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A qualitative evaluation on the informed consent of women undergoing cesarean section

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Abstract

The concept of informed consent means that the patient voluntarily accepts medical intervention with his/her free will after being fully and adequately informed about the medical interventions to be performed. In the context of our thesis, which was completed at Ankara University, Institute of Social Sciences, Department of Women's Studies, Integrated PhD program, the main purpose of the study was to examine whether the informed consent of the woman was obtained within the framework of cesarean section practices, whether and how much the informed consent was obtained properly from a bioethical perspective. The issue was approached from the perspective of women. A qualitative study was conducted with the participation of 10 women who had undergone a cesarean section. The interviewees' reasons for preferring cesarean section, their relevant thoughts, the decision-making process, and their value discourses on informed consent in cesarean section were obtained through in-depth interviews using a prepared questionnaire. The questionnaire used in our study is a questionnaire with open-ended questions for semi-structured interviews that allow for the collection of deeper and contextualized information. The data obtained were evaluated by thematic analysis method. The value discourses that came to the fore in the interviews were categorized into context, main theme, and sub-themes. According to the findings of the study, it was observed that individual, social/environmental and physician factors played a role in the preference for cesarean section, and fear of vaginal delivery and pain was an important factor. In the context of opinions, it was found that the number of interviewees who evaluated cesarean delivery negatively was high. It was determined that there was no material shortage in obtaining information about cesarean delivery, but the fear of vaginal delivery hindered the desire to have that information. Regarding the decision on the mode of delivery, the interviewees agreed that this should be a joint decision of the physician and the woman. The method and scope of informed consent were examined, and it was found that informed consent was not duly applied ethically and that the scope of the information provided to women did not include all the elements that should be included in informed consent. As a result, it has been observed that the condition of information, which is a *sine qua non* to give consent autonomously, is not sufficiently provided.

Keywords: woman, childbirth, cesarean section, informed consent, bioethics

Introduction

The birth process is an important turning point in women's life course. Under the control and supervision of modern medicine, pregnancy and childbirth, which were previously a natural process, have been medicalized since the beginning of the 20th century (Prosen & Krajnc, 2013). It is stated that birth has moved away from the natural way of birth, the place where the birth takes place has been transformed into a hospital, the participants in the birth have changed from women and midwives to physicians and healthcare personnel, the techniques used have changed from natural processes to medication and surgery, and the meaning of birth has changed from a social and personal event to a medical event (Parry, 2008). In our study, cesarean section birth, which is a surgical operation, was discussed. Cesarean section is a surgical intervention that has been used very frequently both in our country and around the world in recent years.

According to John Hopkins Medicine, cesarean section, c-section, or cesarean birth is the surgical delivery of a baby through a cut made in the mother's abdomen and uterus. To put it more bluntly, cesarean section is defined as the delivery of the fetus, placenta and membranes through an incision in the abdominal and uterine walls when vaginal delivery is not possible due to various indications (Dempsey et al., 2017, pp. 37–43). Cesarean section is an operation performed to save the life of the pregnant woman and the baby in cases where vaginal delivery is impossible or dangerous, to reduce the risk of death of the pregnant woman and the baby, or

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to reduce the risk of a crippled birth; it has become a low risk operation to save the life of the fetus; it has become a procedure that will facilitate the lives of the pregnant woman, the baby and the physician. The widespread use of cesarean section has occurred in parallel with medical and technical innovations, such as the monitoring of fetal health, improved surgical techniques, the use of antibiotics, safe surgical and anesthesia methods. According to the World Health Organization (2015), the ideal cesarean section rate is around 10–15%. When we look at Turkey, we see that this rate is 57.3% (OECD, 2023). However, it is stated that a cesarean section rate above 10% has no effect on maternal and infant mortality rates. The Turkey Demographic and Health Survey (TDHS) conducted in 2018 revealed that 38% of cesarean section decisions were made before the onset of labor pains and 14% after the onset of labor pains. This can be interpreted as an indication that cesarean sections are not performed based on indications or out of necessity (Hacettepe University Institute of Population Studies, 2018, pp. 115–116).

Bioethics and cesarean section

In this study, we aim to reveal whether women's informed consent is duly obtained in cesarean section practices in Turkey and to present a bioethical evaluation. The concept of bioethics is defined as the investigation of ethical issues arising in the fields of biology, medicine, health services, and genetics by applying the methods and principles of moral philosophy (Harris, 2001, pp. 1–4). In the book *Principles of Biomedical Ethics*, published by Beauchamp and Childress, the four basic principles of bioethics are respect for autonomy, beneficence, nonmaleficence, and justice. The principle of respect for autonomy is based on two conditions. These are the right of other individuals to respect the autonomous actions of the individual and the individual's right to expect this respect (Beauchamp & Childress, 1989, pp. 67–80; Faden & Beauchamp, 1986, pp. 241–262; Silva, 1990, pp. 40–51; Beauchamp, 1991, pp. 160–162, 180–182).

From an ethical point of view, the balance of benefits and harms for the mother and the baby after cesarean section, whether the pregnant woman's autonomy in decision-making is respected, and the application of the principle of justice emerge as factors to be considered. Informed consent, which is related to these four basic principles within the framework of bioethics, is defined as the patient's voluntary acceptance of the medical intervention with his/her free will after the patient is fully and sufficiently informed about the intervention to be performed, the benefits, harms, and risks of the intervention, and the benefits, harms, and risks of alternative intervention methods (Jonsen, 1998, pp. 3–33). As stated by Kaba and Sooriakumaran (2007), the purpose of informed consent is not only to give information to the other person, but also to achieve the desired result, that is, to enlighten that person.

When we evaluate the cesarean section phenomenon in terms of cesarean section, it is possible to say that women having information in the decision-making process about cesarean section, in other words, being enlightened is effective, and when the literature and research on this subject are examined, it is possible to say that there are problems in informed consent practices regarding cesarean section practices in Turkey. In this context, the questions we investigated in our study include what affects women's birth preference, their thoughts about cesarean section, sources of information about cesarean section, the compatibility of the intervention in the birth decision with patient and human rights, cesarean section practices in Turkey in terms of bioethics, whether elective cesarean section can be recommended despite the risk of complications, the method of application of informed consent in cesarean section, the effect of enlightenment on the birth process, the scope of enlightenment and the inclusion of the components of informed consent.

Materials and method

The study aimed to reveal the perspectives and experiences of women. The qualitative research method was used to present the views of the interviewees directly to the reader as much as possible, to accept subjectivity, emotionality, and sincerity as a principle, and to validate women's feelings and behaviors in contrast to traditional research.

On April 30, 2021, an application was made to Ankara University Ethics Committee within the scope of Non-Clinical Research on Humans. On July 5, 2021 the Ethics Committee decided that the implementation of the study was ethically appropriate. Data were collected through in-depth interviews. Snowball sampling was used, and an interview group of 10 people was formed among women between the ages of 18–45 who had given birth by cesarean section. The interviews were conducted between December 2, 2021 and March 18, 2022, three of them face-to-face and seven of them online. The limitation of the study is that there were no questions regarding the socio-demographic information of the participants in the interview questions. Therefore, the relationship between women's socio-demographic characteristics and their views on informed consent was not included in the study.

Another limitation is that since the subject of the study is the informed consent of women in cesarean section applications, a sample consisting of women who have given birth by cesarean section is included in the study. For this reason, women who gave birth vaginally were not included in the sample group, so the study does not include the views of women who had given birth vaginally about informed consent in the birth process. It should be taken into consideration that the results of the study are not generalizable and no generalizable information was produced.

After the interview, the records were analyzed and an interview code was created for each interviewee to protect their personal data. Codes were created for the interviewees, and the first letter of the word cesarean section, the last two digits of the year of the interview and the order of the interview were used to create the codes. Interview codes were used when referring to the interviewees in the following stages of the study. The interviewees were asked 8 open-ended questions. The interview questions aimed to investigate whether informed consent was duly obtained in cesarean section procedures. In the data obtained after the transcripts, the responses of the interviewees were examined one by one, and all the data obtained in an interview were classified and organized for the next stage.

Thematic analysis was used to analyze the data, codes were created, themes were identified, themes were defined and named after being checked, and the reporting phase began. The answers given by all interviewees were brought together for each question. While answering a question in the interview, it was checked whether it also included the answer of one of the other questions or intersected with another answer. Tables were prepared to make the data more understandable.

Findings and Discussion

The findings are presented in tables and detailed with explanations below.

In Table 1, when the interview results are analyzed, it is seen that the answers to question one (What are your thoughts about cesarean delivery?) and question four (What are your reasons for preferring cesarean delivery?) intersect. The context of the analysis was determined as 'cesarean section' and the 'reason for preference' was determined as the main theme. Sub-themes emerged as 'individual', 'social/environmental' and 'physician's guidance'. When the sub-themes are detailed, 'fear of childbirth, fear of pain', thinking that cesarean delivery is 'comfortable', 'anxiety about loss of sexual function' due to vaginal delivery, 'lack of information' about cesarean/vaginal delivery, and thinking that 'the risk of complications is less in cesarean delivery' were emphasized as individual preference reasons.

Table 1. Interviewees' reasons for preferring cesarean section.

Context	***Themes***	
	Main theme	***Sub-themes***
Cesarean section	Reason for preference	*Individual* Fear of childbirth/pain Comfortable Anxiety about loss of sexual function Lack of information The risk of complications is thought to be low *Social/Environmental* Sharing negative experiences with vaginal birth *Physician's guidance* Indication

Under the social/environmental sub-theme, 'sharing negative experiences about vaginal birth' was emphasized. 'Indication' was emphasized under the sub-theme of physician's guidance. Our analysis revealed that the most emphasized factor among the reasons for individual preference for cesarean delivery was fear of childbirth. Three (3) of the interviewees stated that they wanted to have a cesarean section due to fear of childbirth. In addition, these three (3) interviewees stated that they did not have enough information about vaginal delivery. A qualitative study conducted on a sample of 12 health professionals (seven obstetricians, three midwives and two neonatologists) working in different hospitals in Sweden, it was emphasized that a large proportion of women requesting cesarean section experience fear of childbirth (Fredriksson et al., 2024, pp. 5–7). Fear of childbirth has been a very common problem in recent years, which can occur in all women who have never given birth, will give birth for the first time, or have given birth before, affecting the woman and her family during pregnancy, birth and postpartum periods and causing various health problems (Dencker et al., 2019, pp. 99–111). According to a meta-analysis including 29 studies from 18 countries worldwide, it was revealed that approximately 14% of pregnant women experience fear of childbirth (O'Connell et al., 2017, pp. 907–920). In our study, as the analysis of the responses revealed, the fear of labor/pain was related to the pregnant woman's lack of knowledge about childbirth, and that the reason for preference was related to social/environmental factors and physician guidance. As emerged from the analysis of responses, both personal and environmental stories of risky pregnancies and feedback on adverse birth experiences may lead to a preference for cesarean delivery. The interviewee with protocol number C.22.5 stated in her discourse that she was severely affected by the negative birth experience of her mother's close relatives, and these negative experiences of vaginal delivery caused traumatic fear of childbirth in the interviewee. Another result of our study was that all of the interviewees were directed to cesarean section by the physician due to indications. Two (2) of the interviewees were referred for cesarean section by the physician due to a large baby, two due to preterm labor, two due to low water, two due to the baby being breech, one due to contractions not starting, and one due to lack of oxygen supply to the baby's brain. Therefore, for the interviewees, cesarean section was not a choice, but a necessity.

Table 2. Interviewees' opinions about cesarean section.

Context	***Themes***	
	Main theme	***Sub-Themes***
Cesarean section	Opinions	*Positive* Comfortable and healthy Same as vaginal delivery *Negative* Regret Long recovery period Scary Vaginal birth is more valuable Social pressure related to motherhood *Other* Should not be optional The physician factor is important Information is a comforting factor

In Table 2, which was created in connection with questions one and four, positive, negative and other sub-themes were determined in relation to the main theme of thoughts within the framework of the responses given by the interviewees. When the interview results are analyzed, comments such as 'comfortable and healthy', 'same as vaginal birth' are given under the positive sub-theme; comments such as 'regret', 'recovery process is long', 'scary', 'vaginal birth is more valuable', 'social pressure related to motherhood' are given under the negative sub-theme. Under the other sub-theme, statements such as it 'should not be optional', 'the physician factor is important', and 'information is a comforting factor' were listed. According to the analysis result, it is noteworthy that the number of interviewees who emphasized the negative aspects of cesarean section was higher. There were two (2) interviewees who expressed a positive opinion on cesarean section. As emerged from the analysis of responses, most of the interviewees found vaginal delivery more valuable than cesarean section. The interviewees who stated that they were disappointed because they had a cesarean section stated that they wanted to experience the natural way of birth. Moreover, the results of the analysis show that eight of the interviewees supported the idea of vaginal birth after cesarean section (VBAC) and that they would like to have their second birth vaginally if they did not encounter any medical problems. In the United States, about 90% of pregnant women who had a previous cesarean section had another cesarean section. In a sample of 3006 women in Pennsylvania who gave birth for the first time between 2009 and 2011, 45% of these women wanted to VBAC for the next time. The determinants for women who wanted VBAC were found to be the absence of recurrent indications, planning for three or more children, wanting to experience vaginal birth, and difficulty recovering from the first cesarean section. The most common reason for preferring cesarean delivery was that the first delivery was by cesarean section (Attanasio et al., 2019).

On the other hand, as emerged from the analysis of responses, cesarean section causes social pressure on women due to the belief that they cannot be good mothers. Interviewees stated that the negativities experienced with the newborn were attributed to cesarean delivery, especially by their families.

As emerged from the analysis of responses, the role of the physician in the birth process is very important. In a meta-analysis, in which six databases (PubMed, Web of science Core Collection, Cochrance Network, Embase, CINAHL, PsycINFO) were searched from their inception until May 2023 and 1675 references were reviewed to investigate the form and effectiveness of shared decision-making regarding the mode of delivery after cesarean section, shared decision-making was found to alleviate decision-making conflicts regarding the mode of delivery after cesarean section and to be an effective intervention to improve the quality of decision-making (Yu et al., 2024).

Also, according to the results obtained from the answers given, cesarean section should not be performed unless there is a medical indication and that this type of delivery should not be done by choice. This shows that the interviewees do not have a positive attitude towards elective cesarean section. An elective cesarean section is defined as cesarean delivery at a time determined by the preference of the expectant mother after the baby has completed its normal gestation without any medical necessity (Thulman et al., 1990). In the case of cesarean section, autonomy is limited in direct proportion to protecting the health of both the mother and the newborn. In this context, if there are no maternal or fetal indications, scheduled vaginal delivery should be recommended as the appropriate and safe method. If a cesarean section is preferred after comprehensive clarification about the risks and benefits, the surgical intervention in question should be performed after the 39th gestational week (Dosedla et al., 2024, pp. 30–31).

Table 3. Interviewees' sources of information about cesarean delivery and factors affecting their knowledge acquisition.

Context	***Themes***	
	Main theme	***Sub-themes***
Knowledge acquisition	Information source	*Internet* *Written/visual material* Magazine Book Video *Social environment* *Physician* *Other health personnel* Midwife Anesthesiologist Nurse
	Factors affecting the process	Not wanting to be informed due to fear of childbirth

In Table 3, in relation to the answers given to question two (What is the source of your information about cesarean section?), the sub-themes of 'internet', 'written/visual material', 'social environment', 'physician', 'other health personnel' were formed in relation to the main theme of information source. As emerged from the analysis of responses, most of the interviewees benefited from information about cesarean section on the internet. Regarding the main theme of 'factors affecting the process', the sub-themes of 'not wanting to have information due to fear of childbirth' and consent were formed. According to our analysis of the interview results, some interviewees did not want to learn about childbirth by their own

volition. It was revealed that the reason why the interviewees did not want to be informed was that they did not want to increase their fear of childbirth. It was revealed that fear of childbirth prevents having information about childbirth, but paradoxically, not having information also causes fear of childbirth. The process of obtaining information does not include information about the delivery by physicians and other health personnel. None of the interviewees in our study stated that they gave up their right to be informed before cesarean section. In the qualitative study conducted in Sweden, it was stated that fear of childbirth is not an autonomy problem. It was emphasized that it is important to understand why a pregnant woman experiences fear of childbirth, especially if she is pregnant for the first time, and to help her (Fredriksson et al., 2024, p. 7).

Table 4. The decision-maker on the mode of delivery and the circumstances affecting the decision-maker.

Context	***Themes***	
	Main theme	***Sub-themes***
Mode of delivery	Decision-maker	In partnership with physician and pregnant woman Physician with pregnant consent Physician Medical conditions
	Conditions affecting the decision-maker	Traumatic fear of childbirth Indication

Table 4 is based on the responses to question two (Who should decide on the mode of delivery in your opinion?). The context in which the views of the interviewees were sought was determined as the 'mode of delivery', and 'the decision-maker' and 'the conditions affecting the decision-maker' were put forward as the main themes. In the context of mode of delivery, the sub-themes of physician and pregnant woman in relation to the main theme of decision-maker, physician with the consent of the pregnant woman, physician and medical conditions, and sub-themes of fear of traumatic birth and indication in relation to the main theme of conditions affecting the decision-maker were formed. As it emerges from the analysis of the responses, almost all interviewees said that the physician and the pregnant woman should make a joint decision. It was stated that in the absence of risk, the decision should be left to the woman to a great extent, and in case of risk, a joint decision should be taken. This discourse again brings to mind the practice of elective cesarean section. Elective cesarean sections are unethical except for indications (Figo, 2015, pp. 69–70). The bioethical debate on elective cesarean section suggests that the value of women's autonomy in birth decisions should be taken as a given, and that the decision-making process is not about whether women should be allowed to choose the mode of delivery. From a legal point of view, the right to determine the circumstances of childbirth as a part of private life in terms of Article 8 of the Convention on Human Rights includes the method of childbirth chosen by the woman (Dosedla et al., 2024, pp. 28–29). On the other hand, in the qualitative study conducted in Sweden, which we have mentioned before, it was stated that the medical decision-making process should involve both professionals and patients, that patients should be fully informed about treatment, its benefits and harms, alternative treatment methods, care options, and that the decision-making process

is collective as well as individual; that is, multifaceted. However, it was emphasized that the responsibility for decision-making lies with professionals. (Fredriksson et al., 2024, pp. 10–12).

Table 5. Informed consent method and health personnel providing information to interviewees.

Context	***Themes***	
	Main theme	***Sub-themes***
Informed consent	Method	Only verbal consent Only written consent Both verbal and written consent Neither verbal nor written consent
	Health personnel	Physician Anesthesiologist Assistant Nurse Midwife

In Table 5, question five (Were you informed by the physician about the procedure to be performed before the cesarean section?), question six (Were you informed about possible situations or complications that may be encountered after cesarean section? If you were informed by the physician, what kind of procedure was followed by the physician?), question seven (If you were informed by the physician, what kind of procedure was followed by the physician?) and question eight (Did you think that the information provided to you included all the positive or negative effects of the procedure and was sufficiently explanatory for you? In addition, Table 6, Table 7, Table 8 and Table 9 were prepared based on the answers given to these questions. In this framework, an attempt was made to reach the opinions of the interviewees on whether they were informed about cesarean delivery, if they were informed, what kind of method was followed and whether the informing was done properly, and which health personnel informed the pregnant woman. According to the analysis of the responses given by the interviewees when researching the method of implementation of informed consent in cesarean delivery, as we can see in Table 5, 'informed consent' was determined as the context. 'Method' was identified as the main theme, and sub-themes emerged as 'only verbal consent', 'only written consent', 'both verbal and written consent' and 'neither verbal nor written consent'. In relation to the main theme of 'method', and sub-themes of 'physician', 'anesthesiologist', 'assistant', 'nurse' and 'midwife' were formed in relation to the main theme of 'healthcare personnel'.

Sub-themes that emerged according to the analysis of the interview results in Table 5 are detailed in Table 6. In Table 6 and Table 7, information provided is indicated with (1) and lack of information is indicated with (0). Boxes marked with (–) indicate that the interviewee did not make any comments on that issue. As seen in Table 6, no interviewee stated that they were only verbally informed. One (1) (interviewee with protocol number C.22.10) interviewee was only informed in writing. There were five (5) interviewees (interviewees with protocol numbers C.22.5, C.22.6, C.22.7, C.22.8, C.22.9) for whom both written and verbal informed consent was obtained. As emerged from the analysis of responses, four (4) interviewees (interviewees with protocol numbers C.21.1, C.21.2, C.21.3, C.21.4) specified that neither verbal nor written consent was obtained. It should be noted that two (2) interviewees in our study (interviewees with protocol numbers C.21.1. and C.21.4.) were not in a sufficient condition to give consent

Table 6. Procedure for the implementation of informed consent in the context of cesarean delivery by interviewees.

Interviewees	***Only verbal***	***Only written***	***Both verbal and written***	***Neither verbal nor written***	***Procedure for the implementation of informed consent***
C.21.1	0	0	0	1	
C.21.2	0	0	0	1	
C.21.3	0	0	0	1	
C.21.4	0	0	0	1	
C.22.5	0	0	1	0	
C.22.6	0	0	1	0	
C.22.7	0	0	1	0	
C.22.8	0	0	1	0	
C.22.9	0	0	1	0	
C.22.10	0	1	0	0	
Total	***0***	***1***	***5***	***4***	

due to emergency cesarean section. From an ethical and legal perspective, the physician's disposal of the patient requires the patient's consent and participation. The physician's responsibility is to enlighten the patient. Medical practices performed without informed consent are considered unlawful. In the event of there being a state of necessity in medical practice and the patient cannot perceive or evaluate it, it is accepted that consent exists due to the value given to the right of personality. Medical situations requiring urgent intervention may eliminate the physician's obligation to inform. The situation taken into consideration here is the benefit to be provided by the patient and the fact that the patient's life will be endangered if medical intervention is not performed.

However, in our study, it was revealed that two interviewees (interviewees with protocol numbers C.21.2, C.21.3) were not informed verbally or in writing, although their situations were not emergencies. Consent of the patient is essential in medical interventions. If the patient can declare his/her consent, it is an ethical and legal obligation to comply with this. Even if the patient does not want to be informed, the physician should evaluate this situation and question whether the patient has a valid reason. Obtaining informed consent is, therefore, a fundamental requirement for respecting the autonomy of individuals and ensuring their informed participation in the treatment to be applied. According to the results obtained from the analysis of the interviews, none of the interviewees waived their right to informed consent. The fact that

neither verbal nor written informed consent was obtained from two interviewees despite meeting the qualification requirements shows that ethical standards were not adhered to and that there was an ethical violation. Within the framework of the autonomy of the person, it is the patient's decision, not the physician's, whether to inform or not. It is of great ethical importance that the patient is informed verbally, understands the information, and gives written informed consent autonomously.

Except for the interviewee with protocol number C.22.8, it was learned from the statements of the interviewees who mentioned that both written and verbal procedures were followed regarding consent that they were not informed in detail about the operation, the forms they signed were not sufficiently explanatory about the principles of application, and they did not remember any information written on the form.

Table 7. Information about possible situations before and after cesarean section on the basis of interviewees.

Interviewees	***Anesthesia***	***Labor induction***	***Risks related to cesarean section***	***Risks after cesarean section***	***Wound/cut care***	***Information against possible situations before and after cesarean section***
C.21.1	0	0	0	0	1	
C.21.2	0	0	0	0	0	
C.21.3	0	–	0	0	–	
C.21.4	–	0	0	0	1	
C.22.5	1	−	0	0	−	
C.22.6	–	−	0	0	−	
C.22.7	1	−	–	–	1	
C.22.8	1	−	1	1	1	
C.22.9	–	−	1	1	1	
C.22.10	0	−	0	0	0	
Total	***3***	***0***	***2***	***2***	***5***	

The scope of the information to be provided in clarification should include diagnosis, treatment, treatment alternatives, the chances of success and duration of treatment, side effects and consequences of treatment, dangers if any, and the consequences that may be encountered in the absence of treatment, and the physician should explain this information in a way that the patient can understand. The findings that emerged from the responses received during the interviews are presented in Table 7. When we look at the scope of the information provided about cesarean section, four interviewees stated that they were not informed about anesthesia,

while three (3) interviewees did not express an opinion on this issue. Moreover, seven (7) interviewees were not informed about the risks of cesarean section and the risks that may be encountered after cesarean section, the number of interviewees who did not express an opinion on both issues was 1. Two (2) interviewees stated that they were not informed about wound/cut care, while three (3) interviewees did not express any opinion on this issue.

Informed consent is considered a shared decision that is the result of a surgeon-patient partnership in surgical practice (Dosedla et al., 2024, p. 20). Informed consent should also include the patient's voluntary decision after the content of the medical intervention is conveyed to the patient in all details, providing the patient with sufficient time to make a decision, and giving the patient the opportunity to ask questions in order to eliminate all doubts in his/her mind during the decision-making process. The condition for the patient's consent to the intervention is to be informed and to be able to comprehend the issues they have been informed about. The important point here is that the patient is free to decide whether to accept or reject the proposed treatment or intervention. In order for the patient to understand and comprehend the information provided, it is recommended that the physician simplify the information depending on the patient's capacity to understand, use simple terms, repeat the information clearly, if necessary, and evaluate whether the patient understands it. In addition to these, enlightenment should be done at a level where the patient can make a healthy decision, unnecessary details should be avoided in order not to cause the patient to think in different ways and not to negatively affect the treatment process. If there are issues that the patient does not understand, the physician should make repetitions, allow the patient to ask questions and try to answer their questions.

Regarding the fifth, sixth, seventh, and eighth questions related to informed consent where the answers of the interviewees intersected, the implementation of the basic components of informed consent in the context of cesarean section and the inclusion of the scope of information were investigated. In Table 8, the inclusion of the items related to the basic components of informed consent and the scope of information within the scope of the interviewees' discourses is indicated with a (+) sign and omission is indicated with a (–) sign.
In order to explore whether informed consent was duly obtained in terms of bioethics and the place of the bioethical approach in these practices, it was analyzed which bioethical principles the interviewees defined in accordance with the scope of the process. The principles in question are Article 4, Article 5, Article 6 of the Universal Declaration on Bioethics and Human Rights (2005), within the framework of informed consent. As emerged from the analysis of responses, for most of the interviewees, the condition of information, which is a condition for giving consent autonomously, was not met. Within the framework of the answers given to the four questions related to informed consent; it was revealed that the interviewees were aware of the necessity of obtaining informed consent. On the other hand, according to the analysis of the responses, informed consent is based on respect for individual autonomy and personal rights. The analysis revealed that the physician did not play an adequate role in enlightenment, and that auxiliary health personnel were mostly assigned to have patients sign the consent document. From the analysis of the responses we obtained, patients did not have the opportunity to ask questions about medical intervention or consent and did not have enough time to read and understand the consent form. Furthermore, analysis of the responses also revealed that uninformed interviewees were quantitatively more than informed interviewees.

Within the framework of the basic components of informed consent, six (6) interviewees stated that the information was not disclosed to them, four (4) interviewees stated that they were informed, and information was understood by four (4) informed interviewees. Six (6) interviewees gave consent without information. Four (4) interviewees were informed about the risks of surgical procedures, two (2) interviewees about alternatives, two (2) interviewees about the consequences if the treatment is not accepted, two (2) interviewees about consent to

Table 8. Implementation of the basic components of informed consent in the context of cesarean section and inclusion of the scope of information

Basic components of informed consent	***Status of implementation***									
	C.21.1	***C.21.2***	***C.21.3***	***C.21.4***	***C.22.5***	***C.22.6***	***C.22.7***	***C.22.8***	***C.22.9***	***C.22.10***
Disclosure of information to the patient	–	–	–	–	–	+	+	+	+	–
Understanding of the information by the patient	–	–	–	–	–	+	+	+	+	–
Voluntary consent	–	+	+	–	+	+	+	+	+	+
Patient's competence to give consent	–	+	+	–	+	+	+	+	+	+
Scope of information	***Inclusion Status***									
	C.21.1	***C.21.2***	***C.21.3***	***C.21.4***	***C.22.5***	***C.22.6***	***C.22.7***	***C.22.8***	***C.22.9***	***C.22.10***
Diagnosis and treatment	–	–	–	–	–	+	+	+	+	–
Risks of surgical procedures	–	–	–	–	–	+	+	+	+	–
Alternative treatment methods	–	–	–	–	–	–	–	+	+	–
Consequences if treatment is refused	–	–	–	–	–	–	–	+	+	–
Approval to treat unforeseen conditions	–	–	–	–	–	–	–	+	+	–
Anesthesia	–	–	–	–	+	–	+	+	–	–

treatment of unforeseen conditions, three (3) interviewees about anesthesia. Five (5) interviewees (interviewees with protocol numbers C.21.1., C.21.2., C.21.3., C.21.4. and C.22.10) were not informed about any subject that should be included in the scope of disclosure. Informed consent, which is a legal requirement, is crucial in providing patient-centered care. Informed consent should include discussion of the risks and alternatives of the procedure and should be given voluntarily by a competent person. A study of 88 women who underwent planned cesarean section and 62 women who underwent unplanned cesarean section in a tertiary care obstetrics center in downtown Toronto, Canada, showed higher patient satisfaction with the decision to have an elective cesarean section compared to an emergency (Levy et al., 2022, pp. 785–790).

As it emerges from the analysis of the responses given, for only one (1) interviewee (interviewee with protocol number C.22.8.), informed consent was duly obtained for cesarean

section. When we look at the analysis of the data, it is seen that the factors that positively affect women's perception of birth are the care received by the pregnant woman, being informed about the practices, being informed about the options, participating in decisions, and being able to exercise the right to choose autonomously. Decades of empirical research have shown that people undergoing treatment are unable to make a completely free decision about the treatment they will undergo because they do not receive all the necessary information and do not fully understand the information they receive (Resnik et al., 2021, p. 61). Based on the analysis of the responses, it was found that the most important factors affecting women's choice of delivery were enlightenment and correct application of ethical principles. Also, it was observed that the most important reason for women to prefer cesarean section was fear of labor/pain, and the reason for fear of labor/pain was that women were not sufficiently enlightened. Other factors that increase the preference for cesarean section are negative birth stories and women's sharing of body image.

Table 9. The effects of communication between health personnel and pregnant women.

Context	***Themes***	
	Main theme	***Sub-Themes***
Relationship between health personnel and pregnant women within the framework of informed consent	Communication	*I received satisfactory information* Relaxing Positive effect on the birth process It inspires confidence *I did not receive satisfactory information*

The data obtained in the interviews regarding the context of the 'health personnel/pregnancy relationship within the framework of informed consent' are presented in Table 9. In relation to the main theme of 'communication', the sub-themes of 'I received satisfactory information' and 'I did not receive satisfactory information' were formed. As emerged from the analysis of responses, the number of interviewees who did not receive satisfactory information as a result of their communication with health personnel in the context of informed consent was higher than the number of interviewees who receieved satisfactory information. Only two (2) interviewees (interviewees with protocol numbers C.22.5 and C.22.8) stated that the information given to them was comprehensive. Based on the analysis of the responses, it was found that informing pregnant women positively affected the birth process. Ring et al. stated that maintaining optimal communication between obstetricians, nurses, and anesthesiologists and ensuring that the mother's preferences were listened to were important to promote a safe and positive birth experience (Ring et al., 2021, p. 24). In addition to that, informing the pregnant women and supporting them during pregnancy and the delivery process was effective in reducing cesarean deliveries. Increasing rates of cesarean section reflect the conflict between women's right to self-determination and the medical profession's duty to prioritize the best interests of patients. However, physicians must balance respect for patient autonomy with their responsibility to make decisions based on their expertise and medical science. This also requires a balance between medical preference for vaginal delivery when clinically appropriate (Dosedla et al., 2024, pp. 26–27).

Conclusion

When we look at the results of the research; it is seen that the discourses within the framework of medicalization and the increase in risk definitions lead women to cesarean delivery and that this is an extension of the social roles attributed to women, for example, the discourse of 'child

despite the mother' is still valid or causes the internalization of the role of motherhood by associating womanhood with reproduction and affects women's experiences in terms of meaning load. In the context of informed consent, it was found that the scope of the information provided to women did not include all the elements that should be included in informed consent, there were problems in the ethical implementation of informed consent in Turkey, written consent was not obtained from most of the competent interviewees, and informed consent led to less need for medical intervention and a more positive birth experience.

When we look at the recommendations that emerged as a result of the research, the enlightenment to be made during the pregnancy process should have the quality to ensure that the physician and the woman are prepared for all possibilities that may be encountered. It is considered important to take into consideration that deciding on the mode of delivery is a woman's right within the framework of human rights and the principle of autonomy, to ensure that the information is appropriate for the personal, cultural, social, and psychological characteristics of the woman, and to direct women to vaginal delivery after cesarean section in appropriate cases. Within the legal system in Turkey, the regulation and implementation of the Regulation on Informed Consent should be accepted as a principle. Thus, informed consent practices will be placed on a legal basis. In addition, the mentioned regulation should be made mandatory in order to protect patient autonomy and improve the ethical standards of medical practices by ensuring the consistent implementation and execution of informed consent practices.

It would be beneficial to determine an appropriate roadmap for verbal disclosure and to find alternative methods for specific situations. In order for the physician to be free and autonomous while practicing his/her profession/ decision making, it was seen that the issues of not being subjected to external factors such as coercion/solicitation/performance measurement and increasing bioethics education and making it more effective came to the forefront.

Authors' contributions

Both authors contributed equally to the design of the research. Both authors discussed, substantially revised, and approved the publication of the final text.

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No potential conflict of interest was reported by the author(s)

Data availability statement

This research did not generate empirical data.

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