRae, et al., 2019; Weiner, 2004). The underlying framework of person-centered care is characterized by participation, a genuine and open patient-provider-relationship, and the contexts of care – such as the language used or a therapeutic environment (Kitson, Marshall, Bassett, & Zeitz, 2013). More specifically, for person-centered reproductive healthcare, Sudhinaraset and colleagues lay out eight domains: dignity, autonomy, privacy, communication, social support, supportive care, trust, and health facility environment (Sudhinaraset et al., 2017). The increasing recognition of person-centered care during facility-based birth is also expressed by the implementation of interventions known to improve such person-centered outcomes, for example, autonomy or social support (Rubashkin, Warnock, & Diamond-Smith, 2018). Critical to the discourse around person-centered care in birth is a widely observed preference for person-led decision-making (Vedam, Stoll, McRae, et al., 2019).

In sum, research on birth experiences indicates a need to improve decision-making in birth with a deliberate shift towards PC-DM. People consistently report having little control during labor and to be both insufficiently supported and informed about what happened (Czarnocka & Slade, 2000; Dekel, Stuebe, & Dishy, 2017); and to be limited or having no ability to exercise informed choice with providers dictating the final decision (Jou, Kozhimannil, Johnson, & Sakala, 2015; Newnham, McKellar, & Pincombe, 2017). Others have experienced a total loss of control, pressure to agree to unwanted interventions, conflicts with physicians (Beck, Gable, Sakala, & Declercq, 2011; Lescale et al., 1996; Olde, van der Hart, Kleber, & van Son, 2006; Simpson, Schmied, Dickson, & Dahlen, 2018), or traumatic birth experiences (Elmir, Schmied, Wilkes, & Jackson, 2010; Reed, Sharman, & Inglis, 2017a, 2017b). A systematic review, spanning 34 countries, revealed seven domains of mistreatment in birth (e.g. physical abuse, verbal abuse, stigma and discrimination, poor rapport between birthing people and providers, health system conditions) (Bohren et al., 2015). According to this typology, mistreatment which includes interactions between patients and providers must be considered at every level of care organization. Mistreatment in birth is common and is not limited to a particular geographical area in the world (Bohren et al., 2019; Bohren et al., 2015; Oelhafen, Trachsel, Monteverde, Raio, & Müller, 2021; Ravaldi, Skoko, Battisti, Cerico, & Vannacci, 2018; Vedam, Stoll, Taiwo, et al., 2019). A US study revealed that one in six persons reported one or more types of mistreatment (e.g. loss of autonomy, being shouted at) (Vedam, Stoll, Taiwo, et al., 2019). A Swiss study found that one in four experienced informal coercion (e.g. intimidation, manipulation) (Oelhafen et al., 2021). Naturally, such mistreatment translates into negative birth experiences and sometimes even into postpartum posttraumatic stress disorder (Dekel et al., 2017; Martinez Vazquez, Rodriguez Almagro, Hernandez-Martinez, Delgado-Rodríguez, & Martinez Galiano, 2021).

In birth, problematic relationships between patients and providers are often rooted in ineffective communication and limited autonomy (Bohren et al., 2015). As such, these shortcomings frequently lie at the core of negative birth experiences. Coupled with the prevalence of mistreatment, it is imperative to study the determinants of strained and unsatisfactory decision-making in birth. Bohren and colleagues identified *staff attitudes* as one possible determinant for ineffective communication (Bohren et al., 2015). Thus, our study focuses in on providers' perceptions of and attitudes towards decision-making in birth, particularly regarding person-centeredness, autonomy, informed consent (IC), and decision-making capacity. This is especially relevant for Switzerland for which a recent study showed that informal coercion is a common experience and not an isolated incidence (Oelhafen et al., 2021). As coercion is one form of mistreatment and limited support for decision-making is one way that coercion is actualized, we sought to contribute towards explaining such findings by exploring Swiss providers' perceptions of and attitudes towards decision-making in birth. Ultimately, our findings shed light on the etiology of strained and unsatisfactory decision-making,

provide a framework for future research, and yield points of leverage for enhancing decision-making in birth.

2. Material and methods

2.1. Study design

This study is part of a larger mixed-methods project addressing decision-making in birth in Switzerland. We conducted in-depth interviews with perinatal care providers. Applying a critical lens, our analysis focused on a description and exploration of statements which indicate attitudes or perceptions that might impede decision-making (Bohren et al., 2015). We used a reflexive thematic analytic approach. Study documents were reviewed by the responsible ethics committee (Ethikkommission Nordwest-und Zentralschweiz; EKNZ). Since providers were interviewed, the EKNZ stated that the project does not fall under the remit of the Swiss Human Research Act (Art. 2). Thus, no ethical approval was needed. Still, the EKNZ issued a declaration of no objection (Req-2019-00017) stating that the project fulfills the general ethical and scientific standards for research with humans (Art. 51).

We chose in-depth interviews because, first, they provide the optimum method to capture perinatal care providers' individual attitudes towards decision-making in birth. It is known that individual attitudes and behaviors greatly impact childbearing experiences and outcomes (Behruzi, Hatem, Goulet, & Fraser, 2011; Kozhimannil, Attanasio, Yang, Avery, & Declercq, 2015). By confronting perinatal care providers with interview questions concerning their attitudes and perceptions, the method at hand is well suited to shed light on the question of how decision-making in the intrapartum period is viewed, practiced, and what factors are regarded as hindering or enhancing. Second, we wanted to avoid effects of professional hierarchies (e.g. mixed focus groups) and provide a safe environment allowing interviewees to open up about their attitudes and perceptions.

2.2. Swiss context

In Switzerland, the most common place of birth is the hospital (98.3%) (Federal Statistical Office, 2019). Besides, birthing people can give birth at home or in birth centers: freestanding, midwife-led, primary care facilities in the public health system which might collaborate with hospitals and private gynecologists, but in which no obstetricians work. In the compulsory social health insurance system, pregnancy and birth services are covered by a person's health care insurance.

2.3. Participants

In total, we interviewed 15 providers (8 midwives, 5 physicians, 2 doulas; Table 1). Age ranged from 27 to 57, work experience from 1 to 34 years. At the time of the interview, eight participants worked in a hospital, five in a birth center, and two in both settings (doulas). All participants, at some point in their career worked in a Swiss hospital or did at the time of the interview.

2.4. Study-tool and procedure

A semi-structured interview-guide was informed by a review of the literature and the research team's expertise. The tool consisted of 13 main questions and addressed the following areas: intra-team collaboration, ethical principles associated with intrapartum care, decision-making, person-centeredness, IC, autonomy, decision-making capacity, guidelines, and coercion. Based on participants' preferences interviews were carried out (by MR) either at the research office, via telephone, or video-call between October 2019 and May 2020. Written IC was obtained prior to interviews. All interviews were conducted in German, transcribed verbatim and de-identified. Participants were given the opportunity to check transcripts and to comment on or remove statements. Average duration was 46 min (range: 29–72).

Table 1
Participants characteristics (N = 15).

All participants	Proportion/Mean (SD)	
Gender	14 women, 1 man	
Age (years)	41.5 (9.7)	
Work experience (years)	14.5 (9.6)	
Broken down by profession	Age Mean (SD)	Work experience Mean (SD)
Midwife (n = 8; I1, I2, I4, I6, I7, I9, I11, I15)	40.0 (11.3)	14.8 (10.9)
Physician (n = 5; I3, I5, I8, I13, I14)	45.2 (8.3)	18.0 (6.6)
Doula (n = 2; I10, I12)	38.0 (7.0)	5.0 (5.7)
Setting	At interview ^a	Entire career ^b
Hospital	10	15
Birth center	7	7

II = interviewee.

^a Since doulas worked in both settings, this number exceeds the total N.

^b Since some persons had previously worked in the other setting, this number exceeds the total N.

2.5. Recruitment and data analysis

We approached 21 birth hospitals with more than 1.000 births/year and 14 birth centers in the German-speaking part of Switzerland via email. Additionally, we introduced the study in a postal letter of invitation. Interested providers contacted us. Data were analyzed using MAXQDA and employing reflexive thematic analysis (Braun & Clarke, 2006, 2019) (Fig. 1).

2.6. Reflexivity

Reflecting on underlying assumptions and researcher positionality is crucial for reflexive thematic analysis (Braun & Clarke, 2019). The analyzing researchers have backgrounds in Psychology, Bioethics, Medicine, and Gender Studies (other authors: Psychology, Midwifery, Critical Feminist Theory). All authors are committed to using research to uphold human rights in general, and reproductive rights in particular. Our research aims to better understand decision-making in birth to promote autonomy and improve birth experiences.

We also acknowledge that our discussion of decision-making is situated within a Western context in which individual autonomy is a widely accepted cultural value. However, we do recognize that a more comprehensive account of autonomy goes beyond a narrow individually constructed, capacity-centered understanding by incorporating relational and social, emotional, cultural, and structural determinants as most clearly articulated by feminist and intersectional theorists (Cho, Crenshaw, & McCall, 2013; Crenshaw, 1989; McLeod & Sherwin, 2000; Stoljar, 2018). Moreover, we acknowledge oppressive social conditions

that are both inflicted upon and internalized by childbearing people and pervasively undermine one's autonomy. Epistemologically, we share the conviction that themes “are actively created by the researcher at the intersection of data, analytic process and subjectivity” (Braun & Clarke, 2019, p. 594). Consequently, we do not claim to discover the “truth” that is lying dormant in the data. Instead, constructed themes are interpretive stories about the data – rooted in our positionality and theoretical framework. The conceptual frameworks underlying our research are shared and PC-DM as well as related concepts such as autonomy, IC, or decision-making capacity.

3. Theory

Intrapartum care is subject to fundamental bioethical principles, such as respect for autonomy and non-maleficence (Beauchamp & Childress, 2009), and to quality standards in perinatal care, such as avoidance of unnecessary interventions and continuous support (Gülmezoglu et al., 2016; Lothian, 2014; World Health Organization, 2018). Moreover, human rights are legal rights that cover birth – this means patients must act as authoritative decision-makers regarding their own care (Hayes-Klein, 2017). However, the intrapartum period, marked by physiologic and emotional intensity, is particularly prone to factors potentially hindering decision-making. For patients, hindering factors include a high degree of risk-avoidance, lack of appropriate in-depth birth knowledge, or fear of birth (Dhumale & Goudar, 2017; Hildingsson, 2014; Ledward, 2017; Melender, 2002). These factors might render patients susceptible to paternalistic or coercive behaviors of providers. For providers, impeding factors include limited time and staff, institutional cost-efficacy and risk-management, discontinuity of care due to working shifts, professional hierarchies, legal liability, pathogenic view of birth, and implicit and explicit biases (Afulani, Altman, et al., 2021; Daemers, van Limbeek, Wijnen, Nieuwenhuijze, & de Vries, 2017; Downe, Finlayson, & Fleming, 2010; Dranove & Watanabe, 2009; Dubai, Kaestner, & Waidmann, 1999; Healy, Humphreys, & Kennedy, 2016, 2017; Mundlos, 2015; R. Reed et al., 2017a, 2017b).

In response to mistreatment in birth, the respectful maternity care framework is being utilized by various international organizations and advocates as an essential element of improving care quality and its direct relationship to upholding human rights in birth (The White Ribbon Alliance, 2021; World Health Organization, 2015). While it is clear that respectful decision-making is a bioethical imperative, for birthing people it remains an elusive goal. In birth, “choice is both complex and multifaceted and creates a paradox (...) as they are simultaneously assigned active and passive roles” and is described as rather a myth than a realistic aim (Jomeen, 2012, p. 62; Lothian, 2008). Related to this, patients’ understandings of autonomy extend beyond mere self-determination (e.g. consideration of previous experiences, assessment of current expectations, access to relevant information) (Ledward, 2017). Also, for the intrapartum period, it has been argued that routine obstetric

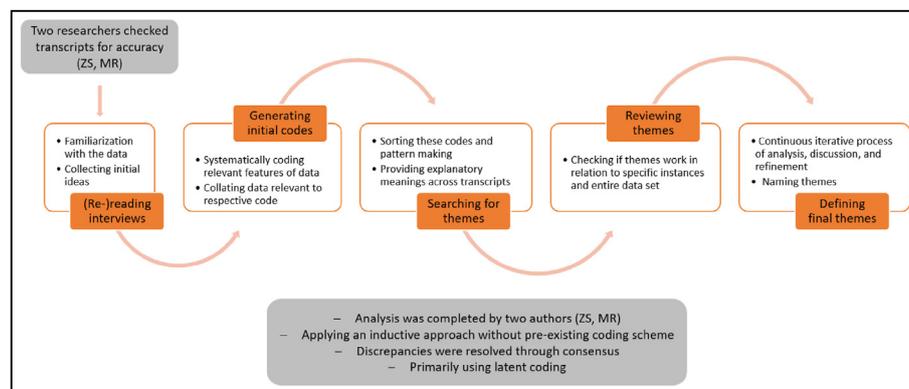


Fig. 1. Data analysis process.

interventions interrupt the fragile state of birthing consciousness and thus interfere with a physiologic birth process, ultimately increasing the likelihood of instrumental birth or cesarean section, which underlines the imperative to carefully reassess (the interruptive potential of) current IC procedures (Dahan, 2021).

Regardless of this debate surrounding the applicability of traditional conceptualizations of autonomy, IC, and choice to birth, the need for and right to respectful maternity care warrants growing attention (Kennedy et al., 2018; World Health Organization, 2018). Scales to measure respectful maternity care as a valid birth outcome in its own right have been developed and are being applied (Afulani, Altman, et al., 2021; Limmer, Stoll, Vedam, & Gross, 2021; Oelhafen et al., 2021; Vedam, Stoll, Martin, et al., 2017; Vedam, Stoll, Rubashkin, et al., 2017; Vedam, Stoll, Taiwo, et al., 2019). A recent systematic review revealed that decision-making experiences are often characterized by uncertainty about the unknowns of birth, maintaining control over bodily autonomy and integrity, and performing good motherhood by managing responsibility and risk. These findings lead the authors to question whether current frameworks for decision-making in birth truly allow for flexibility and promote respect for bodily autonomy and integrity (Yuill, McCourt, Cheyne, & Leister, 2020).

Lastly, mistreatment in birth must be viewed both as a subset of violence against women, in that it stems from structural gender inequality which systematically oppresses women and enables the use of power against them (Jewkes & Penn-Kekana, 2015), and as a form of reproductive violence beyond the scope of gender, in that it is dynamically intersectional and extends beyond the regulation of women to reproductive subjects more broadly (Chadwick, 2021). In fact, it has been shown that historically excluded groups (e.g. Indigenous, Hispanic, or Black people; immigrants) reported more mistreatment in birth (Oelhafen et al., 2021; Vedam, Stoll, Taiwo, et al., 2019), evidencing that an intersectional approach is paramount to understanding and improving decision-making in birth (Davis, 2019).

4. Results

Analysis resulted in the development of three themes and eight sub-themes. First, the “otherness of birth” reflects providers’ perception of birth as an intrinsically different clinical situation. Second, the otherness of birth goes along with an “ethical fading”, that is, principles of ethically sound decision-making do not fully unfold due to various circumstances. Third, the “physiology-pathology-dichotomy” strongly determines decision-making. In the following, we present the themes and subthemes which are further explicated by specific instances (Braun & Clarke, 2006) (Table 2; additional quotes in supplementary material).

4.1. The otherness of birth

The first theme encompasses providers’ view of birth as a clinical situation that is fundamentally different from other clinical situations (Table 2, Fig. 2). First, many providers emphasize that decision-making in birth is different from decision-making in other clinical contexts. One factor that renders it different is that, ideally, it begins before birth, namely with or during pregnancy. Thus, decision-making is anticipated and shaped by antenatal communication.

“I believe that a good birth [and decision-making] begins during pregnancy. This is the basic thing that women need to know. (...) And that’s the big difference.” (I1)

Also, decision-making in birth was considered unique because of many particularities, such as the need “to consider harm to the child” (I3), the possibility of an abrupt “turning point as soon as something is pathological” (I4), the importance of respecting “how the couple or the whole family envisions birth” (I4), the fact that “a woman usually comes in with a birth plan” (I6), the frequently occurring case that “things have

Table 2
Themes, subthemes, and specific instances of providers’ perceptions and attitudes.

	Theme 3rd order	Subtheme 2nd order	Specific instances 1st order
Antecedents	I Otherness of birth	1) Decision-making	It begins with pregnancy Particularities Limited applicability of bioethical principles
		2) Pathology-paradox	A-priori, not pathological If, then hyper-pathological
		3) Two perceptions	Birthing people’s versus providers’ experiences Interindividual differences among birthing people
Intrapartum situation	II Ethical fading	1) Informed consent	Focus on informing, less on consenting Process only fully possible, if physiological Means to achieve lege artis care
		2) Decisional capacity	Mistaken equations and beliefs Often limited because of visceral factors No standardized evaluation
		3) Autonomy	Narrow understanding Lack of awareness of undue interference
	III Physiology-pathology-dichotomy	1) Decision-making approaches	Decisional cascade dependent on acuity Incompatibility of emergency and autonomy
		2) Normative weighing	Pathology: First do no harm trumps autonomy Pathology: Child’s interests trump autonomy Pathology might justify coercion

to happen quickly” (I15), the “sensitivity and intimacy of the moment”, or feelings of “helplessness, fear” and “pain” (I11), “a lack of control” (I13) and “vulnerability” (I12) on the part of patients. Some participants even questioned the distinctiveness of decisions being made during birth, describing decisions as not necessarily distinguishable events but as “a process, it just happens” (I13). Sometimes, this procedurality was attributed to a presumed preference for being guided and for not being fully independent in decision-making.

“During birth, I just think it’s little ..., it’s such a fluid process where there are few real decisions, right? (...) So it’s often the case that people are happy that it’s being addressed and it’s then like a flowing process (...) So real decision-making is hard to find during birth.” (I2).

Lastly, bioethical principles and concepts are seen to have limited applicability to birth. Regarding IC, hampering factors such as visceral factors on the part of birthing people (e.g. pain, fear), limited time (e.g. emergency, guidelines), or a presumed lack of comprehension (e.g. frequencies of certain events, risks, obstetric expertise) were regularly cited.

“That’s what I call informed consent: when I present the most recent literature directly in such a way that the woman can understand it and that she can then also make a decision on her own with this information. That would be the ideal. (...) I find it much more difficult during birth, because women are simply in an extraordinary situation.

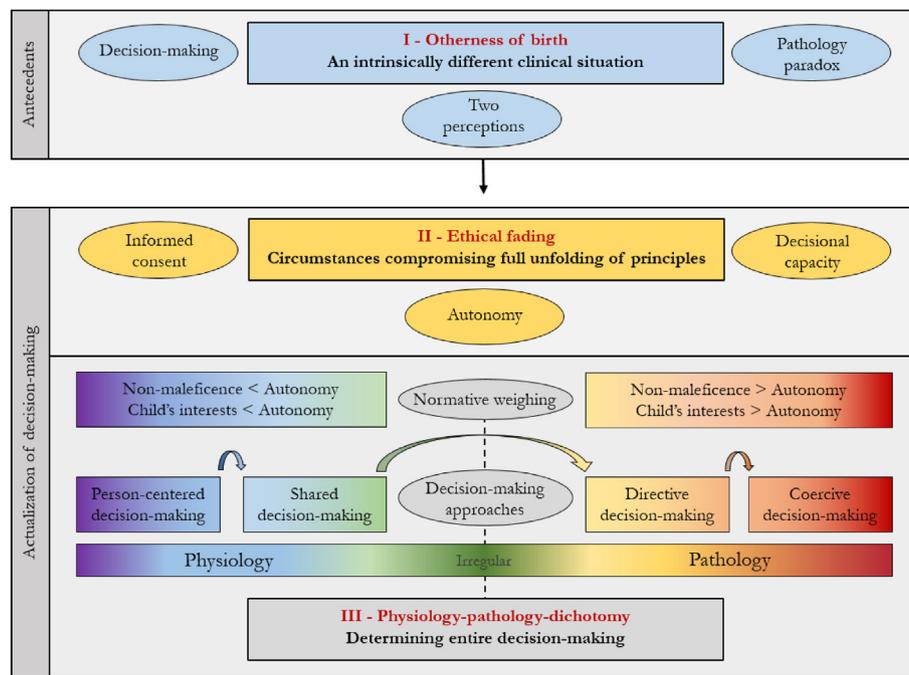


Fig. 2. Themes and subthemes.

And then to argue with some numbers, statistics ‘look, if we don't do the vacuum, 15% chance for cerebral palsy’, that's not real, that's not pragmatic enough.” (I3)

Correspondingly, decision-making capacity, a prerequisite for IC, was perceived as limited and at times as absent during birth.

“I have the impression that it is not necessarily the case with birth [to deem women capable as a default]. So that one sees the woman a little bit as incapable. Unfortunately, I experience that again and again. And yes, that (...) one doesn't take her seriously ... that one makes decisions over her head.” (I12)

Providers critically reflected upon the applicability of the concept of decision-making capacity during birth. Many recounted how birth itself ushers in the perception that birthing people are entering into a different mental state: patients were “diving into these hormones” and “getting into this state of somehow half-here-and-half-somewhere-else” (I15). Participants suggest that this ‘out of body’ mental state limits the ability to intelligibly participate in decision-making.

“I think the problem is that (...) it's extremely difficult for me to make a decision in my head during labor. If you go with Michel Odent [French obstetrician], then it's actually about switching off the head altogether, that is not having to think at all, adrenaline is a complete no-go during birth and as soon as I switch on my brain and think, then adrenaline is yes and oxytocin is no.” (I10)

Finally, with respect to the applicability of bioethical principles and concepts, providers emphasized that they are responsible for two patients, not one. This dual responsibility in turn, holds direct implications for a person's autonomy. In providers' accounts, autonomy implies a singular self and can hardly be applied to two individuals simultaneously – parent and child. In this way providers continued to consider birth as different from other clinical situations and therefore requiring a different logic of care.

“We face a special situation; it is not only about the woman's body. It's about an expectant life. So we have two people to care for.” (I3)

Second, providers' statements on the nature of birth reveal some sort of built-in paradox. One the one hand, many providers apostrophized

birth to be something non-pathological “I know it's [birth] nothing pathological, it's something natural.” (I10). One the other hand, whenever a pathology arises, they often described it as a hyper-pathological and acute situation in which actions need to be taken immediately.

“But how much room she has for autonomy: basically, as long as it's in the physiological range, always completely. And when we think, we have to help, to act, then it will be limited.” (I11)

Third, there seems to be a broad consensus on the part of providers that patients' and providers' perceptions of the same birth are ineluctably different from one another.

“Although, actually, medically, the procedure - everything went right. And in the end the birth was without complications (...) but that the woman then somehow ..., it's still not right for her. (...) And often from the medical perspective you think ‘it was a model birth, normal birth, no vacuum, child got out well, mother has - don't know - born her first child in 8 hours’, but for the woman it is still not true.” (I5)

Additionally, understanding patient perceptions is further complicated by interindividually different perceptions among birthing people themselves.

“(…) for the women it was incredibly traumatic. And other women who have really difficult births with [poor] outcomes of the children and who say ‘that was the most beautiful thing for me’ (...). That is exactly what is difficult, this individuality.” (I13)

4.2. Ethical fading

The second theme captures providers' mostly experience-driven attitudes towards implementing key elements of ethically sound decision-making in birth (Table 2, Fig. 2). This means ethical dimensions – to some extent – fade into the background as they are obscured by various circumstances that are related to birth, birthing people, and providers. First, in practice, decision-making and the IC procedure is subordinate(d) to medical imperatives, but this often happens at the expense of ethical considerations. For instance, when delineating IC procedures, providers focused on informing, but less on consenting.

“So for vaginal surgical deliveries (..) there is like none [consent] (...) I don't explicitly ask ‘do you agree?’ I really have to say that. But rather I explain that it's necessary now, for this and that reason. And that we explain what we're doing.” (I14)

Furthermore, providers frequently considered IC and both shared and PC-DM only fully possible, if birth progresses physiologically. In pathological situations IC and decision-making is deprioritized.

“So when it comes to it, that we see: waiting even longer and the child will have really severe damage. We don't discuss it for a long time, we have to say ‘now we have to do an emergency caesarean section, I'll explain everything to you’. And we don't do ‘what do you think Mrs. Müller, should we ... ‘.’” (I9)

Sometimes the process of shared decision-making was initiated to convince patients of the need to perform care that providers present as medically indicated. In these instances, decision-making is not an end in itself, but is repurposed, becoming a coercive means serving providers' interests (e.g. guideline-adherence).

“There are also many things that women are talked into, like ‘yes, you need an epidural now’, because there is too little time and so on. And the woman didn't want to.” (I7)

Second, while decision-making capacity is ethically and legally crucial for IC which, in turn, protects autonomy, providers frequently did not seem to fully recognize both its content and scope. They mistakenly equated decision-making capacity with “reasonableness” (I5), not agreeing to the suggested course of action – “no, I do not want that at all” (I7), a “wrong judgement” and “contractual capacity” (I11), “expertise, training and experience” (I9), or with an “obstetrical background” (I15).

“Women often have little expertise or little experience. (...) We are the professionals. They expect us to make decisions, too, right. And so, to what extent are they capable of judgment? They don't have that training and that experience. They almost have to rely on us.” (I9)

Participants frequently assumed that patients' decision-making capacity is limited because of physiologic factors related to pregnancy and birth, such as “pain” (I3), “hormones” (I5), “fears” and “labor” (I12).

“So many women say afterwards ‘yes, I could no longer decide at that moment’. So it's really because of the pain and the intensity of the experience that women are no longer able to make decisions.” (I7)

Despite the lack of decision-making capacity, a few participants acknowledged the value of embodied knowledge which enables patients to make (the right) decision, sometimes even better than providers do.

“But it can also be that the woman has such a good body feeling and that I am wrong and that she has decided correctly.” (I11)

Furthermore, participants indicated that in birth, decision-making capacity is rarely assessed in a standardized way – “we don't check by default, whether they're cognitively capable” (I9). On the contrary, if decision-making capacity is assessed, providers' reported a spectrum of assessment methods ranging from “feelings” (I4) and a “subjective impression” (I8) to a more elaborated approach of personal judgement:

“I can recognize, can the woman respond to my questions, does she understand this question, can she repeat my statements. I can do a summary. I can say to her ‘can you briefly explain to me again what I have just told you, what is the most important thing for you?’. So there are definitely possibilities in the interaction, in the dialog, that you can pay attention to a good cooperation, a good communication with the woman.” (I3)

Third, providers sometimes exhibited a rather narrow understanding of the principle of respect for autonomy. Participants construed autonomy to mean: “to be allowed to have a say” (I9), “to be involved” (I6), “to

express their preferences” (I8), “to be well informed and (...) to co-decide” (I14), or “to be allowed to express wishes and ideas” (I8).

“I actually see a lot of room for autonomy. When I think of my mother, of the generation back then. So it's often said ‘my God, women today can give birth in water, they're allowed to eat, they're allowed to bring music,’ etc. ‘they are allowed to have a say’, so there you are already a bit further. She can also choose, for example, whether she wants to give birth in a birth center.” (I9)

In general, there was a wide absence of any explicit and critical reference to a person's autonomous decisions being free from undue interference (e.g. informal coercion by providers). While providers acknowledged that autonomy encompasses a person's ability to decide, they commonly lacked a critical examination of how their own actions might (unduly) interfere with the ability and right to self-determination. Limiting autonomy because of “a risk to the health of the child” (I14), “little expertise or little experience” (I9) on the part of the woman, or “medical guidelines” (I11) appeared to be reconcilable with the principle of respect for autonomy. Hence, such interference with autonomy was implicitly approved as a legitimate action for the safety's sake. Here, providers regularly attributed the deprivation of autonomy to factors outside of their agency, insufficiently articulating that they are the – autonomy facilitating or limiting – hinge between birth trajectory and autonomy. This is also mirrored in their word choice: “we have to do an emergency caesarean section” and “I cannot put this wish above everything” (I9), “things (.) simply force us to act” (I8), or “it needs a medical intervention” (I3).

4.3. The physiology-pathology-dichotomy

The third theme describes the permeative power of the physiology-pathology-dichotomy (Table 2, Fig. 2). *First*, the physiology-pathology-dichotomy determined the process of decision-making. Providers support of PC-DM decreased as the perception of pathology arose, that is decision-making is the “more directive” (I4) and “coercive” (I7), the more characterized by “not including a woman” and “forcing a decision” (I6), the less “safety is there” (I6), the more “urgent the decision” (I13), and the more “pathological something is” (I4). Accordingly, decision-making is moderated by providers' assessment of a situation. However, it appears that providers' decision-making approaches fall on a spectrum that is discontinuous, containing gaps in person-centeredness. Deciding whose autonomy is allowed and which preferences are acceptable remain at the discretion of the provider. This discontinuous decision-making spectrum ranges from being person-centered – to shared – to directive – and ultimately to coercive, with the main tipping point being between whether the labor process is physiologic or pathologic (Fig. 2).

As the assessment of physiology and pathology fluctuates so do providers' decision-making approaches. Examples of physiology-pathology-assessments exist on a range from physiologic labor (“a normally progressing birth”, I4) to brewing suspicions of deviations (e.g. “green amniotic fluid”, I1; “deviant”, I4; “suspect”, I5; “protracted birth”, I5; “irregular area”, I11) to pathologies sometimes confirmed with clinical evidence (e.g. “bad cerebral blood flow”, I3; a “bleeding”, I4; “bad heart sounds”, I8; “placenta does not work properly”, I9) and situations indicating an increased risk for postpartum pathologies (e.g. “cerebral palsy”, I3). Many participants seemed to dichotomize situations into physiological versus pathological, thereby creating two main clusters of situations that shaped their decision-making approaches.

“That [decision-making] always depends, is something simply deviant or is it really pathological? If something is really pathological, then I also change to a more directive approach. Then she has to take the position that I tell her, because it's about the well-being of the child or (..) about her personal well-being, her personal life. That's where I try to explain the situation, but then be directive. But if it's just deviant, then I just proceed as I described earlier and say ‘this

would benefit the progress now', but if she doesn't want it, then I leave that up to her as well, but just knowing that that could then change to pathological and there it changes to directive. So that's actually the tipping point for me, as soon as something is pathological." (I4)

Such a perspective ties in with providers' perceptions of an incompatibility of an emergency and autonomy.

"That you can't let the woman decide the way she would like to if there are emergencies. If the safety is no longer there, then she is not allowed to decide." (I6)

Second, the dichotomy also underlies providers' normative weighing of ethical principles. In a pathological situation, providers tended to prioritize non-maleficence over birthing people's autonomy.

"I think that sometimes things develop during birth (...). I'd say, for me, that's really the most important thing, that the child and the women are healthy. And yes ... I'd say that sometimes the autonomy, how shall I put it, the wishes of women move into the background when something is really no longer ok." (I8)

Similarly, in pathological situations providers tended to prioritize interests of the fetus.

"Whenever it could harm the child and we have to recognize to the best of our knowledge and belief that we now would have a problem with the child. And that's where, for me, autonomy ends a bit." (I3)

Imagining a situation in which a person's life can only be saved, if providers overrule autonomy, one provider provided the following rationale.

"In that situation, I am who I am. There my personality is involved and I am almost convinced that I would then simply say 'no, we'll do it this way now', without primarily looking at the consequences that this would imply for me. And I just think, that in doing so I would do the right thing in this situation, even if that would be against the woman's will. That would be completely an extreme situation, meaning the woman doesn't want blood [transfusion], she wants to die. That would never happen with me. That doesn't exist. I would not respect that and even if I had to go to jail for it - I don't care. That's just how I understand medicine." (I3)

Such situations were reported to, sometimes, lead to, if not justify coercion. Providers described the application of coercive measures as necessary in rare cases to averting severe harm to the child, mother, or both.

"What is always perfidious is that it is always immediately justified with the well-being of the child and then every woman is in a position of coercion, because she cannot say 'no', because no one wants the child to suffer. I find that something very bad. There are X stories of perineal incisions that were actually not wanted. (...) and then the woman said 'yes, but I don't want that' - 'yes, but it is needed now' and then it is done. I think it's about such cases, where women feel really restricted in their self-determination." (I7)

5. Discussion

Our study is the first to systematically explore perinatal care providers' perceptions of and attitudes towards decision-making in birth. It is particularly crucial, since studies have reported poor decision-making for many countries including Switzerland, USA, Germany, and Canada (Bohren et al., 2015; Limmer et al., 2021; Niles, Stoll, Wang, Black, & Vedam, 2021; Oelhafen et al., 2021; Vedam, Stoll, Taiwo, et al., 2019).

5.1. How different is birth?

Decision-making in birth was described as different from other clinical situations because it should already begin in pregnancy. This aligns with the recommendation of the World Health Organization to have at least eight antenatal care contacts to not only reduce perinatal mortality, but also to improve experiences of birth through communication on birth-preparedness and complication-readiness (World Health Organization, 2016). Such a continuity-model supports the development of a trusting relationship with providers during the antenatal period and may help facilitate labor and birth that are rooted in autonomy and respect. Providers further opined that additional particularities render decision-making different. While these particularities undoubtedly exist, the contention that respective bioethical principles are only applicable to *some* extent because of these peculiarities warrants critical examination. The influence of visceral factors, limited time, or a lack of comprehension are also at play in other disciplines of care, but they generally do not override ethical imperatives (Joseph-Williams, Elwyn, & Edwards, 2014; Legare, Ratte, Gravel, & Graham, 2008; Rost, Nast, Elger, & Shaw, 2020). Also, most patient-reported barriers to shared decision-making are modifiable in terms of their impact on patient involvement and can be addressed by attitudinal changes at the provider level (Joseph-Williams et al., 2014). Besides visceral factors, limited time in cases of emergencies was said to complicate shared decision-making. A review on engaging patients in healthcare decisions in the emergency department, however, concluded that there is no evidence to suggest shared decision-making is not feasible and emphasized the importance of decision aids as part of the decision-making process (Flynn et al., 2012). Thus, despite visceral factors and possible emergencies, the same bioethical principles as those applied in other settings can and must be met in birth. Initiatives addressing respectful maternity care are lacking and may be enhanced by education on how bioethical principles must be respected in clinical practice. Still, a few particularities, such as the fluidity of decisions, the interdependence of birthing people's and fetal health, the cognitive features of birthing consciousness, or the salience of gender (attributes) are distinguishing features of birth and, therefore, add further layers of complexity.

The hyper-pathologization of birth can be attributed to providers' view that, unlike other clinical situations, they are caring for two patients and that many situations require immediate action. The conceptualization of the fetus as a patient in its own right has been contested for decades, with proponents advocating for a patient status of late-term, viable fetuses, and opponents arguing that a personification of the fetus gives it a practical status that should be reserved for persons and that most of the times birthing people's and fetal interests are inextricably related anyway (Chervenak & McCullough, 1996; Duden, 1993; Kukla & Wayne, 2018). In cases of emergency, caring for two patients appears to make providers perceive a hyper-, that is twice as pathological situation.

Birthing people's and providers' perceptions were assessed to be systematically different and the former, in turn, to be interindividually different. Differences between birthing people's and midwives' perceptions of autonomy (mostly for information-giving and decision-making), privacy, and IC have been described before (Scott et al., 2003). What follows from different perceptions is a person-centered approach to decision-making including role-clarification, identification of the main focus for the decision, assessing preferences and needs, ensuring comprehension, and responding to all questions (Birth Place Lab, 2017; Vedam, 2019). A systematic discrepancy between providers and birthing people perceptions of risk, safety, and autonomy necessitates a continuous assessment of birthing people's perceptions, preferences, and needs through birth. Only by correctly identifying and, subsequently, prioritizing the latter, individually tailored and person-centered care can materialize.

5.2. Do ethics have to fade?

Decision-making was frequently subordinate(d) to medical imperatives. IC was not always recognized as a person's right. Instead, providers focused on informing and predicated the possibility of both shared and PC-DM on physiological situations. They sometimes described decision-making as a means to convince birthing people to agree to medically indicated actions. Decision-making has a direct role in promoting positive birth experiences. The World Health Organization states "most women want (...) to have a sense of personal achievement and control through involvement in decision-making, even when medical interventions are needed" (World Health Organization, 2018, p. 12). Evidence demonstrates that most people want to lead decision-making during care (Goldberg, 2009; Vedam, Stoll, McRae, et al., 2019). The ideal of PC-DM asks providers to prioritize a person's needs and preferences and to facilitate experiences of individualization and choice in every situation (Berwick, 2009; Vedam, Stoll, McRae, et al., 2019; Weiner, 2004), which means that decision-making is – primarily – shaped around each individual person. Furthermore, IC, in Switzerland and elsewhere, is both ethically and legally mandatory before an intervention is performed (Swiss Academy of Medical Sciences, 2008, 2019). Unnoteworthy, this includes birth (Büchler, 2017b; Glezer, 2018; Stohl, 2018). It is derived from the principle of respect for autonomy and closely linked to privacy and bodily integrity (Gefenas, 2012). While the amount of information needed for IC has been debated, actually giving consent and thereby authorizing providers undoubtedly represents an essential component and cannot be passed over (ACOG, 2021; Gefenas, 2012). The American College of Obstetricians and Gynecologists states: "pregnancy does not lessen or limit the requirement to obtain IC or to honor a pregnant woman's refusal of recommended treatment" (The American College of Obstetricians and Gynecologists, 2016, p. 7). Alternative concepts, such as simple or even implied consent for decisions of lower risk (McCullough, McGuire, & Whitney, 2007; Whitney, McGuire, & McCullough, 2004), must be critically examined in light of birthing people's frequent reports about non-consented interventions, pressure to consent, being inadequately informed, and insufficient time to decide (Bohren et al., 2015; Limmer et al., 2021; Niles et al., 2021; Oelhafen et al., 2021; Stoll, Wang, Niles, Wells, & Vedam, 2021), and in light of the associated risks of adverse psychological outcomes (Ayers, Bond, Bertullies, & Wijma, 2016; Dekel et al., 2017). These reports call for greater emphasis on adequate information, explicit consent, and sufficient time to avoid experiences of lacking control and agency.

Decision-making capacity was mistakenly equated, believed to be oftentimes limited, and reported not to be evaluated in a standardized way. In Switzerland as for many other healthcare settings, decision-making capacity is generally assumed to be present. It requires certain abilities (i.e. cognitive, evaluative, decisional, expressive), and its evaluation has to take into account birthing people's and providers' socio-cultural norms. Decision-making incapacity, in turn, cannot be ascribed merely on the basis of unexpected care decisions which can arise during labor and are "at odds with the recommendations and perspective of the person conducting the assessment", but can only be ascribed in cases of significantly impaired mental abilities (Swiss Academy of Medical Sciences, 2019, p. 8). In short, decision-making capacity requires a person to be able to make reasonable decisions, not to actually make reasonable decisions (Swiss Academy of Medical Sciences, 2019, 2020). Unfortunately, there lacks a mechanism for accountability in terms of supporting a person's ability and right to actually exercise their reproductive autonomy. Of course, during birth, decision-making capacity can be compromised (Büchler, 2017b; Swiss Academy of Medical Sciences, 2015). In these cases, a physician's ascription of incapacity has to be appropriately justified and documented (Büchler, 2017b; Swiss Academy of Medical Sciences, 2019). Moreover, diminished or absent decision-making capacity can only be ascribed in a situation- and time-specific manner and a key aspect of care is to promote autonomous decision-making by appropriate interventions, whenever possible (Swiss

Academy of Medical Sciences, 2019). Related to the questioning of birthing people's, particularly women's, decisional capacity, Lyerly has pointed out how structures of power are reinforced by shaming women through certain birthing practices, that is their experience of shame disempower them and seemingly legitimizes the oppression which elicited it (Lyerly, 2006). In conclusion, setting decision-making capacity requirements in birth too high or differently than in other fields can be seen as a form of paternalism and shaming – feeding into the patriarchal medical model that persistently sublimates birthing people and their right to self-determination.

Providers sometimes exhibited a narrow understanding of autonomy and neglected their role as facilitators of autonomy. While autonomy is a powerful principle in medical ethics (O'Neill, 2004; Steinbock, 2007), it has also been widely criticized for being too individualistic. Today, it is commonly 'practiced' as and wrongly conflated with formalized consent procedures where a paper is signed. In this way decision-making is a stagnant event – marked by a document that permits providers to actively manage care (Dove et al., 2017; O'Neill, 2004). Against this backdrop, feminist bioethics advocate for broadening the understanding of autonomy; for example, the inclusion of relational aspects or critical awareness of the oppressive social conditions and gender norms that erode agents' autonomy (Dove et al., 2017; Stoljar, 2018). At a minimum, autonomy encompasses two conditions – liberty (independence from undue interference) and agency (capacity for intentional action) (Beauchamp & Childress, 2009; Steinbock, 2007). For autonomy in healthcare, there are at least four interpretations: autonomy as (1) independence and freedom to make own choices (liberal view), (2) self-determined and rational choice (Kantian ideal of moral autonomy), (3) a person's life plan within its own historical and cultural context (narrative approach), (4) decisions as a result of communication with others (ethics of care) (van Thiel & van Delden, 2001). More specifically, reproductive autonomy has been defined as being able to determine how, where, and when to give birth (Purdy, 2006). These requirements are also core components of reproductive justice frameworks. Taken together, respect for autonomy requires more than involving persons or giving them a say in decisions. It mandates, amongst others, provision of unbiased information and recognition of own values, enabling persons to be the final decision-maker, full renunciation of coercion, considering relational aspects, and respecting unreasonable choices. Interviewed providers strongly supported autonomy in birth, but simultaneously approved several justifications for interference and externalized their responsibility. Such inconsistent provider perceptions of autonomy have also been reported in an Australian study (Kruske, Young, Jenkinson, & Catchlove, 2013) and a Swiss study found that the risk of informal coercion increased the higher a person's preference for autonomy (Oelhafen et al., 2021). Indeed, empirical evidence shows that bodily autonomy is of major relevance for birthing people and closely related to feelings of control and agency during birth (Yuill et al., 2020). However, the legal scholar Abrams rightly stresses that a fetal-focused shared decision-making framework (i.e. electing the outcome that minimizes any fetal risks) perpetuates an illusion of autonomy and concludes that "law standards should explicitly govern not just the 'what' of birth outcomes, but the 'how' of birth decision-making (...) to ensure that women's autonomy is actual and not illusory" (Abrams, 2017). The otherness of birth and resulting ethical fading likely lead to a lack of power and autonomy conferred to birthing people in decision-making.

5.3. How to approach decision-making in birth?

Providers' decision-making approaches were reported to be strongly determined by their physiology-pathology-assessment. If labor was deemed pathologic, full respect for autonomy was often labeled an impossibility and a potential source of harm. Accordingly, providers' decision-making approaches were dependent on the acuity of the situation, resulting in a decisional cascade from person-centered to shared to directive to coercive decision-making. However, proponents of person-

centered care argue that there should not be fluctuating degrees of person-centeredness (Berwick, 2009). The clinician Berwick defines person-centered care as “the experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care” (Berwick, 2009, p. 560). Rigorously applying such an understanding, meant that PC-DM should be maintained along the entire physiology-pathology-continuum: that is an absolute primacy of birthing people's needs and preferences (Vedam, Stoll, McRae, et al., 2019; Weiner, 2004).

The physiology-pathology-dichotomy also strongly determined providers' normative weighing of ethical principles. In pathological situations, both non-maleficence and a child's best interests outweighed birthing people's autonomy. Furthermore, a pathology was occasionally described as an eliciting factor, if not justification for (informal) coercion. These findings testify to beliefs that are not in line with legal and ethical requirements, given that it is not a possible pathology, but a lack of decision-making capacity that can justify overruling autonomy (Glezer, 2018). For Swiss providers it is legally impermissible to impose coercive measures on a patient with capacity, even in cases of an absolute indication for a cesarean section (Büchler, 2017a; 2017b). Similarly, it is widely considered ethically wrong to coerce birthing people, by major professional organizations, such as the Swiss Academy of Medical Sciences, the Nuffield Council on Bioethics, or the American College of Obstetricians and Gynecologists (Kotaska, 2017; Nuffield Council on Bioethics, 2006; Swiss Academy of Medical Sciences, 2015; The American College of Obstetricians and Gynecologists, 2016). Providers not only overlooked the ethical nub of the matter (i.e. only incapacity justifies overriding autonomy), but also there appeared to be no standardized evaluation or shared understanding of decision-making capacity. This leaves providers in an impotent position for handling difficult situations and at risk of legal challenge, and is likely to result in unequal treatment of equal situations. Here, the responsible provider is what often leads decision-making – as opposed to the individual circumstances of patients. Apart from the normative dimension of overruling autonomy, it is well known that coercive and autonomy-depriving decision-making causes adverse psychological outcomes (Ayers et al., 2016; Dekel et al., 2017) and can lead to ongoing mistrust of medical providers (Glezer, 2018; Niles et al., 2021). Finally, providers' belief that birthing people's needs can be overridden for fetal safety has been reported elsewhere and must be examined taking into account providers' legal accountability, or their understanding thereof, and the practice of defensive medicine (Glezer, 2018; Kruske et al., 2013).

In the 1990s, the anthropologist Brigitte Jordan elaborated the concept of authoritative knowledge, which designates a knowledge system that, despite the existence of equally legitimate, parallel knowledge systems, “by consensus, come[s] to carry more weight than others, either because [it] explain[s] the state of the world better for the purposes at hand (‘efficacy’) or because [it is] associated with a stronger power base (‘structural superiority’), and usually both” (Jordan, 1992, p. 3; Jordan, 1997). It does not refer to correctness, but to the fact that the authoritative knowledge “counts”, to its status within a “particular social group and to the work it does in maintaining the groups' definition of morality and rationality” (Jordan, 1992, p. 4). Studying intrapartum care, Jordan described the co-existence of two alternative claims to relevant knowledge (i.e. birthing people's and providers') and a hierarchical distribution of knowledge in such a high-technological setting (i.e. obstetrician's knowledge is communicated downward along a hierarchy of which the birthing person is most distal), which ultimately devalued birthing people's ways of knowing and deprived them of the opportunity to make informed choices (Jordan, 1992). While certainly decision-making in birth today has moved close(r) to respect and person-centeredness, and away from authoritative knowledge and paternalistic attitudes, there is still some way to go until the full actualization of autonomy and PC-DM. Birthing people's and providers' systems of knowledge are not yet on an

equal footing, medical ways of knowing regularly obscure birthing people's knowledge and autonomy. Recognizing multiple co-existing and equally legitimate ways of knowing regarding birth can be a starting point to overcome a widely implied legalistic, paternalistic, and formal model of decision-making where providers may approach birthing people as potential adversaries (and not allies) incapable of actively leading their own care as they navigate their autonomy in birth (Holm, 2012).

5.4. Limitations

Self-selection-bias resulting in interviews with providers who hold strong attitudes towards the topic could have skewed our results. Still, this would render our results even more significant and does not invalidate them, because then attitudes towards autonomy and PC-DM among the interviewed sample can be assumed to be more positive than among Swiss providers in general. Moreover, we only interviewed providers from the German-speaking part of Switzerland. Providers from other major language regions could have expressed different attitudes and perceptions.

6. Conclusions

Decision-making in birth is crucial for birthing people's sense of control and characterized by bioethical complexity. The aim of our study was to enhance decision-making by elucidating how providers understand principles and concepts surrounding decision-making in birth, particularly focusing on attitudinal determinants of strained and unsatisfactory decision-making. We acknowledge that a plethora of structural determinants exist, which impact how care is delivered, but which lay beyond the control of providers. Nevertheless, our study reveals important insights into how autonomy-depriving decision-making and ineffective communication can unfold as a result of providers' perceptions and attitudes and despite best intentions.

Implementing antenatal care contacts as a standard for every birthing person stretches the decision-making process, which ultimately allows to address needs and preferences earlier, to explore their reasoning, and to avoid uncertainty and misunderstandings during birth. Decision aids or courses on PC-DM can further facilitate decision-making (Flynn et al., 2012; Vedam, 2019; Yahanda & Mozersky, 2020). Moreover, given its ethical importance, providers should become more knowledgeable about evaluation, ascription, and normative implications of decision-making capacity as well as about the role of pathologies in this context. Overall, bioethical principles and the otherness of birth appear to be reconcilable, but this requires – at least in some regards – a purposeful redesign of perinatal care practices (e.g. antenatal care contacts as a default, implementation of decision aids, active and iterative application of IC in care, standardized evaluation of capacity), and improved knowledge of the ethical and legal basis of decision-making in birth (e.g. autonomy trumps non-maleficence, fetus de jure no person) (Kotaska, 2017). Nonetheless, our findings raise the question whether existing ethical frameworks for decision-making in birth need to be refined and supplemented by currently rarely or non-considered principles to do full justice to birthing people (e.g. shifting the focus from autonomy to respect, less emphasis on maternal-fetal-conflict) (De Vries, 2017).

7. Individual contributions

Michael Rost and Louisa Arnold conceptualized the study. Michael Rost and Zelda Stuermer developed the idea for this paper and contributed equally to the drafting of the manuscript. Michael Rost carried out data collection and Zelda Stuermer carried out data management. Michael Rost and Zelda Stuermer carried out the qualitative analysis. Paulomi Niles and Louisa Arnold provided substantial contributions to the interpretation of results and application of the theoretical background. All authors critically revised the manuscript for content and interpretation of the data and approved the final version of the manuscript for submission.

Data availability statement

Since participants have not provided consent to share their data, study materials cannot be made openly available. However, we will share portions of the study material relevant for the manuscript upon reasonable request. Please contact the corresponding author.

Ethical statement

Study documents were reviewed by the responsible ethics committee (Ethikkommission Nordwest-und Zentralschweiz; EKNZ). Since providers were interviewed, the EKNZ stated that the project does not fall under the remit of the Swiss Human Research Act (Art. 2). Thus, no ethical approval was needed. Still, the EKNZ issued a declaration of no objection (Req-2019-00017) stating that the project fulfills the general ethical and scientific standards for research with humans (Art. 51).

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Declaration of interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

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