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Perceived Reality and Subjective Importance of Shared Decision-Making During Perinatal Care

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Aim: The aim of the study is to explore perceived reality and subjective importance of shared decision-making (SDM) during antenatal, intrapartum, and/or postpartum care, provided by the midwife and/or obstetrician. **Methods:** A cross-sectional study was conducted among women in Flanders, Belgium. SDM was measured with the Observing PatienT InvOlvemeNt scale. *t* Tests examined the differences between perceived reality and subjective importance of SDM. A multivariate generalized linear model tested the main and interaction effects between SDM and the maternity care providers and the perinatal care periods. Bonferroni post hoc tests examined further significance. **Results:** A total of 1,216 pregnant and postpartum participants completed 1,987 self-reports of perceived reality and subjective importance of SDM. The community midwives' SDM was evaluated 924/1,987 times, the hospital midwives' SDM 309/1,987 times, and the obstetricians' SDM 754/1,987 times. Perceived reality and subjective importance of SDM showed significant differences between care professionals ($p < .001$; $p < .001$), explained by the differences between community and hospital midwives' SDM ($p < .001$, d .85; $p < .001$; d .28) and between community midwives and obstetricians' SDM ($p < .001$, d .72; $p < .001$; d .31). **Conclusions:** Despite the overall high OPTION scores, the findings indicate optimizing the decision-making process during perinatal care by aligning subjective importance and perceived

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reality of SDM throughout the perinatal care episodes. Community midwives seem to be benchmarkers of shared decision-making during perinatal care.

Keywords: childbirth; maternity care; postpartum; pregnancy; shared decision-making

Childbearing women occupy a central role in perinatal care and therefore play a vital role in deciding on care management and care procedures during their antenatal, intrapartum, and postpartum care. Shared decision-making (SDM) is a care strategy to pursue autonomy, control, decision responsibility, and empowerment of childbearing women (Fontein-Kuipers et al., 2018). In this decision-making process, the care provider informs the childbearing woman about options, benefits, and possible outcomes and (evidence-based) knowledge of care, and the woman deliberates and exchanges her preferences, knowledge, fears, concerns, needs, hopes, norms, and values with the care provider (Begley et al., 2019; Waddell et al., 2021). A healthcare environment that supports SDM is characterized by professionals who recognize the woman as an essential stakeholder in her care and who regard the woman's authoritative experiential knowledge and subjective perceptions as legitimate (Begley et al., 2019; Elwyn et al., 2010; Fersini et al., 2019; (Fontein)Kuipers & Mestdagh, 2022; Waddell et al., 2021). This environment contributes to a bilateral dynamic decision-making collaboration between the maternity care professional and the woman (Begley et al., 2019; Schulz & Wirtz, 2022). There is increasing evidence that SDM may contribute to a more egalitarian relationship-based model of care (Begley et al., 2019; Fersini et al., 2019; Fontein-Kuipers et al., 2018), satisfactory care processes, reduction in overuse of interventions, to optimal primary treatment outcomes, positive birth experiences, and to increased maternal emotional well-being (Villarmea & Kelly, 2020). A lack of the woman's involvement in the decision-making process may contribute to a negative or even traumatic childbirth experience (Koster et al., 2020).

Health policy and professional standards advocate for women's involvement in SDM during perinatal care (Thompson & Miller, 2014). In Belgium, SDM is a key component of perinatal care and is recommended by the Belgian Healthcare Knowledge Centre (Benahmed et al., 2019). Maternity care services in Flanders (the northern and Dutch-speaking part of Belgium), following Belgian guidelines and recommendations, are mainly provided by obstetricians in a medical model of care, showing high intrapartum intervention rates (DeVlieger et al., 2021; Goemaes et al., 2020). However, in Flanders currently, hospital midwives are becoming more involved in antenatal care, and independent community midwives are also increasingly providing care throughout the perinatal period, predominantly in the antenatal and postpartum period (Helsloot & Walraevens, 2015). Nevertheless, most Flemish women still have an obstetrician as their primary care provider (DeVlieger et al., 2021). Labor and birth usually take place in a hospital setting with both a hospital midwife, usually unknown to

the woman, and an obstetrician present. After birth, women are cared for by hospital midwives until discharge (DeVlieger et al., 2021). At this point, community midwives can be consulted up to ten times within the first year after birth (Benahmed et al., 2019; Helsloot & Walraevens, 2015).

Ethical and legal obligations require maternity care professionals to involve women in decision-making (WHO, 2016). In general, women desire involvement in decision-making during the perinatal period, but it can be challenging (Yuill et al., 2020). Begley et al. (2019) advised the use of validated SDM questionnaires to assess women's perceptions of SDM. Approaching SDM with a dual focus on perceptions of actual SDM as well as perceptions of importance aligns with the concept of woman-centered care in which outcomes and the woman's sense of reality are of similar importance (Fontein-Kuipers et al., 2018). Perceived reality mirrors women's experiences regarding the actual care received, while the subjective importance represents the importance women ascribe to care, one informing the other (Hildingsson & Sandin-Bojö, 2011; Hildingsson et al., 2021). Both are regarded as valid indicators of SDM in various maternity care settings (Schulz & Wirtz, 2022). Potential discrepancies between subjective importance and perceived reality provide information on if and how perinatal SDM processes could be improved—aligning expectations with experiences—contributing to resolving discrepancies in maternal care experiences (Hildingsson et al., 2021; Johansson & Hildingsson, 2013).

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Despite Belgian recommendations for SDM (Benahmed et al., 2019), the extent to which this has been implemented or perceived as important by Flemish women is unclear, although it can be assumed that childbearing women are involved in decision-making and consider shared decision-making as an important part of their care (Yuill et al., 2020). Therefore, this study aimed to explore to what extent Flemish women have experienced SDM (perceived reality) during antenatal, intrapartum, and/or postpartum care, either provided by the midwife or obstetrician, and if SDM in maternity care is perceived as important (subjective importance).

METHODS

Design

We conducted a cross-sectional, online survey among pregnant and postpartum women aged 18 years or older who received antenatal or intrapartum (labor and birth) and postpartum care in Flanders from a community midwife, hospital midwife, and/or obstetrician. Participants included pregnant women of all trimesters and postpartum women who gave birth between 6 weeks and 1 year before participation. The first 6 weeks postpartum were excluded due to the potential for under- or overestimation of observed effects during the period (Hildingsson et al., 2021; Schulz & Wirtz, 2022). Exclusions were also made for births before 32 weeks' gestation, severe/life-threatening complications/

morbidity during pregnancy, birth, or postpartum, or fetal/neonatal death. Very and extreme prematurity was also excluded due to the complex ethical issues affecting decision-making (Waldenström, 2004). This study focused on monodisciplinary SDM and did not include joined multidisciplinary SDM in such complex circumstances (Barker et al., 2019; Wubben et al., 2021). This study is part of a larger research project about midwife-led care readiness in Flanders.

Sampling

Two cohorts were formed for the study: (a) pregnancy, including the antenatal period, and (b) childbirth, including the intrapartum and postpartum period. Non-probability recruitment strategies such as convenience sampling, voluntary response sampling, and snowballing were utilized. Ninety independent community midwives in Flanders were contacted to disseminate invitations for participation through flyers and posters to pregnant and postpartum women. Five independent midwifery practices shared the invitation on their closed Facebook© groups. Additionally, five Flemish maternity units were approached to display posters and to distribute the flyers. Recruitment was proportionate to the distribution of community midwives and maternity hospitals in Flanders. Maternity service providers acted as intermediaries to contact potential participants. Furthermore, 88 open Facebook© groups and 12 other open social media platforms, specifically targeting pregnant women and young mothers, were used to recruit participants. The questionnaire was anonymously accessible through a Uniform Resource Locator (URL) link or Quick Response (QR) code.

Data Collection

The data were collected between 28 February and 22 July 2022, using online self-completed questionnaires. In cohort one, participants were asked to reflect on their current pregnancy, while participants in cohort 2 were asked to reflect on their last labor and birth and/or postpartum period—with specific attention given to SDM during clinical encounters. For each perinatal period (antenatal, intrapartum, postpartum), participants reported on the perceived reality of SDM of community midwives, hospital midwives, and/or obstetricians. In cohort 1, the participants selected one to three maternity care professionals during the antenatal period. In cohort 2, the participants selected up to six professionals during the intrapartum and the postpartum period (up to three per period). Participants retrospectively self-reported on the subjective importance of SDM for each chosen clinician per perinatal period, answering the same SDM items twice: (a) the perceived reality of SDM during care provision and (b) the extent to which SDM item was important to them during that specific perinatal care period from that specific maternity care professional (subjective importance). This dyad assessment of statements has previously been used in studies about intrapartum and postpartum care (Hildingsson & Sandin-Bojö, 2011; Hildingsson et al., 2021).

Measures

The main outcome of interest for this study was self-reported SDM during perinatal clinical encounters measured with the Observing PatienT InvOlvemeNt (OPTION) scale. The OPTION scale is a 12-item rating scale used to assess the quality of SDM from clinical professionals during clinical encounters from an observer's perspective, covering the whole SDM process (Elwyn et al., 2005a). Sociodemographic and personal details were collected from the participants. Participants were asked about their prior involvement in SDM processes using a five-point scale: 1 (never) to 5 (very often). A list of 12 potential influencers (e.g., friends, experts, society, celebrities, media) on personal decision-making was included (Emami Naeini et al., 2018). Participants were informed that experts included care professionals and family included the partner. Participants could choose a maximum of three influencers. COVID-19-related items were also included such as whether participants had tested positive, been ill, and/or quarantined or if a significant other had died due to COVID-19. The questionnaire was available in the Dutch, French and English languages.

Observing Patient Involvement (OPTION-12). In this study, childbearing women—being the observer—retrospectively reported on observed SDM practices (perceived reality) and perceived importance (subjective importance) of SDM. Each OPTION item is rated on a five-point scale ranging from 0 (behavior not observed) to 4 (behavior observed to a high standard)/0 (I do not consider this to be important) to 4 (I consider this to be very important; Elwyn et al., 2005a). A total score (range 0–48) is obtained by summing the scores of each item, with higher scores indicating higher levels of perceived reality and subjective importance of SDM. There is no cutoff score for the OPTION scale (Elwyn et al., 2005a,b). Psychometric assessment of the OPTION scale has shown acceptable to excellent internal consistency with α ranging between 0.68 and 0.90 (Nicolai et al., 2012). The scale has been used to assess SDM in maternity care services, showing good internal consistency ($\alpha = 0.90$; Fersini et al., 2019). The validated Dutch, French, and English versions of the scale were included in this study (Elwyn et al., 2005b).

Statistical Analysis

Statistical Package for the Social Sciences© (SPSS) version 27 was used for data analysis. Descriptive statistics were computed for participants' sociodemographic and personal details. One-way ANOVA and χ^2 were used to examine differences between completers and non-completers. The OPTION scores were summed, and Cronbach's alpha was calculated to assess internal consistency. The normality of OPTION score distribution was assessed with the Shapiro–Wilk test. To check statistical dependence between cohort 2 intra- and postpartum OPTION scores, the Pearson Product Moment Correlation (PPMC) was used to detect linear relationships between these scores. T-tests examined the differences between perceived reality and subjective importance of SMD. A multivariate generalized linear model tested the main effect of professionals (community

midwives, hospital midwives, and obstetricians) and the perinatal (antenatal, intrapartum, and postpartum) periods on the OPTION scores (perceived reality and subjective importance) and the interaction effects of the independent variables. When significant differences were observed, a post hoc Bonferroni correction was performed. The linear relationship between previous experiences of SDM perceived reality, and subjective importance of SDM was assessed using a two-tailed Pearson correlation. The level of significance was set at <.05. Stratified sampling size calculation indicated that a minimum of 232 participants for the antenatal sample, 565 participants for the intrapartum, and 419 participants for the postpartum sample were required to make reliable inferences ($p < .05$, CI 95%).

Ethics

AQ5 The Ethics Committee Social and Human Sciences XXX University (SHW_22_04, 16 February 2022) approved the study after review of the research proposal, the information letter for participants, the informed consent form, and the surveys. Before initiating the survey, all respondents signed an electronic informed consent form.

RESULTS

A total of 2,475 questionnaires were collected, of which 323 were excluded due to missing socio-demographic details or no consent given, resulting in a response rate of 87%. After removing 595 questionnaires due to incomplete OPTION scales, a completion rate of 67.1% ($n = 1216$) was achieved (Figure 1). Completers had more previous experiences with SDM compared with non-completers ($p < .001$). Non-completers had been pregnant more often than completers (p .024). The 1,216 participants completed a total of 1,987 OPTION scales for both perceived reality and subjective importance of SDM, with an average of 1.62 (±.68, range 1–6) per participant for both scales (see Table 1). In total, the community midwives' SDM was evaluated 924/1,987 times (46.5%), the hospital midwives' SDM 309/1,987 times (15.6%), and the obstetricians' SDM 754/1,987 times (37.9%). PPMC showed no linear relationships between intrapartum and postpartum perceived reality and subjective importance OPTION scores (r –.01, p .98; r .19, p .29), suggesting no data dependency among cohort 2 intrapartum and postpartum scores for overall perceived reality and the subjective importance SDM.

Participants

All 1,216 participants self-identified as female. The majority (93%) were born in Belgium, and 96.3% were in a relationship. Nearly 88.9% of the participants had a paid or unpaid job, and 62% reported a high level of education. More than half of the sample (59.7%) had more than one child. Of cohort 2, 80% had a spontaneous

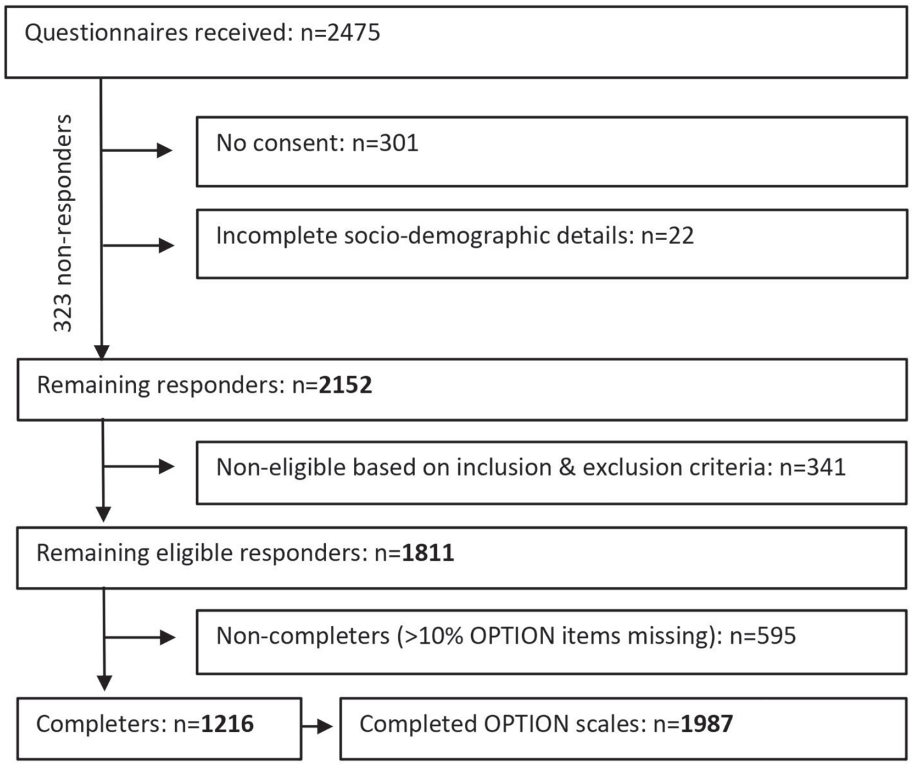

Figure 1. Flowchart participants.

TABLE 1. Completed OPTION Scale Cohorts 1 and 2

Participants	OPTION scales	Care professionals
Cohort 1 (n = 324)	OPTION antenatal SDM (n = 354)	Community midwife (n = 99) Hospital midwife (n = 15) Obstetrician (n = 240)
Cohort 2 (n = 892 of which 790 reported on intrapartum care)	OPTION intrapartum SDM (n = 1010)	Community midwife (n = 345) Hospital midwife (n = 208) Obstetrician (n = 457)
Cohort 2 (n = 892 of which 586 reported on postpartum care)	OPTION postpartum SDM (n = 623)	Community midwife (n = 480) Hospital midwife (n = 86) Obstetrician (n = 57)
N = 1216	N = 1987	N = 1987

vaginal birth, and 7.9% of the sample had an out-of-hospital birth/92.1% hospital births. The mean of participants' previous experiences with SDM scores during (maternity) care was 3.77 on a scale from 1 to 5. Experts/healthcare professionals, family/partner, and friends had the most influence on the participants' decision-making (Table 2). Of the cohort 2 sample, 222 participants (30.6%)

had received antenatal, intrapartum, and postpartum care from the same care professional, 80.3% from a community midwife, and 19.7% from an obstetrician.

OPTION-12 Scales

We included a total of 1,987 questionnaires in our analysis. We observed excellent internal consistency of the OPTION-12 scale during antenatal, intrapartum, and postpartum care for both perceived reality (α .93; α .93; α .92) and subjective importance of SDM (α .95; α .93; α .96). Shapiro–Wilk test showed a non-normal distribution for the OPTION-12 for both perceived reality and subjective importance of SDM (W = .82, p < .001; W = .84, p < .001). More than half of the participants reported OPTION-12 scores of perceived reality and subjective importance of SDM above the third quartile (Q3: score 40–48, 51.9%; Q3: score 41–48, 58%).

Perceived Reality and Subjective Importance of SDM. We observed a statistically significant difference between the perceived reality of SDM (M = 36.23, SD = 13.43) and the subjective importance of SDM (M = 40.77, SD = 7.2; p < .001). Table 3 shows the differences between the care professionals and the perinatal periods. We observed a large main effect for care professionals on both perceived reality ($F_{2,1985}$ = 77.56, p < .001, η^2 .07) and a medium effect on subjective importance of SDM ($F_{2,1985}$ = 15.82, p < .001; η^2 .02). We observed no effect for the perinatal period on subjective importance of SDM ($F_{4,1983}$ = 2.41, p .061; η^2 .003) or for the perceived reality of SDM ($F_{2,1985}$ = .90, p .41). We observed no interaction effects between care professional and perinatal period for perceived reality ($F_{4,1983}$ = 1.54, p .19; η^2 .003) or for subjective importance of SDM ($F_{2,1985}$ = 2.81, p .61; η^2 .005).

Post Hoc Bonferroni SDM Differences Between the Various Maternity Care Professionals. The statistically significant differences in perceived reality were attributed to OPTION mean differences between the community midwives and hospital midwives (p < .001; d .85) and between the community midwives and obstetricians (p < .001; d .72), showing a large effect. The differences in subjective importance were explained by OPTION mean differences between community midwives and hospital midwives (p < .001; d .28) and community midwives and obstetricians (p < .001; d .31), showing a medium effect (Table 4).

Correlations Between Previous SDM Experiences, Perceived Reality, and Subjective Importance of SDM. Significant weak positive correlations between previous experiences with SDM and perceived reality of SDM during antenatal (r .15, p .004), intrapartum care (r .13, p < .001), and postpartum care (r .17, p < .001) were observed. A significant weak positive correlation was also observed between previous experiences with SDM and the subjective importance of SDM during postpartum care (r .14, p < .001).

TABLE 2. Characteristics Participants

N = 1216			Flemish data
	Mean (*SD*±) range	*N* (%)	
Age participants (in years)	30.38 (± 4.2) 18–46		30.8 (± 4.7) years
Born in Belgium (yes)		1131 (93)	84.8%
Relationship			
In a relationship		1171 (96.3)	92%
Single		45 (3.7)	8%
Highest level of education			
Primary education		34 (2.8)	15%
Secondary education		428 (35.2)	35.1%
Bachelor/master/PhD		754 (62)	49.9%
Work situation			
Paid job		1056 (86.8)	77.9%
Unpaid job		25 (2.1)	2.5%
Student		23 (1.9)	
Job seeking		34 (2.8)	3.5%
Maternity/parental leave/ benefits		78 (6.4)	
Previous SDM experiences	3.77 (± 1.1) 1–5		
Others influencing decision-making[a]			
Nobody		206 (16.9)	
Experts (including care professionals)		948 (77.6)	
Family members (including partner)		771 (63.1)	
Friends		302 (24.7)	
Colleagues		37 (3)	
Society		60 (4.9)	
Government (regulations)		25 (2)	
Industry		1 (.1)	
Non-profit organizations		7 (.6)	
Line manager(s)		8 (.7)	
Celebrities		1 (.1)	
Unknown		29 (2.4)	
Nulliparous/primiparous women		490 (40.3)	45.6%
Multiparous women		726 (59.7)	54.4%
Number of pregnancies cohort 1 and cohort 2	1.99 (± 1.2) 1–10		
Cohort 1[b]. Number of pregnancies	2.22 (± 1.3) 1–7		
Cohort 1[b]. Number of births	1.3 (± .9) 0–6		
Cohort 1[b]. Length of gestation (in weeks)	25.17 (± 9.0) 4–40		
Cohort 2[c]. Number of pregnancies	1.9 (± 1.1) 1–10		
Cohort 2[c]. Number of births	1.7 (± 9.) 1–11		
Cohort 2[c]. Gestational age at birth (in weeks)	39 (± 1.5) 32–42		38 (± 2)

(*Continued*)

TABLE 2. Characteristics Participants (*Continued*)

N = 1216			Flemish data
	Mean (*SD*±) range	*N* (%)	
Cohort 2[c]. Length of postpartum period (in weeks)	24.5 (± 14.2) 6–53		
Cohort 2[c]. Place of birth			
Hospital		827 (92.1)	99.2%
Home		63 (7)	.7%
Birth center		7 (.8)	.1%
Unassisted		1 (.1)	-
Cohort 2. Type of birth			
Spontaneous vaginal birth		719 (80)	67.6
Instrumental birth		6 (.7)	9.9%
Planned cesarean section		87 (9.7)	11.8%
Secondary cesarean section		86 (9.6)	10.2%
Induction		236 (26.3)	26.7%

[a]Maximum of three influencers possible.

[b]Cohort 1: participants reporting on antenatal period (pregnancy) (*n* = 324).

[c]Cohort 2: participants reporting on intrapartum (labor and birth) and/or postpartum period (*n* = 892). The COVID-19 questions were not included in the analysis due to a non-response rate of 40.2% of the total sample.

DISCUSSION

The study found notable differences between perceived reality and subjective importance of SDM. Participants assigned high importance to SDM but observed or experienced SDM to a lesser extent. Variations were found between the different maternity care professionals. The participants reported experiencing SDM, that is, recognizing and acknowledging that a decision is required, knowing, and understanding the best available evidence, and incorporating the woman's values and preferences into the decision during perinatal care (Begley et al., 2019; Waddell et al., 2021), of all care professionals as well as regarding it as important that all care professionals execute the SDM process. However, the community midwife achieved the highest mean scores for both observed and experienced SDM, suggesting being the reputed care professional who enables women to participate in decision-making during their care [27]. Our findings show SDM to be most important and most often experienced during the postpartum period, although the fairly high OPTION scores suggest that participants think SDM to be important throughout perinatal care. The discrepancies between perceived reality and subjective importance of SDM indicate that optimization of the decision-making process is required to meet women's needs (Begley et al., 2019; Fersini et al., 2019; Fontein-Kuipers et al., 2018; Koster et al., 2020; Villarmea & Kelly, 2020).

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The perceived reality of SDM, mirroring women's actual experiences of SDM, shows the discrepancy between the community midwife, the hospital midwife, and the obstetrician. The differences between the values suggest a dichotomy between primary and secondary care, with the community midwife being the

TABLE 3. Perceived Reality and Subjective Importance per Perinatal Period and Care Professional

	Perceived reality of SDM			Subjective importance of SDM			*P* value
	Mean	*SD*	Range	Mean	*SD*	Range	
Perinatal period							
Pregnancy	34.46	± 12.87	0–48	41.18	± 5.74	17–48	<.001
Labor and birth	34.92	± 13.96	0–48	39.87	± 7.36	0–48	<.001
Postpartum	39.35	± 12.30	0–48	42.04	± 7.47	0–48	<.001
Care professional							
Community midwife	41.26	± 9.16	0–48	41.91	± 6.35	0–48	.020
Hospital midwife	30.38	± 15.71	0–48	39.94	± 7.54	0–48	<.001
Obstetrician	32.46	± 14.59	0–48	39.72	± 7.80	0–48	<.001

TABLE 4. Post Hoc Bonferroni: Observed and Perceived Importance of Shared Decision-Making of Different Maternity Care Professionals

SDM	Maternity care professionals		Mean difference	Std. error	*P* value	95% Confidence Interval	
						Lower bound	Upper bound
Perceived reality SDM	Community midwife	Hospital midwife	10.88	.83	<.001	8.9	12.86
		Obstetrician	8.8	.62	<.001	7.32	10.28
	Hospital midwife	Community midwife	−10.88	.83	<.001	−12.86	−8.90
		Obstetrician	−2.08	.85	.043	−4.11	.05
	Obstetrician	Community midwife	−8.8	.62	<.001	−10.28	−7.32
		Hospital midwife	2.08	.85	.043	−05	4.11
Observed importance SDM	Community midwife	Hospital midwife	1.97	.47	<.001	.85	3.08
		Obstetrician	2.2	.35	<.001	1.37	3.03
	Hospital midwife	Community midwife	−1.97	.47	<.001	−3.08	−.85
		Obstetrician	.23	.48	1.0	−.92	1.37
	Obstetrician	Community midwife	−2.2	.35	<.001	−3.03	−1.37
		Hospital midwife	−.23	.48	1.0	−1.37	.92

primary care professional and the hospital midwife and obstetrician working in secondary/tertiary care. These settings are organized differently, shaping different professional cultures and visions that affect SDM (Waddell et al., 2021). The findings suggest being setting-dependent (Elwyn et al., 2010) likely due to paradigm disparity, such as medical versus biopsychological characteristics or obstetric-led versus midwife-led care (Fontein-Kuipers et al., 2019; Schulz & Wirtz, 2022). The study did not collect characteristics of the maternity care providers, so it is unclear whether the commitment to a certain model, ideology, or hospital policies affected SDM and, in turn, the sample's perceived reality scores (Fontein-Kuipers et al., 2019; Van Kelst et al., 2013; Villarmea & Kelly, 2020; Waddell et al., 2021).

Studies indicate that the inclusion of choice in maternity services and healthcare legislation encourages public acknowledgment of SDM and changes women's expectations about decision-making (Borrelli, 2014). The sample characteristics and reported birth outcomes and the self-reported subjective importance of SDM suggest that the participants had an interest in decision-making, expected this, were less willing to accept routine procedures, such as choosing the community midwife as lead professional throughout the perinatal period, and preferred less medicalized births, such as home births. A very high percentage of our sample received continuity of care from the community midwife, and the participants in our study most often evaluated the community midwife—which does not reflect the current organization of Belgian maternity services or perinatal outcomes (DeVlieger et al., 2021; Goemaes et al., 2020; Helsloot & Walraevens, 2015). It is known that continuity of care from community midwives strengthens SDM (Hildingsson et al., 2021; Koster et al., 2020), and it is therefore likely that the community midwife's prominent role in postpartum care might have contributed to the high postpartum SDM scores. All these aspects may have contributed to a higher awareness of the benefits of SDM and the midwife's role as a gatekeeper of normalcy (Borrelli, 2014; Christiaens et al., 2008, 2010; Fontein-Kuipers et al., 2019; Thompson & Miller, 2014; Van Kelst et al., 2013)—potentially positively enhancing women's perinatal experiences (Ellberg et al., 2010; WHO, 2016). All these aspects might explain why participants' subjective importance of the community midwife's SDM was higher than that of other care professionals, indicating women's expectations of the midwife's role and advocacy for SDM. Our findings suggest that a unique group of maternity users responded to the study call, likely being promotors of community midwifery—benchmarking the community midwife's SDM during perinatal care (Kuipers et al., 2024). Because the community midwife received the highest scores, this care professional can catalyze enhancing the quality of SDM, to aid the promotion and optimization of shared decision-making, and to be a facilitator of a positive SDM culture in Flemish maternity services (Kuipers et al., 2024). Overall, our participants reported high SDM scores. The prevalence of SDM may be inflated based on previous research indicating women's liberal assessments of maternity care providers (Elwyn et al., 2005b; Kuipers et al.,

2024). However, using the multiple items OPTION scale may yield more objective results compared to subjective evaluations (Nicolai et al., 2012). The OPTION scale has no cut-off value to estimate optimal or suboptimal SDM. However, when using the effect sizes to interpret the clinical relevance of our findings, we can assume that the care provider plays a prominent role in SDM.

The present study has several limitations that warrant discussion. The generalizability of the findings may be impaired due to the sample characteristics: the non-completers differed from the completers, with the latter group having more experience with SDM, higher levels of education, more out-of-hospital births, and more spontaneous vaginal births compared to national data (DeVlieger et al., 2021; Statistics Flanders, 2022; Statbel, 2022; Steunpunt Werk, 2022). Such selection bias limits the generalizability of the findings. Although the findings of the study provide a basis for further reflection on SDM in maternity care in Flanders, the likelihood of response bias due to self-selection should be considered. Additionally, the validity of the findings relies on the accuracy of women's recall of perceptions of decision-making processes. More than half of the participants scored SDM of more than one care provider, indicating their ability to compare the quality of SDM provided. Despite weak correlations between previous SDM experiences and current perceptions, participants were able to draw from past experiences and current experiences to report on the perceived reality of SDM during perinatal care. Additionally, although the cohort 2 data showed no data dependency, we nonetheless recommend considering recall bias when interpreting our findings. It is known that (dis)satisfaction with intrapartum experiences, care, and care professionals affect the overall perceived reality of SDM (Waddell et al., 2021), which could have influenced our findings. By including the first 6 weeks postpartum as an exclusion criterium, we attempted to reduce emotional biases (Schulz & Wirtz, 2022; Waldenström, 2004). The participants may have reflected on a single moment with a specific individual clinician or on the totality of clinical encounters, including more than one individual care professional, which could affect the interpretation of the findings. The OPTION-12 is commonly used as a scale to observe practitioners by researchers (Elwyn et al., 2005a,b; Nicolai et al., 2012) and not by service users as in our study. Moreover, the scale has not been validated for measuring the subjective importance of SDM. Although we might have used the scale in another way as it was designed, we perceive the experiential knowledge reported by the women in our study as authoritative and legitimate knowledge and therefore valid and reliable (Begley et al., 2019; Elwyn et al., 2010; Fersini et al., 2019; (Fontein)Kuipers & Mestdagh, 2022; Waddell et al., 2019). Given the expected involvement of the partner in many decisions and the congruence between perceived reality and subjective importance of intrapartum care (Thies-Lagergren & Johansson, 2019) and participants appointing family/partner to influence decision-making, it would be of interest for future research to evaluate how partners perceive SDM and to what extent they find this important. Lastly, we were unaware if decision aids were used during SDM, which could have affected the findings.

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CONCLUSIONS

This study showed various notable differences between perceived reality and subjective importance of SDM during perinatal care, among different maternity care professionals and between the perinatal periods regarding subjective importance of SDM. Women consistently assigned the highest OPTION scores to the community midwife, for both perceived reality and subjective importance SDM, followed by the obstetrician and the hospital-based midwife. The differences in OPTION scores suggest a dichotomy in shared decision-making between primary and secondary care settings, in how women experience and observe this and the importance they assign to it. Community-based midwives might be designated exemplars of SDM and might aid the promotion and optimization of shared decision-making in Flemish maternity services. Bearing in mind this study included a unique sample of Flemish maternity care users and notwithstanding the limitations that have been noted, this study provides new and valuable evidence of the current state of decision-making for current perinatal practice in Flanders, Belgium, as perceived by the participants in this study. Despite the high scores of the perceived reality of SDM, there is a need to optimize the SDM process during perinatal care in Flanders to respond to women's needs in terms of subjective importance. The results of this study may be useful at the micro-level in formulating or modifying local protocols and guidelines promoting SDM in maternity care services and in informing reflection on how to optimize the decision-making process in maternity services.

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