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Labouring Together: Women's experiences of "Getting the care that I want and need" in maternity care

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Labouring Together: Women's Experiences of "Getting the Care that I Want and Need" in Maternity Care.

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Keywords:	collaboration; shared decision-making; decisional-control; Mixed Methods; maternity care

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	Maryann Street, PhD
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Abstract:	Objective Poor interprofessional collaboration and lack of decision-making with women have been identified as being detrimental to the quality, safety, and experience of maternity care. The aim of the Labouring Together study was to explore childbearing women's preferences for and experiences of collaboration and control over decision-making in maternity care. Design A sequential, mixed-method, multi-site case study approach was used to explore the perceptions and experiences of childbearing women regarding collaboration and decision-making. Women's preferred role for decision-making compared to the actual experiences, and the influences upon their preferences and experiences of collaboration were explored using semi-structured interviews. An inductive approach was used for qualitative analysis of interviews, and cross-case analyses were conducted using replication logic. Setting Postnatal wards of 1private and 3 public maternity services in both metropolitan and regional Victoria, Australia. Participants Postnatal women, over the age of 18 years (n=182) Findings Half (48.3%) of the participants indicated a preference for a shared decision-making role and 35% preferred an active role. Only 16.7% participants indicated a preference for a passive role, however 24.4% of women reported experiencing a passive decision-making role during their maternity care. Statistically significant differences were also identified between preferences for and experiences of decision-making among women who chose the private obstetrician model of maternity care compared to the public maternity care system. Negative impacts upon women's autonomy over decision-making included: poor access to midwifery models of care; poor access to relational continuity of care; poor understanding of the rights of the woman; inadequate

	information for women about the risks and benefits of all proposed interventions; and a bureaucratic style of decision-making based upon a dominant discourse of risk avoidance that could ultimately veto the woman's choice. Key conclusions Despite evidence of the benefits for women of having autonomy over decision-making in their own care, fundamental barriers were identified that hindered women's participation in collaboration in maternity care. Shared decision-making with childbearing women is not routine practice in maternity care in Victoria, Australia. Implications for practice Relational continuity of care is imperative to promote the autonomy of childbearing women and an environment conducive to women's active engagement in maternity care and participation in shared decision-making.

Detailed response to reviewers

Reviewer 1 comments	Response
Reviewer 1: This is a very well written piece of work and my only suggestions are to add the following into the introduction (page 3 onwards) and discussion section	Thank you for the generous suggestion of other research on shared decision-making in maternity care for inclusion to strengthen this manuscript. I have reviewed the papers, and incorporated them into both the introduction (pages 3-4), and the discussion (page 16)

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Page 10, under 'women's decision-making role by case and socio-demographic characteristic', please delete ATSI in the first para. Its not used again and can be offensive to some Aboriginal and Torres Strait Islander people.	Thank you for pointing this out. I have modified the wording accordingly.
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Tables 6 and 7 - for the benefit of an international audience, could you either spell out TAFE or have what it stands for in the legend? Could you do the same with 'TSI'? With the four ethnic groups, why were these listed and not others? What does 'Anglo' comprise (Caucasian or European origin? What about Australians - were they in this group?). A small explanation would be helpful.	Thank you for identifying this oversight. I have amended the tables 4, 5, 6 and 7 to ensure that all labels are defined without the use of acronyms. 'Anglo' in this context is defined as identifying with the ethnicity of high-income English-speaking countries (including Australia, New Zealand, United Kingdom, Ireland, and United States of America). This An explanation of the definition has been added to the notes of tables 6 and 7. A note had been made in the limitations section to highlight this potential limitation of the study.
Congratulations on a very interesting, illuminating paper!	Thank you for your kind feedback- it is much appreciated.

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Dr Debra Bick
Editor-in-chief
Midwifery
20th April 2022

Manuscript title: Labouring Together: Women's Experiences of "Getting the Care that I Want and Need" in Maternity Care

Dear Dr Bick,

On behalf of my co-authors, I wish to resubmit an original research article entitled Labouring Together: Women's Experiences of "Getting the Care that I Want and Need" in Maternity Care for consideration by *Midwifery* journal. The Labouring Together study was a mixed methods study designed to explore interprofessional collaboration and decision-making in maternity care in Victoria, Australia using a multi-site case study approach. A combination of cross-sectional surveys and in-depth interviews afforded in-depth analysis of factors associated with collaboration and shared decision-making from the perspectives of childbearing women, midwives, and doctors, and incorporating a range of models of maternity care in both public and private maternity care.

The findings from the perspectives of the women participants are reported in this manuscript make a significant contribution to the evidence base. Individual, micro, meso and macro-level factors that impact upon the woman's choices for and experience of decisional-control, shared decision-making, decisional regret in both public and private maternity care settings are reported. I confirm that this work is original research and formed part of my PhD thesis. These findings have not been published elsewhere, nor are they under consideration. There are no conflicts of interest to disclose.

The feedback received from both reviewers was very constructive and helpful and has helped to strengthen the manuscript. I have tabulated the feedback and responses below.

Thank you for your consideration of this manuscript.

Yours faithfully,

Dr Vanessa Watkins PhD, RN, RM

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Congratulations on a very interesting, illuminating paper!	Thank you for your kind feedback- it is much appreciated.

Title: Labouring Together: Women's Experiences of "Getting the Care that I Want and Need" in Maternity Care.

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Conflict of Interest: None declared

Ethical Approval: Deakin University HREC (2014-238)

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Highlights:

- Most women prefer an active or shared role with decision-making in maternity care
- Women choose private obstetric maternity care to ensure relational continuity
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Abstract

Objective: Poor interprofessional collaboration and lack of decision-making with women have been identified as being detrimental to the quality, safety, and experience of maternity care. The aim of the Labouring Together study was to explore childbearing women's preferences for and experiences of collaboration and control over decision-making in maternity care.

Design: A sequential, mixed-method, multi-site case study approach was used to explore the perceptions and experiences of childbearing women regarding collaboration and decision-making. Women's preferred role for decision-making compared to the actual experiences, and the influences upon their preferences and experiences of collaboration were explored using semi-structured interviews. An inductive approach was used for qualitative analysis of interviews, and cross-case analyses were conducted using replication logic.

Setting: Postnatal wards of 1 private and 3 public maternity services in both metropolitan and regional Victoria, Australia.

Participants: Postnatal women, over the age of 18 years (n=182)

Findings: Half (48.3%) of the participants indicated a preference for a shared decision-making role and 35% preferred an active role. Only 16.7% participants indicated a preference for a passive role, however 24.4% of women reported experiencing a passive decision-making role during their maternity care. Statistically significant differences were also identified between preferences for and experiences of decision-making among women who chose the private obstetrician model of maternity care compared to the public maternity

care system. Negative impacts upon women's autonomy over decision-making included: poor access to midwifery models of care; poor access to relational continuity of care; poor understanding of the rights of the woman; inadequate information for women about the risks and benefits of all proposed interventions; and a bureaucratic style of decision-making based upon a dominant discourse of risk avoidance that could ultimately veto the woman's choice.

Key conclusions: Despite evidence of the benefits for women of having autonomy over decision-making in their own care, fundamental barriers were identified that hindered women's participation in collaboration in maternity care. Shared decision-making with childbearing women is not routine practice in maternity care in Victoria, Australia.

Implications for practice: Relational continuity of care is imperative to promote the autonomy of childbearing women and an environment conducive to women's active engagement in maternity care and participation in shared decision-making.

Introduction

Research into interprofessional collaboration has emphasised the importance of a supportive interprofessional culture, based upon mutual trust and respect (Downe, Finlayson, & Fleming, 2010; Heatley & Kruske, 2011; Smith, 2015); professional autonomy, accountability, and clear and respected professional boundaries (Downe et al., 2010; Smith, 2015; Suter et al., 2009); and expectations for communication, shared rules and goals of maternity care (Downe et al., 2010; Heatley & Kruske, 2011; Mulvale, Embrett, & Razavi, 2016; Smith, 2015). Nevertheless, the role of the woman in collaborative decision-making over her maternity care remains unclear. Governance, policy and professional-level guidance for collaboration in Australian maternity care all reference the concepts of partnering with consumers, shared decision-making and the philosophy of woman-centred care (ACM, 2014; ACSQHC, 2017, pp. 14-19; DOH, 2019a; NHMRC, 1999, 2010; NMBA, 2018a, 2018b). However, the focus of collaboration is on "how health professionals interact with each other" (Heatley & Kruske, 2011, p. 54), neglecting the inclusion of the woman in collaborative decision-making.

A review of the literature revealed a lack of understanding of both interprofessional collaboration and shared decision-making in clinical practice at many levels of maternity service provision. Aligned concepts of information sharing, communication, coordination, teamwork, autonomy, and authority have been used interchangeably with the term *collaboration* (Downe et al., 2010). Similarly, the term *shared decision-making* (SDM) is often mistakenly applied to the concept of *informed consent* (Kunneman & Montori, 2017). The term *informed consent* refers to a legal standard in which health care professionals discuss the potential risks and benefits of, and alternatives to, a recommended medical treatment or procedure. It has been suggested that within informed consent, the role of the patient (woman) is to either accept or decline the choices offered, often late in the decision-making process (Kunneman & Montori, 2017). In contrast, adoption of a SDM approach promotes the autonomy of the consumer as an individual person, as all options, choices and decisions are viewed in the light of the best available evidence (Elwyn et al., 2017; Legare et al., 2013; McKinnon, 2014).

A recent scoping review of SDM in perinatal care suggested that although SDM has potential to decrease decisional conflict there was paucity of research in this area, and the included studies were not specific in their definitions of SDM (Megregian, Emeis, & Nieuwenhuijze, 2020). Following a Delphi study of experts in maternity care, SDM was conceptualised as a complex, dynamic process that transverses the continuum of maternity care. Essential to

SDM is the facility (i.e., the opportunity, time and space) for women to discuss their values, desires and choices over childbirth (Nieuwenhuijze, Korstjens, de Jonge, de Vries, & Lagro-Janssen, 2014). The experts agreed that opportunities for women to build relationships with professionals during pregnancy increased the potential to anticipate situations and revisit complex decisions. Open and respectful communication between the clinician and the woman, and the information shared to be accurate, evidence-based and understandable to the woman were identified as essential elements of SDM in maternity care (Nieuwenhuijze, Korstjens, et al., 2014).

Several factors have been identified that may challenge a woman's ability to engage in decision-making activities for her maternity care. These include: lack of time, resources, familiarity with and access to their preferred model of maternity care (IOM, 2015; Légaré & Witteman, 2013; Pearson, 2011); health policy and/or health funding models (Légaré & Witteman, 2013; Noseworthy, Phibbs, & Benn, 2013); cultural or language barriers, and/or limited health literacy (IOM, 2015; Légaré & Witteman, 2013); and poverty (Noseworthy et al., 2013). Women also fear that they may be perceived as difficult, with the associated negative consequences upon the quality of the maternity care they may receive (Légaré et al., 2010). Barriers to participation in decision-making have been associated with women's experiences of compromise to her decisional-autonomy, amplification of perceptions of loss of control, and negative impacts upon perinatal mental health (Fenwick, Toohill, Creedy, Smith, & Gamble, 2015; Nieuwenhuijze, Low, Korstjens, & Lagro-Janssen, 2014; Noseworthy et al., 2013).

A combination of interprofessional collaboration with SDM has been suggested as logical pairing to understand how clinical decisions are made in a multi-disciplinary context; to integrate both key elements into clinical practice; and to address the power imbalance in the doctor–patient relationship (Daemers, van Limbeek, Wijnen, Nieuwenhuijze, & de Vries, 2017; Joseph-Williams, Elwyn, & Edwards, 2014; Légaré & Witteman, 2013). However, to date, this linkage has not been explored in the context of maternity care provision in Australia. Furthermore, women's preferences for autonomy over decision-making in maternity care remain unclear.

Research pertaining to new mothers in Australia revealed that well organised care, with continuity and consistent information is important, particularly in the antenatal period (Ford, Hindmarsh, Browne, & Todd, 2015; Jenkins, Ford, Morris, & Roberts, 2014; Todd, Ampt, & Roberts, 2017). However, it is argued that continuity of management or information inadequately compensates for the lack of an ongoing therapeutic relationship with a known

caregiver (Burge et al., 2011; Sandall, Soltani, Gates, Shennan, & Devane, 2016), as decision-making within the midwifery continuity model of care relies upon “social networks, the relationship with the midwife and the unfolding birth event” (Noseworthy et al., 2013, p. e47).

Continuous and personalised care provided by a known midwife has been associated with active involvement in decision-making (Allen et al., 2019), and the highest level of satisfaction with maternity care (Allen et al., 2019; Macpherson, Roqué-Sánchez, Legget, Fuertes, & Segarra, 2016). Studies have revealed relational continuity of midwifery care as beneficial to the psychological and physiological recovery of the woman “often surpassing clinical action ... and/or physiological determinants” (Macpherson et al., 2016, p. 68), with midwives observed by women to go “above and beyond” to support women to be empowered, nurtured and safe during pregnancy, labour and birth (Allen, Kildea, Hartz, Tracy, & Tracy, 2017, pp. 151-153).

Relational continuity of midwifery care was found to be particularly advantageous for women from ethnically diverse, vulnerable, or socially disadvantaged backgrounds through the benefits of midwifery advocacy and the midwifery role of risk-negotiation (Dove & Muir-Cochrane, 2014; Ebert, Bellchambers, Ferguson, & Browne, 2014), as these women often feel as “outsiders’ (Ebert et al., 2014, p. 137) within the wider healthcare system. The close relationship between vulnerable women and midwives has been shown to enable discussion of concerns, and feelings of safety (Beake, Acosta, Cooke, & McCourt, 2013). Themes of “knowing and being known”, “gaining trust and confidence” and “communication” have been identified as particularly important to vulnerable women (Beake et al., 2013, pp. 996-1002), and often choose to delegate the responsibility for negotiation of and advocacy for their maternity care choices to their trusted midwives.

In interviews conducted with childbearing women, midwives and doctors, participants identified clinicians’ lack of understanding of women’s autonomy; and decision-making and the law pin pointed as particular barriers to shared decision-making (SDM) (Jenkinson, Kruske, & Kildea, 2017), associated with historical medical dominance and the patriarchal institution of motherhood (Jenkinson et al., 2017; Kruske, Young, Jenkinson, & Catchlove, 2013). Ongoing discussions of risk has been perceived by both midwives and women as pressure to consent to recommended care by doctors (Jenkinson et al., 2017; Jenkinson et al., 2016), and midwives have reported using their trusted relationship with women to encourage continued engagement with healthcare services, particularly when the women in their care make choices that are not aligned with organisational guidelines and policies

(Thompson, 2013). A structured process to document refusal of recommended maternity care was identified as potentially helpful to support both midwives and doctors to feel protected and reassured, whilst maintaining the woman's engagement and therefore access to hospital maternity care (Jenkinson et al., 2015, 2016; Jomeen, Jefford, & Martin). However, in many hospital settings, governance and policy guidelines fall short of providing implementation frameworks for the operationalisation and integration of these concepts into clinical practice (ACSQHC, 2017; DOH, 2019b).

The Labouring Together study was conducted to explore these issues further. Study aims were to investigate: (a) perceptions of collaborative maternity care held by maternity care professionals and women from a variety of maternity care models available in Victoria, Australia; (b) how the essential elements hypothesised to influence the effectiveness of collaborative alliances are reflected in perceptions of collaboration in maternity care in Victoria; and (c) childbearing women's' preferences for and experiences of collaboration and control over decision-making in maternity care (Watkins, Nagle, Kent, & Hutchinson, 2017). The findings from the data pertaining to the women participants of the Labouring Together study will be presented in this paper.

Methods

The Labouring Together study utilised a sequential, mixed methods, multi-site case study approach employing cross-sectional surveys and interviews. The full study protocol has been published elsewhere (Watkins et al., 2017).

Selection of case studies

Four hospitals in Victoria, Australia, were purposively selected as cases to represent a range of models of maternity care available in both metropolitan and regional Victorian hospitals. The attributes of the models of maternity care offered in the selected cases are presented in Table 1.

Contextual characteristics of case studies

Contextual characteristics were sought to describe each case to provide context for other data collected during the Labouring Together study. Contextual characteristics included the models of maternity care available, demographic characteristics of the women participants, and selected clinical outcomes related directly to decision-making in the provision of maternity care. The outcome data are reported in the Victorian Department of Health Victorian Perinatal Services Performance Indicators (PSPI) annual report "as key areas for

monitoring the quality of care provided to mothers and babies" (Hunt, 2016, p. 2), and are in the public domain. Performance and outcome indicators included the rates of outcomes for standard primiparae (Hunt, 2016), vaginal birth after primary caesarean section (VBAC), and breastfeeding in hospital (Table 2).

Study Participants and Recruitment

A convenience sample of postnatal women was recruited from each case to participate in the cross-sectional survey and/or an in-depth interview, aiming for a minimum of 30 participants from each case. At the discretion of the midwife in charge (to minimise intrusion or potential distress to families who may have experienced perinatal trauma or loss), all eligible women were invited to participate in the study during their stay on the postnatal ward at each case study hospital. Data collection continued until childbearing women who had accessed maternity care from the range of maternity models identified in the study had been sampled and data saturation has been reached.

Cross sectional survey

Postnatal women were invited to participate in a cross-sectional survey to investigate their preferences for and experiences of decision-making during maternity care, using the Control Preferences Scale (CPS) (Degner, Sloan, & Venkatesh, 1997). The CPS is a 5-point scale to represent the degree of control the woman wished to relinquish (i.e. passive), retain (i.e. active), or share (i.e. collaborative) over treatment decision-making (Degner, Sloan, et al., 1997). Women were asked to rate their preferences for decisional control during their maternity care, and then again to rate their actual experiences of decisional control during their maternity care. This method provided an index of how childbearing women believed their maternity care accommodated their preference for decisional control. To minimise intrusion upon participants, the CPS was administered in a paper-based survey to women on the postnatal ward using a fixed scale format rather than individual cards.

For data analysis, CPS preferences were categorized as active, shared, or passive. If data were partially complete, the preference selected first was accepted using the "pick one" (Degner, Sloan, et al., 1997, p. 35) approach. These methods have been successfully validated by researchers (Degner, Sloan, et al., 1997), and have been utilised in several published studies (Degner, Kristjanson, et al., 1997; O'Donnell & Hunskaar, 2007; O' Donnell, Monz, & Hunskaar, 2007; Singh et al., 2010).

Semi structured interviews

Telephone interviews were conducted with women following postnatal discharge from hospital to explore their perceptions and experiences of collaboration and decision-making over the course of their maternity care. An interview guide underpinned by the Comprehensive Theory of Collaboration (Gray & Wood, 1991; Wood & Gray, 1991) and incorporating the SURE test to screen for decisional conflict, was used to guide the interviews (Table 3). The SURE test is a 4-item screening test for decisional-conflict in patients and is designed for use by clinicians to assess patient satisfaction with decision-making, and to identify patients with clinically significant decisional-conflict (Légaré et al., 2010; Légaré & Witteman, 2013). Interviews were audio-recorded, transcribed verbatim, then coded and analysed using an inductive thematic analysis approach (Braun & Clarke, 2006). The initial emergent codes, themes, sub-themes, and features of the sub-themes were then compared by the research team, and any overlapping and/or similar categories were refined and synthesised to develop the final conceptual framework.

Ethical considerations

Consent was implied by submission of the survey, which included a Plain Language Statement on the front page. Survey participants were invited to enter their contact details at the end of the survey form if they were interested in participating in a telephone interview. A written Plain Language Statement and Consent Form was also e-mailed to all potential interview participants. Verbal consent was obtained prior to participation in interviews, which was audio-recorded and transcribed as part of the interview record. Ethics approval was granted by the Human Research Ethics Committees of individual health services and endorsed by the university.

Results

Contextual characteristics of cases

Descriptive data were used to describe and compare the contextual characteristics of the four cases, including birthing numbers, metropolitan and regional geographical location, type of funding of the hospital, and the models of maternity available, and these details are presented in Table 4. Cases 1, 2 and 3 were public hospitals, whereas Case 4 was a private hospital.

Cross-Case Analysis of Perinatal Performance Indicators

Cross-case analysis was conducted on selected Victorian State-wide Perinatal Service Performance Indicators (PSPI) that directly relate to decision-making in maternity care: planned vaginal birth after caesarean (planned VBAC); successful vaginal birth after caesarean (successful VBAC); initiation of breast feeding; and breast fed before discharge. The data for selected PSPI were plotted onto radar charts for visual comparison between cases. Across the four cases, results were generally similar for indicators where higher rates are preferable (Figure 1). For indicators where lower rates are preferable, results were closely aligned in the public maternity services (Cases 1, 2 and 3). In contrast, the private maternity service (Case 4) had far higher rates for all three indicators. (Figure 2).

Socio-demographic characteristics of participants

A total of 182 women participated in the Labouring Together study, by either completion of a survey or an interview, or by participation in both data collection methods. The socio-demographic characteristics of the participants from each case were tabulated for cross-case comparison (Table 5).

Women's Preferred Decision-Making Role

Of the 180 women who responded to the survey, 98% (n=176) of women chose to share information on their preferences and experiences, whereas 2% (n=4) of women preferred to shared information on their preferences only. Overall, 48.3% (n=86) of women indicated they preferred a shared role in decision-making, while 35% (n=65) specified a preference for an active role and 16.7% (n=29) of women preferred a passive role. There were differences in women's decisional-control preferences between Cases; a higher proportion of women from Case 3 indicated a preference for an active role for decision-making compared to a shared role (39.5% compared to 38.2%); whereas a higher proportion of women from Case 4 specified a preference for a passive role in decision-making over their maternity care than an active role (29.0% compared to 23.3%) (Figure 3).

Women's Actual Decision-Making Role

Of the 176 women who chose to share information on their experiences of their decision-making role during their maternity care, the highest proportion of women (49.4%, n=87) indicated that they experienced a shared role in decision-making. Between individual Cases, a higher proportion of women from Case 3 indicated a passive decisional-control experience compared to a shared or active role (38.1% compared to 35.7% and 26.2% respectively; whereas fewer women from Case 4 indicated a passive decisional control experience than

Cases 1, 2 and 3 (10% compared to 24.6%, 20.9% and 38.1% respectively). A higher proportion of women from Cases 1 and 4 indicated an active experience compared to a passive experience, whereas fewer women from Cases 2 and 3 indicated an active experience to a passive experience (Figure 4).

Concordance between preferred and actual role for decision-making

At Cases 1, 2 and 3, more women experienced a passive role than desired. In contrast, for Case 4 a higher proportion of women experienced more decisional control than preferred (Figure 5). A Chi-square test of independence examined the relationship between the women's preferred and actual roles for decision-making. Compared to the proportion of women who indicated a preference for an active decision-making role, statistically significantly (χ^2 (df=4, N = 176) = 32.239, p <0.001) fewer women experienced an active decision-making role.

Paired data for the preferences and experiences of each individual woman participant (n=174) revealed variation for the rates of concordance between cases. More women from Cases 1, 2 and 3 reported concordance than discordance between their preferred and actual decision-making role (50.8%-69.7%), whereas women from Case 4 reported a much lower rate of concordance between their preferred role and actual experience (23.3%) compared with the other three cases (Figure 6). Most women who experienced discordance between their preferred and actual role for decision-making (n=81), indicated movement to the next level on the decisional-control scale (i.e. shift from an active preference to a shared experience; a shared preference to an active or passive experience; or a shared preference to a passive experience) (n= 71, 87.7%). Only 12.3% (n=10) of women indicated extreme discordance between their preferred role and actual experience.

Women's decision-making role by maternity care funding status.

Comparing private maternity care (Case 4) and public maternity care (Cases 1, 2 and 3), broadly equal proportions preferred a shared role in decision-making. Of those that preferred a passive role, the greater proportion were the private group and of those that preferred active participation, the great proportion were the public group (Figure 6).

As both active and shared roles require some degree of active participation in the decision-making process, the results for an active or shared preferred role were pooled for comparison to the passive preferred role results. Chi-square analyses indicated a statistically significant difference between private and public maternity care funded groups and the

distribution of both the preferred role for decisional control (X^2 (*df*=1, N = 180) = 4.123, p = 0.042) and the actual role experienced (X^2 (*df*=1, N = 176) = 4.080, p = 0.043). Furthermore, women with privately funded maternity care were less likely to experience the level of decision control they preferred, compared to women with publicly funded maternity care (23.3% vs 60.3%) and this was also statistically significant (X^2 (*df*=1, N = 176) = 13.671, *p* <0 .001).

Women's Decision-Making Role by Case and Socio-Demographic Characteristic

Cross-case analysis was performed to explore the relationships between the socio-demographic variables (age, prior experience of maternity care, level of education, ethnicity), and the role preferences and actual experiences of women participants. No significant relationship was identified between the decisional control preferences of woman participants and their previous experience of maternity care, or demographic characteristics, with the exception of ethnicity (Table 6). At Case 3, five women who identified their ethnicity as Aboriginal and/or Torres Strait Islander indicated a preference for a passive role in decision making, which was statistically significant (p<0.001). However, this result should be interpreted with caution due to the small number of participants who identified as Aboriginal and/or Torres Strait Islander in this study, all of whom were under the age of 25 years and experiencing maternity care for the first time.

There was no statistically significant association between the socio-demographic characteristics and the decision-making role the women experienced (Table 7). Fewer women participants from Case 4 experienced a passive role than women from Cases 1, 2 or 3; independent from the influence of the socio-demographic variables. Although not statistically significant, this inference may have clinical significance.

Semi-structured interviews

Findings from the semi structured interviews were synthesised to develop a conceptual framework, comprising two major themes: Organisation of care and Woman-centred care. Women's reports of their experiences of using the maternity service for their maternity care aligned with the theme *Organisation of care: Using the service*. This theme is comprised of two subthemes: Systems: A well-oiled wheel or a broken cog; and Culture: Different ways of working. Women's references to their experiences of maternity care to meet the unique needs of themselves and their family in the transition to parenthood aligned with the theme *Woman-centred care: Meeting my unique needs.* Four subthemes are reflected in this theme: Continuity: Trusted care provider or new face every time; Autonomy: Getting the care

that I want; Communication: Laying all the cards on the table; and Decision-making: Making the decisions myself (Figure 7).

Organisation of Care: Using the Service

Systems: a well-oiled wheel or a broken cog

The information provided to women about the choice and availability of different maternity models of care in the public system were identified as *"confusing and a minefield to … understand" (Case 2, Woman 1).* While most women indicated that the choice of model of maternity care was important to them, almost half of the women interviewed from public maternity care (47%) felt they were not able to access their preferred model of maternity care. This was due to high demand for midwifery-led care; confusion about the features of different models of maternity care available; or pre-existing obstetric complications: *"I would have loved the [continuity of midwifery-led care] program...But I was told that I couldn't because I was high risk...and so they were like, your only real option is GP shared care" (Case 2, Woman 4).*

In contrast, women from Case 4 identified a smooth navigation of the health care system. Several women indicated that the longer postnatal stay in hospital, and *"knowing that I wasn't going to be kicked out of the hospital after a couple of days and that I could have my five days" (Case 4, Woman 1)* was an attractive feature of the private obstetric model of care compared to the public maternity system.

Culture: Different ways of working

Some women reported resistance if they requested an option that was not part of standard care, and a perceived unwillingness from clinicians to individualise a plan of care or even discuss the safety of alternative options during pregnancy and birth: *"… you can be pushed around a lot, and you … get very subjected to people's beliefs. If you pull out your birth plan you inevitably get the 'things don't always go to plan', and their eyes roll back. And I think that is a really unhelpful way to go". (Case 3, Woman 1).*

Women called for flexibility to be built into the maternity care system to enable choice in maternity care provider with whom women could relate, or to procure a second opinion should the woman's choices deviate from standard care: *"… I could talk to some of them about stuff I couldn't say to others ... Like they are trustworthy, and I can talk to them without them judging me. (Case 2: Woman 5).* However, feelings of marginalisation and exclusion

from information-sharing with clinicians were expressed. One woman perceived *"a couple of dips in confidence*" in her private obstetrician, whom she perceived required *"prompting" (Case 4, Woman 7)* to offer the full range of maternity care options available. Another woman described feeling a lack of respect for her knowledge during her second experience of a complex pregnancy, and perceived the doctors' attempts to assuage her concerns as inappropriate: *"… they just want to make me feel like everything is all OK, and 'don't worry' … I am not worried. I just want this followed up" (Case 1, Woman 2).*

Woman-centred care: Meeting my unique needs

Continuity: Trusted care provider or a new face every time

Few women who were cared for in a publicly funded hospital experienced relational continuity in any part of their maternity care: *The midwives were all great, but it was always a different face each time, so no real relationship built up (Case 1, Woman 6).* One woman reported experiencing challenges with not being able to build a trusted relationship to enable discussion of her choices: *"… I saw three different midwives … and I spoke to all of them about it, but … I sort of felt a bit dismissed (Case 2, Woman 2).* Clinicians were also perceived as *"always so rushed for time and overbooked" (Case 1, Woman 1)*, which impeded the opportunity for questions or individualised care planning.

Despite the lack of relational continuity in the public maternity care system, most women reported that they felt comfortable to talk to the clinicians about their concerns. One woman expressed the belief that the midwives had *"a sense of how that mother is doing, or how that mother is feeling"* and possessed the emotional intelligence and interpersonal skills that enabled *"building that rapport quickly but in a genuine and nurturing way" (Case 1, Woman 10).* Another woman revealed that meeting with a senior obstetrician at the end of pregnancy enabled support for her choice for a vaginal breech birth, as she had opportunity to discuss all *"my questions and queries … I was lucky that I got him because he was so high up and he knew all the answers" (Case 1, Woman 5)*

Conversely, relational continuity was the primary reason for choice of the private obstetrician model of care identified by the women at Case 4 *"because I just think it is a very important thing that you are doing, and to have that one-on-one" (Case 4, Woman 8).* The women revealed they had *"carefully selected our obstetrician as he was the best in the business" (Case 4, Woman 3)*, as the facilitation of trust in the obstetrician could ensure a smooth navigation through the maternity care system. However, most women from Case 4 experienced little continuity of midwifery carer during the postnatal phase of care. One

woman conveyed her experience of meeting *"three midwives a day … so maybe there was 15 or 16 individuals"* which she described as a confusing and disjointed transition to motherhood: *"... I wouldn't have said that there was a lot of consistency at all" (Case 4, Woman 7).*

Autonomy: Getting the care that I want

Most women preferred an active or shared role in decision-making, particularly from Cases 1, 2 and 3. At interview, many explained that they also wanted to have control over the final decisions for their maternity care: *"I was very much wanting no interference in my pregnancy. I didn't want to be poked, prodded and blood tested to death" (Case 1, Woman 4).* However, some women identified a passive experience of decision-making, due to an obstetric emergency, complex medical needs, and/or mental health disorders. A woman who experienced a pre-term emergency caesarean section stated that she was not able to participate in the decision for surgical birth: *"I had an appointment with my GP just to have a regular check-up ... at 10.15am and my son was born at 11.15am the same day ... I understand … that they acted upon the best interest of my son ... But I did not have a voice in that decision-making process" (Case 2, Woman 4).*

In contrast, many women from Case 4 stated that they deliberately chose to adopt a passive role in decision-making so *"… not have to think about anything" (Case 4, Woman 6).* One woman explained that she felt reassured by the financial arrangement between the obstetrician and herself as *"we were happy to pay for his expertise, so we did not need to worry or to second guess his suggestions" (Case 4, Woman 3).* Another chose to adopt a passive role for decisions in her maternity care, but would cross-reference advice given by her private obstetrician, as *"…being a scientist, I … looked up a few papers as well" (Case 4, Woman 2).*

Communication: Laying all the cards on the table

The handheld documentation system used in Cases 1 and 2 was identified as helpful to communication as *"… they recorded the information really well and that sort of compensated for not having the same midwife each time as they were always on the same page that I was on each time" (Case 2, Woman 6).* Another participant stated, *"I felt like I was still part of it and could be in control. And also, you knew that no one was dropping the ball on you ... you could make sure that you had everything covered" (Case 2, Woman 4).* Several women expressed feelings of empowerment by holding their own maternity record which contained useful information about the schedule of standard care: *"I was aware of all the decisions at*

each appointment … what was going to be scheduled and going on … It was a good sort of visual timeline" (Case 1, Woman 6).

Decision-making: Making the decisions myself

Most women from Cases 1, 2 and 3 expressed self-confidence in their health literacy and had obtained information from a variety of sources to support active involvement in decision-making in their maternity care. Interactions with midwives were mostly framed as respectful of the woman's autonomy: *"I was instantly drawn to midwives who obviously specialise in pregnant women … I felt that I was informed and that I was allowed to make my own decisions. And that was exactly what I wanted … I was treated like a human being with choices. (Case1, Woman 4).* One woman chose to employ a privately practicing midwife for support during pregnancy and birth to promote her feelings of decisional autonomy: *"I took a lot of mental notes about what he [the obstetrician] was saying and then went back and did some more looking into that and talking to my midwife about it, so that I was prepared for the next appointment with more questions relating to what he had said" (Case 3, Woman 1).*

An undesired passive decision-making role was associated with negative outcomes for perinatal mental health and wellbeing by several women. A woman with complex medical needs indicated that she would have felt happier *"if I am just sort of basically told what is best, as long as I am told why and I have an understanding of why that has to happen or why that is the best approach ... But sometimes I didn't always get that sense … like it was not a decision, it was just sort of like being told what was happening (Case 1, Woman 2).* Concerningly, several women expressed the experience of an emotional crisis-point before clinicians recognised or addressed their needs or preferences, if at all: "*Just the mere fact that it was just very hostile … I had to breakdown just to be heard. You know? It was just – it is just not on, and it is not the way to start motherhood either" (Case 1, Woman 8).*

Decisional Conflict

All interview participants agreed to choose an aspect of their maternity care that required them to make a decision and reflected upon the four questions of the SURE test (Légaré et al., 2010). Responses from approximately a quarter of the interview participants (n=7, 25.9%) were associated with clinically significant decisional conflict on the SURE test (Légaré et al., 2010). Several of these women disclosed that their experience of decisional conflict was associated with serious consequences for their emotional and psychological wellbeing: *"I beat myself up about my own mental health and anxiety as it is… the decision of wanting to [have a caesarean section] … was the hard thing because I thought … maybe I*

was cheating? You know, by trying to take an easy way out. The doctors told me it is not an easy way out, but for me it was … It was really awful, like it was really awful. The whole pregnancy I just cried and cried and cried … for trying to make a decision that would make me feel safe, feeling like I was copping out" (Case 2, Woman 2)

Discussion

Findings of the Labouring together study present new evidence about childbearing women's preference to be more actively involved in collaborative decision-making for the provision of maternity care than is currently experienced. The results of both the surveys and interviews determined that most women would prefer to share or actively participate in the decision-making process regarding their maternity care, particularly if choosing to have maternity care in the public maternity system. Compared to a study of the preferred role in decision-making, a higher proportion of women preferred an active role in decision-making in maternity care (35%) compared to 26% of patients with cancer (Singh et al., 2010). However, multiple barriers to participation of women in collaborative decision-making were identified.

As previously discussed, relational continuity of care with a midwife has been associated with women's feelings of satisfaction and empowerment (Allen et al., 2017; Macpherson et al., 2016) and active involvement in decision-making (Allen et al., 2019), and to ameliorate challenges with the woman's engagement in care, particularly for women of ethnically diverse, vulnerable, or socially disadvantaged backgrounds (Beake et al., 2013; Dove & Muir-Cochrane, 2014; Ebert et al., 2014; Noseworthy et al., 2013). However, in the findings of the Labouring Together study, several women were unable to access any midwifery care at all in the antenatal period, either due to inadequate provision / oversubscription of midwifery models of care in the public maternity care system, or due to the presence of complex medical or obstetric needs.

At interview, women with complex needs indicated a greater need for relational continuity to support information sharing and discussion of options for a 'shared' style of decision-making than women with uncomplicated pregnancy. This finding is consistent with patients' preferences and perceived involvement reported in the mental health setting (Eliacin, Salyers, Kukla, & Matthias, 2015). As it was, many of these women experienced a bureaucratic style of decision-making based upon practice guidelines or hospital policies designed to avoid risk rather than to support the woman's preference or choice. Indeed, at times, clinician's knowledge of the woman's right to make autonomous decisions over her pregnancy care appeared to be lacking. This finding was evidenced by inadequate provision of evidence-based information for women about the risks and benefits of all proposed

interventions for some women and compounded by inadequate policy at the organisational and governance levels to protect the woman's rights, and is consistent with other studies of shared decision-making in maternity care (Coates, Goodfellow, & Sinclair, 2020; Declercq, Cheng, & Sakala, 2018).

Factors supportive of shared decision-making with women were identified at the individual clinician and organisational level in the study. These included: effective interpersonal skills to support relationship building; systems of communication that were inclusive of the woman such as the handheld maternity record and handover of shift processes that were conducted in the presence of the woman; and relationship building between the woman and the clinician that she considered to be her main maternity provider.

Interestingly, the women who chose the private obstetric model of care were found to prefer a more passive role in decision-making compared to women who chose the public system; independent of the influence of previous experience of maternity care or socio-demographic characteristics. Although this finding was not statistically significant, it is a novel finding from the Labouring Together study and may have clinical significance. At interview, these women attributed their preference for a passive decision-making role to the trust built with the obstetrician employed by them, afforded by the relational continuity of care inherent in the private obstetric model. However, women at Case 4 also reported significantly more discordance between their decision-making preferences and experiences compared to women from Cases 1, 2 and 3. It is unlikely that this discordance can also be explained by the improved relational continuity of care experienced in the private obstetric model of care compared to the public system.

Upon review of the performance indicator data for obstetric interventions, including induction of labour, caesarean section birth and artificial infant feeding, Case 4 is an outlier in comparison to Cases 1, 2 and 3. It is possible that the discordance between a preferred more passive role and the experience of a more active role for decision making could be explained by these comparatively higher rates obstetric intervention, as the women participants in the private obstetric model may have been required to consider and decide upon obstetric interventions at higher rates than the women in public maternity system. This novel finding may also have clinical significance and has not been reported in other studies to date. Further research on differences in rates of obstetric intervention and the decision-making role preferences and experiences in both private and public models of maternity care is required.

Strengths and limitations

The major strength of the Labouring Together study was the robust study design, which incorporated the benefits of mixed methods and a multi-site case study approach. This design afforded in-depth analysis of factors associated with individual, professional, contextual, governance and policy levels of healthcare.

Limitations of the Labouring Together study include resource limitations, potential recruitment bias, and relatively small sample sizes from each case. Whilst every attempt was made to recruit a broad range of participants to the Labouring Together study, it is possible that some participants contributed to the study as they had extreme viewpoints or were discontented with the current context of maternity care provision. The limitations of relatively small sample sizes in each case were offset by the use of replication logic in the purposive selection of the case study sites within the Labouring Together study design.

Conclusion

In Australian maternity care, a woman-centred philosophy and partnering with women are central to both healthcare policy and professional guidance. Findings from the Labouring Together study indicate that the majority of childbearing women would prefer to participate in collaborative decision-making with clinicians to develop plans for maternity care relevant to their individual context, health, and wellbeing. However, effective collaboration and shared decision-making with women are not routine practice and woman's autonomy is hindered by a variety of factors; primarily the dominant discourse of risk avoidance at the micro, meso and macro levels of maternity care that ultimately veto choice.

Policy and governance-level changes are required to offset the power imbalances associated with the hierarchical maternity care system. Balancing of the risk-avoidance paradigm with a salutogenic approach that accounts for the mental health and well-being of the woman could enable maternity care provision that is more relevant to the needs and individual context of the childbearing woman and her family. Existing evidence suggests that prioritisation and expansion of relational continuity models of midwifery care for woman of all levels of risk and socio-economic status would engage women in taking a more collaborative role for decision-making, through the information sharing and advocacy roles of the midwife. Findings from the Labouring Together study have provided more evidence to support this call. Recognition of the contribution of relational continuity of midwifery care to support optimal perinatal outcomes for the health and wellbeing of all childbearing women is vital.

Table 1

Models of Maternity Care Included in the Labouring Together Study

Model of Care	Description
Midwifery Group Practice	Publicly funded continuity of low-risk maternity care is primarily provided by a named midwife or small team of midwives throughout pregnancy, birth and in the early weeks of caring for the new baby.
Midwifery Shared Care	Publicly funded low-risk maternity care is primarily provided by midwives, shared with obstetric doctors via the maternity hospital throughout pregnancy, birth and in the early weeks of caring for the new baby.
General Practitioner (GP) Shared Care	Publicly or privately funded low to moderate-risk antenatal care is primarily provided by a General Practitioner (GP), shared with an obstetrician and/or midwife/team of midwives via the maternity hospital throughout pregnancy and birth and in the early weeks of caring for the new baby.
Obstetric High-Risk Pregnancy Care	Publicly funded maternity care is provided to women with medically complex pregnancies by a team of obstetricians, physicians, midwives and other healthcare providers throughout pregnancy and birth and in the early weeks of caring for the new baby.
Specialist Maternity Services	Publicly funded low to high-risk maternity care is provided to vulnerable women and/or babies by a team of midwives, obstetricians and other healthcare providers throughout pregnancy and birth and in the early weeks of caring for the new baby.
Private Obstetric Care	Privately funded low to high-risk maternity care is provided by a named obstetrician during pregnancy and birth.

Table 2

Victorian State-wide Perinatal Performance Indictors and Desired Outcomes

Indicator	Indicator Description	Desired Outcome
Outcomes for standard primiparae[1]	Rate of induction of labour in standard primiparae Rate of caesarean sections in standard primiparae	Rates should be low and consistent for this low-risk group of women. Variation in rates may indicate that clinical practice and/or system processes may not be supported by evidence for best clinical practice
Vaginal birth after primary caesarean section (VBAC)	Rate of women who planned a VBAC Rate of women who had a planned a VBAC	Unless contraindicated, women should be provided with the opportunity for VBAC and information to support decision-making. Rates should be moderately high, with little variation across peer-group hospitals.
Breastfeeding in hospital	Rate of breastfeeding initiation in term babies Rate of use of infant formula in term breastfed babies Rate of final feed exclusively from the breast for term breastfed babies.	Rates should be high and consistent among peer-group hospitals

Note. Source: (Hunt, 2016)

[1] A 'standard primipara' represents healthy woman aged 20–34 years who is giving birth for the first time to a single baby at term. (37 – 40 weeks).

Table 3

Interview Guide

Sequence	Question
1	Which type of maternity care did you choose?
2	Did you get to know/ build up a relationship with the midwives/ doctors during your antenatal care? • Did you feel able to talk about things that were worrying you? • Were you able to ask questions?
3	What was your experience of decision making during your pregnancy care? • Were you aware when decisions about your pregnancy care needed to be made? • Did you feel that you had enough information to make an informed decision?
4*	Think about one aspect of your pregnancy, labour, or postnatal care where you had to make a decision. When you were making your decision: • Did you feel sure about the best choice for you or your baby? Yes or No (please explain) • Did you understand the benefits or risks of all options? Yes or No *(please explain)* • Were you clear about which risks, or benefits mattered most to you? Yes or No *(please explain)* • Do you think that you had enough support and advice to make the choice? Yes or No *(please explain)*
5	Have you got any other thoughts or suggestions to improve the way decisions are made in maternity care in the future?

Note. * Items comprise the SURE test (Légaré et al., 2010)

Table 4

Contextual characteristics of cases

Contextual Characteristics	Case 1	Case 2	Case 3	Case 4
Range of births per annum	>2000- 4000	>2000- 4000	750-1500	100-600
Location				
Metropolitan Melbourne	•	•		
Regional Victoria			•	•
Hospital funding model				
Publicly funded	•	•	•	
Privately funded				•
Models of care available				
Midwifery Group Practice	•	•		
Midwifery Shared Care	•	•	•	
GP Shared Care	•	•	•	
Obstetric High-Risk	•	•	•	
Specialist Maternity Services	•	•	•	
Private Obstetric Care	•	•	•	•

Table 5

Sociodemographic Characteristics of Women Participants by Case

Characteristic	Distribution per Case (%)			
	Case 1	Case 2	Case 3	Case 4
Age (years)				
Under 20	-	-	7	-
20-25	10	7	18	3
26-30	29	29	41	19
31-35	40	40	20	48
36-40	19	20	9	19
Over 40	2	4	5	6
Undisclosed	-	-	-	3
First experience of maternity care				
Yes	71	69	66	65
No	29	31	33	32
Undisclosed	-	-	2	3
Level of education				
Secondary School	10	22	48	10
Technical and Further Education	13	20	20	6
University	76	58	27	81
Undisclosed	2	-	5	3
Ethnicity				
Aboriginal and/or Torres Strait Islander[1]	-	-	11	-
African	2	2	-	-
American	2	-	-	-
Australian	56	76	79	94
British or Irish	3	7	-	-
Chinese Asian	16	2	-	-
Eastern European	-	-	2	-
Greek	2	-	-	-
Indian	3	2	-	-
Italian	2	-	-	-
Latino	2	-	-	-
Middle Eastern	-	4	2	-
New Zealander	2	2	5	3
Pacific Islander	2	-	-	-
Filipino	-	2	-	-
South-East Asian	5	2	-	-
South Korean	2	-	-	-
Undisclosed	3	-	2	3

Table 6

Women's Preferred Decision-Making Role by Case and Socio-Demographic Characteristic

Case / Characteristic	Preferred role (%)			□	*df*	*p*-value
	Active	Shared	Passive			
Case [a]				11.431	6	0.076
Case 1	33.3	41.4	16.7			
Case 2	28.6	23.0	20.0			
Case 3	27.0	18.4	33.3			
Case 4	11.1	17.2	30.0			
Age (*years*) [b]				5.479	6	0.484
≤25	9.5	9.2	24.1			
26-30	28.6	32.2	24.1			
31-35	39.7	36.8	34.5			
≥36	22.2	21.8	17.2			
First Experience [c]				0.845	2	0.655
Yes	66.7	67.8	75.9			
No	33.3	32.2	24.1			
Level of Education [d]				3.125	4	0.537
Secondary	16.1	16.3	20.7			
Technical and Further Education	21.0	15.1	6.9			
University	62.9	68.6	72.4			
Ethnicity [e]				29.847	6	<0.001***
Anglo	87.3	79.3	67.9			
Aboriginal/ Torres Strait Islander	-	-	17.9			
Asian	9.5	13.8	7.1			
Other[2]	3.2	6.9	7.1			

Note.

statistically significant (p<.05) **statistically significant (p<.01) * statistically significant (p<.001)*

a N=176 b N=175 c N=175 d N=173 e N=174

[1] 'Anglo' in this context is defined as identifying with the ethnicity of high-income English-speaking countries (including Australia, New Zealand, United Kingdom, Ireland, and United States of America)

Table 7

Women's Actual Decision-Making Role by Case and Socio-Demographic Characteristic

Case / Characteristic	Role Experienced (%)			□	*df*	*p*-value
	Active	Shared	Passive			
Case [a]				11.666	6	0.07
Case 1	41.3	31.0	34.9			
Case 2	17.4	29.9	20.9			
Case 3	23.9	17.2	37.2			
Case 4	17.4	21.8	7.0			
Age (*years*)[b]				4.677	6	0.586
≤25	8.7	11.6	11.6			
26-30	30.4	32.6	20.8			
31-35	30.4	47.7	30.8			
≥36	30.4	44.7	18.4			
First Experience [c]				2.182	2	0.336
Yes	71.7	62.8	74.4			
No	28.3	37.2	25.6			
Level of Education [d]				5.109	4	0.276
Secondary	11.1	17.6	20.9			
Technical and Further Education	8.9	20	16.3			
University	80	64.2	62.8			
Ethnicity [e]				10.964	6	0.09
Anglo	87	80.2	76.2			
Aboriginal/ Torres Strait Islander	2.2	0	7.1			
Asian	8.7	13	7.1			
Other	2.2	4	9.5			

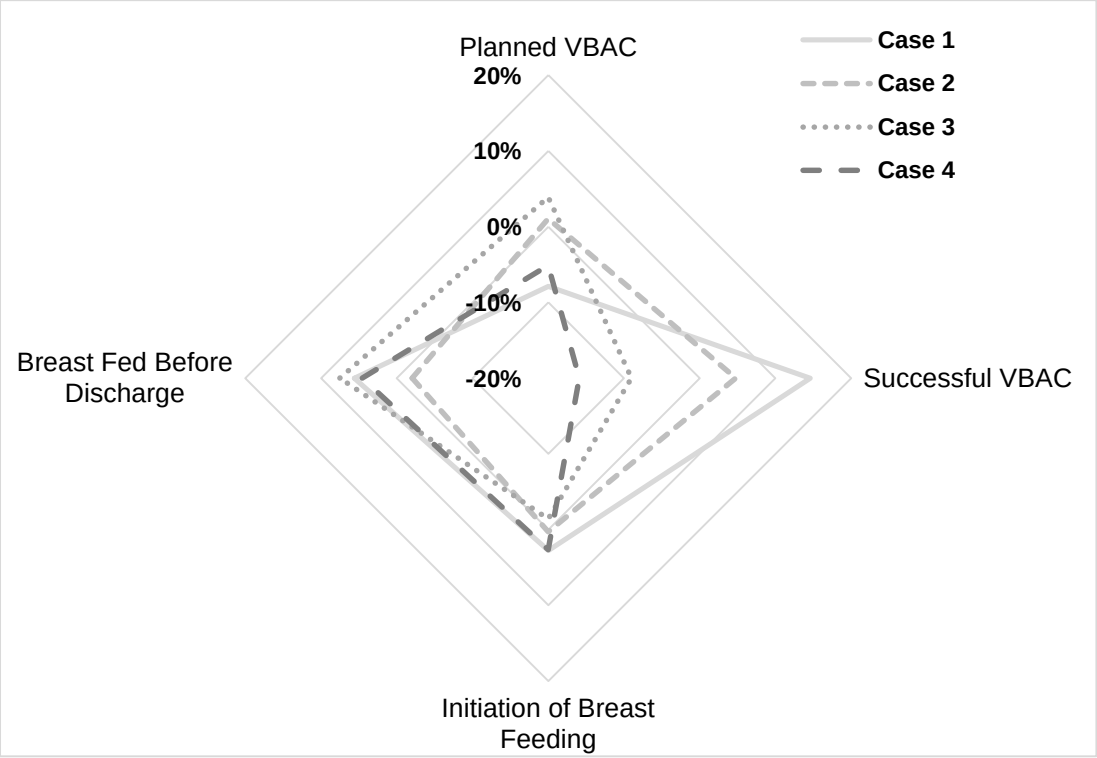
*Note. *statistically significant (p<.05) **statistically significant (p<.01) *** statistically significant (p<.001)*

[a] *N*=176 [b] *N*=175 [c] *N*=175 [d] *N*=173 [e] *N*=174

[1] 'Anglo' in this context is defined as identifying with the ethnicity of high-income English-speaking countries (including Australia, New Zealand, United Kingdom, Ireland, and United States of America)

Figure 1

Performance Indictor Radar Plot: ***Higher Rates*** *More Favourable*



VBAC = Vaginal birth after caesarean

Figure 2

Performance Indicator Radar Plot: ***Lower Rates*** *More Favourable*

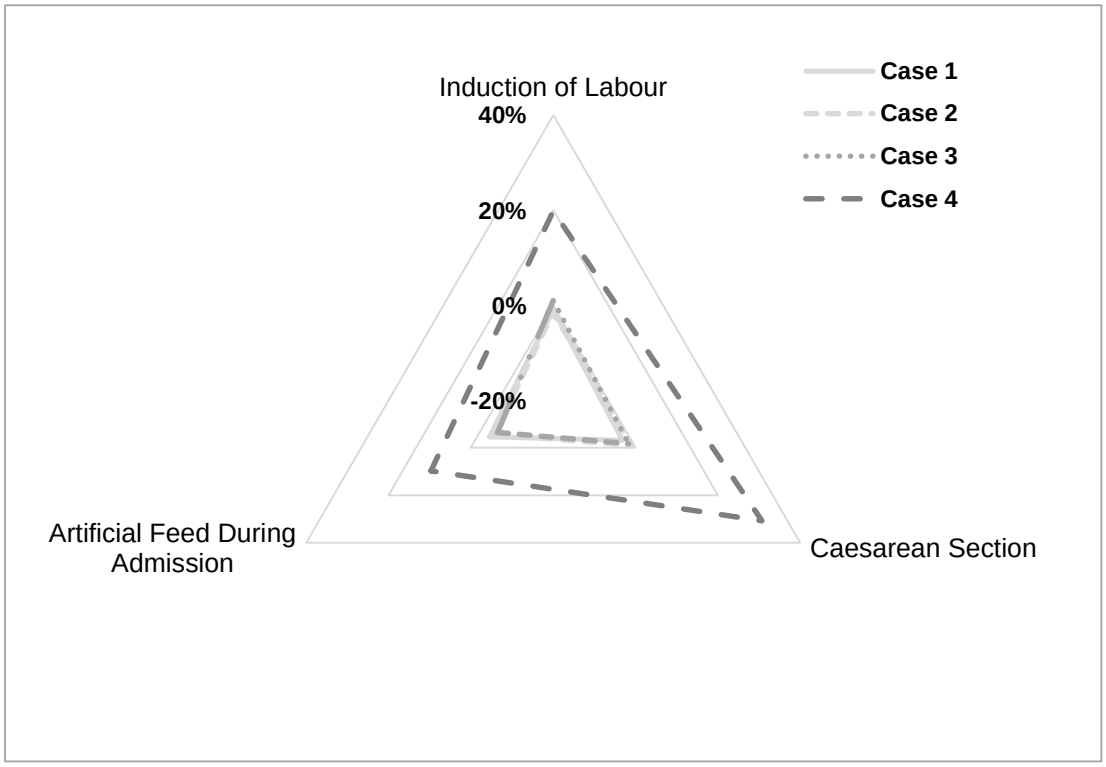


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Figure 3

Women's Preferred Role for Decision-Making by Case

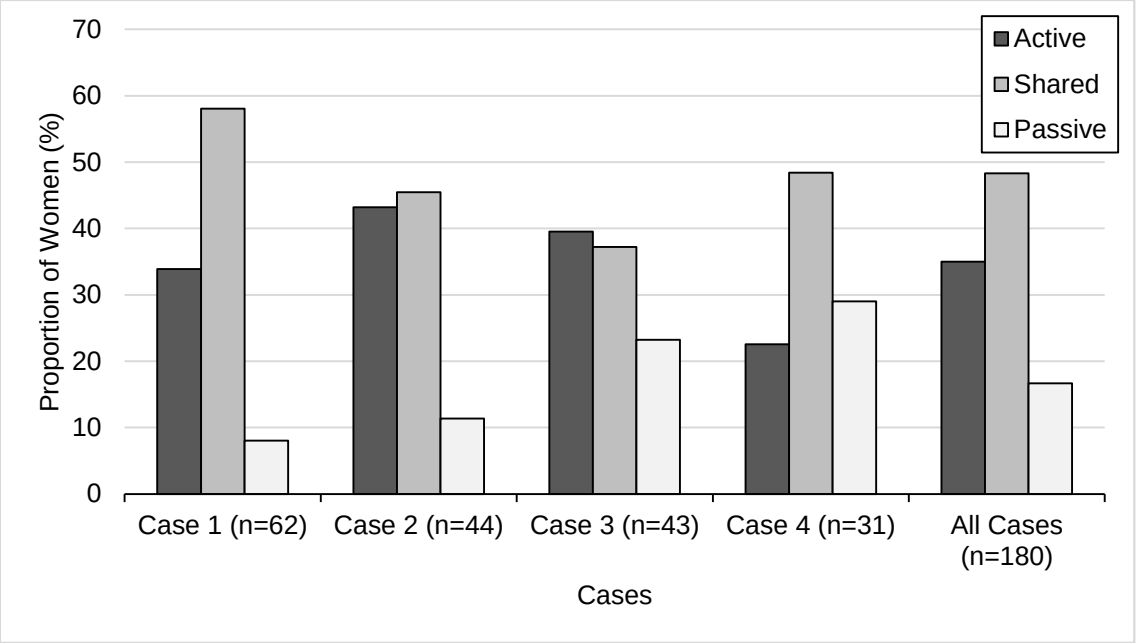


Figure 4

Women's Actual Role for Decision-Making by Case

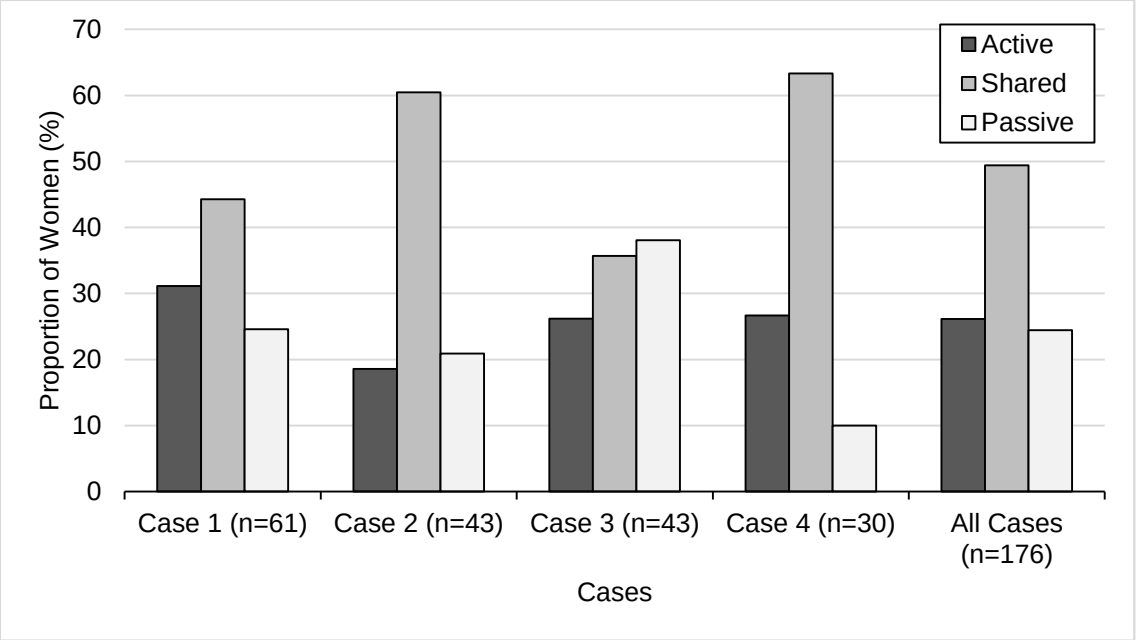


Figure 5

Concordance Between Women's Preferred and Actual Decision-Making Role

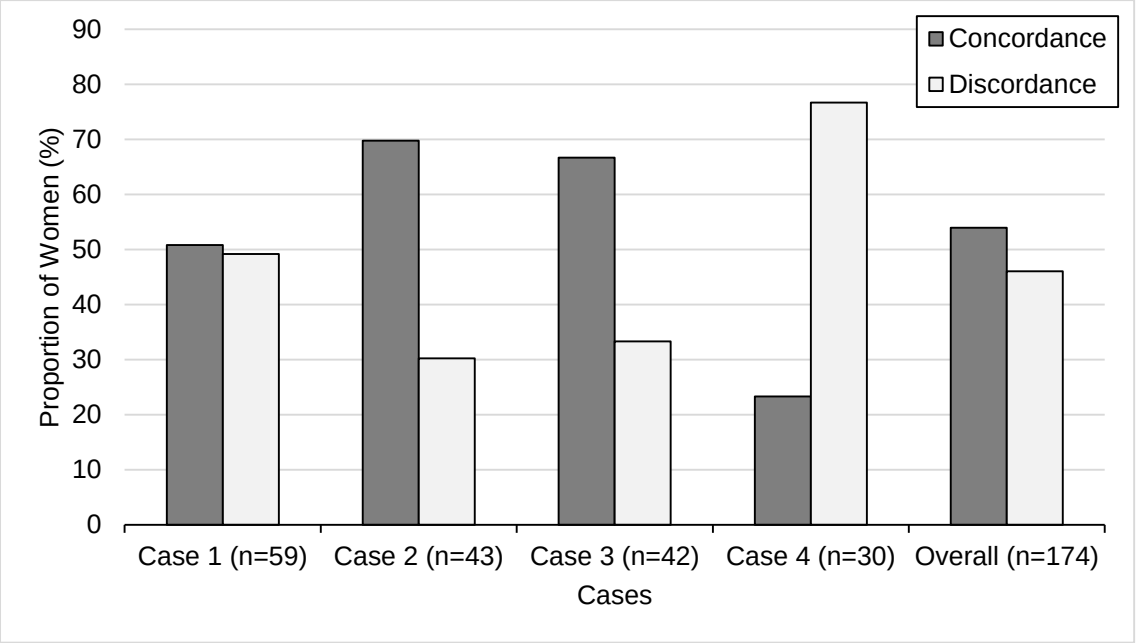


Figure 6

Women's Role for Decision-Making by Maternity Care Funding Status

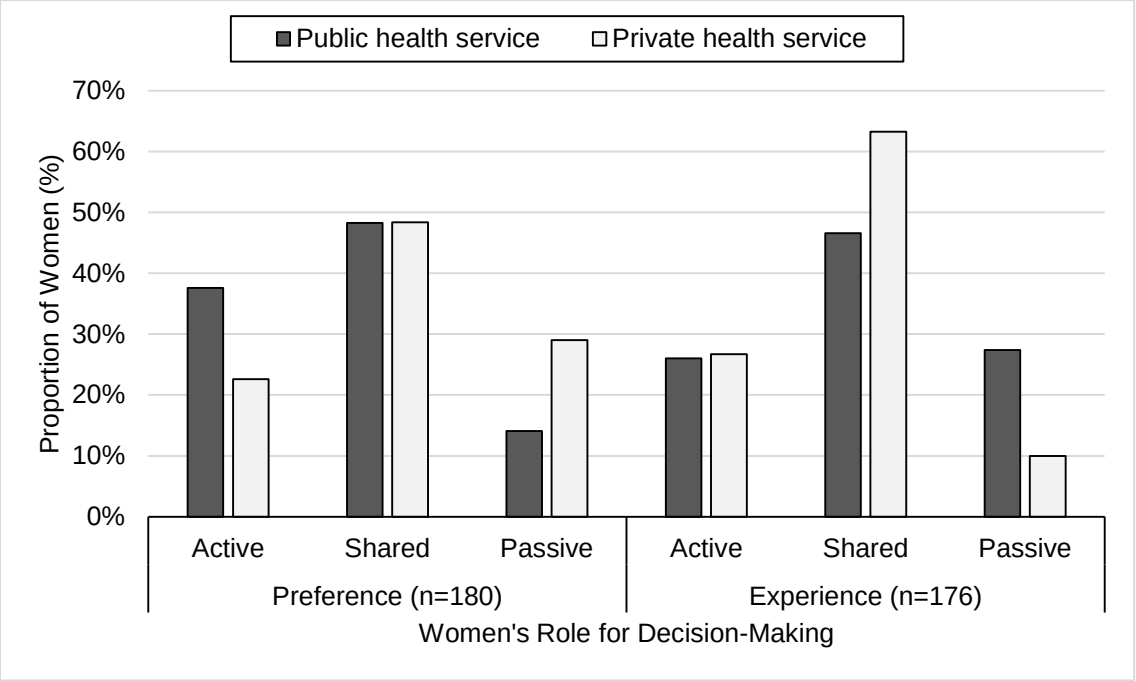
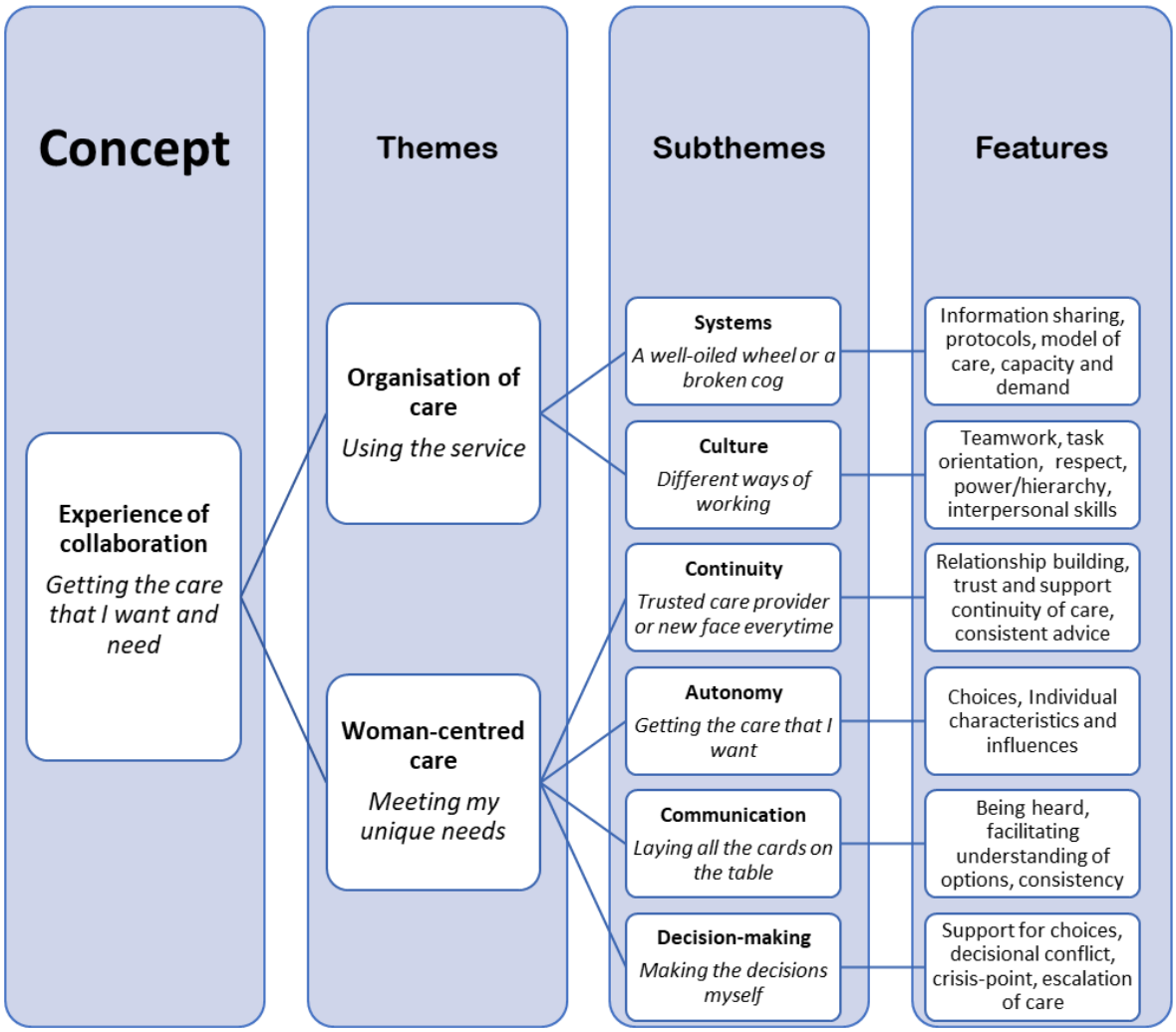


Figure 7

Women's Experience of Collaboration- Getting the Care That I Want, and I Need



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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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Dr Vanessa Watkins: Conceptualization, Methodology, Investigation, Formal analysis, Data Curation, Writing- Original draft preparation, reviewing and editing

Associate Professor Cate Nagle: PhD supervision, Methodology, Formal analysis, Writing - Review & Editing

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