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Portrayal of Shared Decision-Making in Lifetime Documentary Series 'One Born Every Minute'

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Abstract

Background: Pregnant women use childbirth reality programs to prepare themselves for childbirth. It is unknown how shared decision-making in intrapartum midwifery care is represented in televised birth. We aimed to explore the portrayal of shared decision-making during labour and birth in lifetime documentary series One born every minute.

Methods: We analysed a total of 41 labour and birth storylines, triangulating deductive and inductive content analysis methods. We described the participants' personal and birth details. We coded, quantified and organised woman-midwife dialogues and selected the shared-decision making data. Content analysis of shared decision-making fragments was organised following the three-steps of shared decision-making.

Results: A first investigation resulted in a classification of: 'building-a-relationship' and 'decision-making'. The decision-making fragments included 'unilateral decision-making' and 'shared decision-making'. 287 shared decision-making fragments were ordered in three themes: 1. *Choice talk:* Women presented their personal wishes, resonating their awareness of having intrapartum care options. More often, midwives introduced decision-making with implicit referral to the proposal of choices. 2. *Option talk:* Midwives predominantly provided detailed information of various options and the consequences of these options. 3. *Decision talk* mainly included the midwife's support of women's decisions for which consent was obtained, albeit it in a rather informal way. Choice talk and decision talk most often occurred, sometimes simultaneously. Listing women's options, exploring her preferences, wishes and values and deliberation of women's intrapartum choices were underexposed.

Conclusion: Shared decision-making is being portrayed as both woman and midwife-initiated. The midwives in this study did not always follow the linear stepwise model but tended to utilise a more fluid transition between choice, option and decision talk. Shared decision-making is facilitated by the relationship between the woman and the midwife during the intrapartum period, requiring evaluation and reflection. Birth partners should not be disregarded in intrapartum shared decision-making processes.

Introduction

Pregnant women frequently use media, such as the internet and television programs to obtain information about the childbirth process [1,2]. Seventy-nine % of pregnant women read blogs, watch YouTube and join forums - serving as sources of information about labour and birth. Sixty-eight % of pregnant women watch reality television programs that portray pregnancy and birth experiences of Western women [3,4]. Contemporary women use these media sources to prepare themselves for birth, creating images of the unknown [1,3] - as in current society it is rare for a woman to be present at a birth before she gives birth herself. Child birth reality television and the internet provide an opportunity to witness the reality of birth and to learn from other one's experiences [5]. The overall finding, however, is that the portrayal of childbirth in these programs does not align with reality and over represents medicalised childbirth [1,6,7]. Moreover, birthing women are often portrayed as being very vulnerable, showing socially desirable and submissive behaviour (e.g. being quiet, listening, being obedient) and are generally portrayed as being patronised (e.g. "you're a good girl") while fulfilling a passive and sometimes subordinate role when it comes to participation and self-management of care [6,8]. Attention for aspects such as women's autonomous choice, informed decision and informed consent are often lacking in childbirth reality programs [6-9].

In times with increased attention to shared decision-making for both childbearing women and midwives [10,11], it seems vital to know and to understand how shared decision-making aspects are being portrayed in childbirth reality programs, considering that women highly depend on these programs as their source of information and preparation for childbirth. Evidence shows that in televised birth, the portrayal of informed choice during labour and birth is absent [12] and the intrapartum decision-making processes are usually portrayed as being clinician-determined [13]. Despite the portrayal of interpersonal midwifery practice in childbirth reality television [9,12,14], a knowledge gap exists as to how the recognised individual steps of shared decision-making in intrapartum midwifery services are being portrayed: Introducing a decision (*choice talk*), discussing options (*option talk*), discussing preferences and weighing options before making a final decision

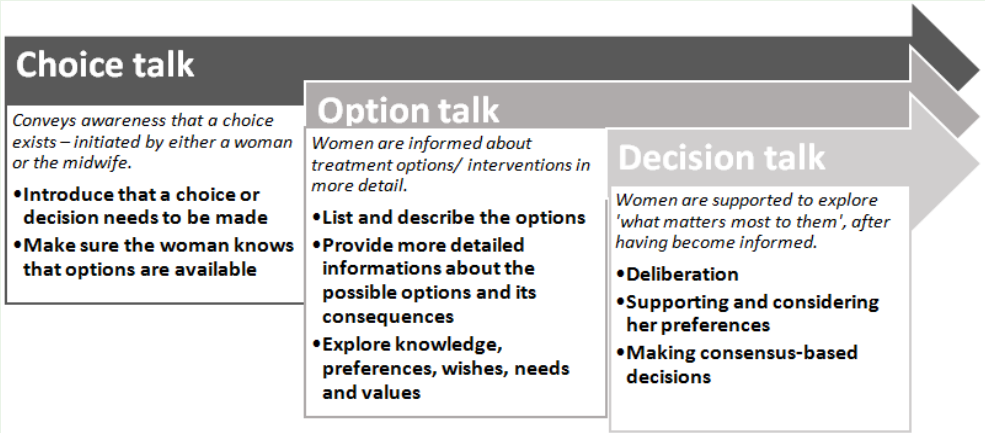

Figure 1. Elwyn's shared-decision making model [15].

(*decision talk*)-steps according to Elwyn's shared-decision making model [15], which is presented in (Figure 1). In this model, the woman and the midwife are regarded as the participants in the decision-making process [15].

One born every minute

One born every minute, a lifetime documentary series (reality television genre), was first aired in 2010. The series documents the drama and emotion of a maternity unit from the perspective of the parents-to-be and the maternity ward staff [16]. Per episode, the series attracts approximately 3285 female viewers in the United Kingdom, 577,000 female viewers between 19-49 years of age in the United States and 1000 to 2000 female viewers in the age group between 20 and 34 years in the Netherlands [17- 19]. These audience numbers highlight the potential impact of the series on (future) Western childbearing women's thoughts, ideas and expectations of birth and more specifically, on women's perceptions towards shared decision-making and their own decision-making role.

The research question posed for this study was: How is shared decision-making portrayed during labour and birth in lifetime documentary series *One born every minute*? Recognising that the series serves as the audience's frame of reference, we aimed to explore *what* occurs *in practice*.

Methods

Design

We performed a media analysis. We aspired to transform knowledge, leading to informed action or to advocating for an empowered role of women in maternity care services. We sought to broaden intrapartum shared-decision making research through an emancipatory lens as our study discussed reproductive consciousness and explored woman-midwife interaction, women's experiences and emotions with concern for potential power relations [20]. Our study orientated towards the production of knowledge in such a form and way that can be used for women, simultaneously aiming to facilitate the reflexivity of the midwifery profession [20]. We triangulated deductive and inductive content analysis methods. Inductive content analysis was chosen to analyse the manifest content to provide a means of describing the phenomenon [21]. The deductive method was chosen to retest the *One born every minute* series in a new context [12,13], being the three-step shared-decision making model [15].

Procedure *One born every minute* (United Kingdom)

Prior to filming, arrangements with maternity units were firmed up with a code of conduct, which included rigorous consent procedures for both families and staff involved in the production of the series. Women and their families were approached by the producers in the antenatal period. They were informed that to capture the stories, a number of 40 cameras were fixed to the walls of birth rooms, the corridors and the midwives' offices. The midwives, women and birth partners were asked to wear microphones. During the editing process, the producers put together footage they thought best told a particular story. Editorial decisions led to 15 minutes film per birth for each episode. All families and staff that had played a major role viewed the episodes before these were finalised and were invited to raise and discuss any concerns they had. Staff and relatives/ friends who did not want to be involved were either not filmed or were edited out. As a token of appreciation, the producers donated to charity funds that were chosen by the maternity staff involved in the filming [22].

Data collection

Our data included the three most recent seasons (2015 to 2017) out of the eight original British series available at the time of the study (February-May 2018). Based upon ease of availability of episodes

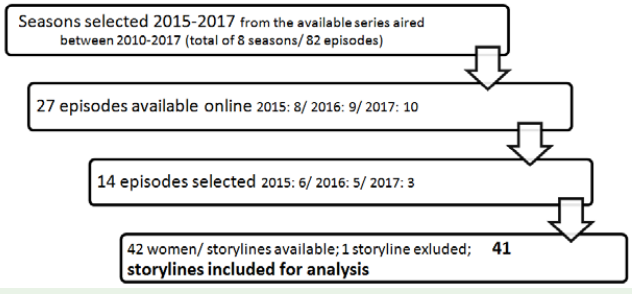

Figure 2: Selection episodes and storylines.

viewable online, we selected 14 episodes. Each episode included three storylines, i.e. stories of individual women. The 14 episodes featured labour and birth experiences of a total of 42 women. We included dialogues/ interaction between women and midwives. With our focus on the (verbal) dialogue, we excluded one storyline that featured the woman's inability to effectively communicate due to muteness, affecting utility for transcription. Figure 2 shows the selection of episodes and storylines. We excluded fragments that showed decision-making processes involving obstetricians/ registrars- because the focus of study was specifically on the interaction and dialogue between women and midwives. We also excluded fragments where midwives passed on the obstetrician's/ registrar's decisions. When music replaced the dialogue, these fragments were excluded for analysis. We made notes of visual recordings. Details of the childbearing women and their births, like for example parity or type of birth, were collected based on what was shown or told in the episodes by women, partners, family members or maternity staff.

Ethical considerations

The study design was approved by the Rotterdam University Research Centre of Innovations in Care.

Analysis

Two of the researchers independently watched the episodes several times to get a sense of the content as a whole, searching for fragments of woman-midwife interaction/ dialogue and decision-making, making notes of what was prominent. We transcribed all spoken text verbatim and added notes of visual recordings to the transcripts to aid the interpretation of the audio data. We used an unconstrained matrix (MS Excel) to code, quantify and organise the dialogues within the storylines, following the principles of inductive content analysis [21]. From the matrix we selected the data that fitted the categorisation frame: Elwyn's shared-decision making model [15], following a deductive method [21]. For the remaining data, we used a process of open coding (labelling), creating categories and abstraction, known as content analysis [21,23]. We collected the labels/ codes, clustered them in preliminary categories and then ordered similar categories into core themes according to Elwyn's [15] shared decision-making model (Figure 1) - a framework to answer the research question as adequate as possible [23]. We calculated the birth details using SPSS version 24.0. As a research group, we interpreted the findings, discussed findings and meaning throughout the process of data collection and analysis, reaching consensus on the content of the themes.

Results

Our findings included the storylines/ birth events of a total of 41, predominantly British (93%) women, who were in a (heterosexual) relationship (85%),with varying ages (16 to 42 years) and differences in parity (18/44% primiparous; 23/56% multiparous). The storylines included a total sample of 57 midwives. The woman's birth partner (i.e. labour companion) was either her partner (85%) and/ or her mother (39%) and/ or another relative/ close friend (20%). All women gave birth in a hospital setting but it was difficult to identify if it was a midwifery-led or an obstetric-led unit, although there was a very high visibility of midwives. Most of the women had a vaginal birth (27/41) in the semi-recumbent position (24/ 89 %), on all-fours (2/ 7%) or in lithotomy/ supine position (1/ 4%). Most women used Entonox as a method of pain relief and had continuous monitoring of the foetal heart rate. The birth details are presented in Table 1.

We observed the portrayal of midwives that put great effort in establishing rapport and in building a relationship with the women in their care. The midwives showed empathy and genuine interest in the individual woman, in her emotional and physical needs, and interest in the woman's significant other (e.g. partner, family members). We also observed two types of decision-making processes: one was characterised by unilateral decision-making, i.e. midwife-determined, including moments where midwives presented an authoritative decision to the woman, where midwives utilised a directive and controlling approach with a strong sense of compulsion, or midwives acting without unambiguous consent [13,24]. The other type of decision-making was characterised by a bilateral process with elements of reciprocity, sharing thoughts and ideas, an active liaison and dynamic verbal interaction between the woman and the midwife. The dialogues were classified in two main coding categories: 'building-a-relationship' (n=227); and 'decision-making' (n=435). The decision-making dialogues were either identified as 'unilateral decision-making' (n=145) or as 'shared decision-making' (n=287). For our analysis we chose the aspects from the data that fitted the categorisation frame: Elwyn's shared-decision making model [15]. The 287 shared decision-making findings were structured in three themes according to the model of Elwyn [15], reflecting a comprehensive understanding of the features of the phenomenon of shareddecision-making [25]. The themes included: Choice talk, Option talk and Decision talk. Quotes were added to illustrate the findings. The themes, categories and codes (coding tree) are presented in Table 2.

Theme 1: ChoiceTalk

Most dialogues portrayed introduction of choice with implied meaning of awareness and articulating or eliciting goals - introduced by women, partners or midwives, albeit predominantly the midwife. Some women were more assertive than others and midwives used different ways of questioning. The moment of decision-making was always imminent. Women often hold and articulated prior knowledge regarding their choice. Women introduced moments of choice by presenting personal wishes. The way women presented their needs, implied their awareness of having options. Jodie (participant 1) said: "I had an emergency section last time (…) which is why we opted for an elective this time". Nadine (participant 8) said: "It's in my birth plan (…) I actually have got a checklist up here (…) uhm so, I was prepared for the birthing (…) it is for you [midwife] to keep."Kathryn (participant 32) said: "I need to change [birthing position]". Some women voiced their choice more firmly, strongly referring to their awareness of having a choice. These choices predominantly concerned pain relief. Sarah (participant 23) said: "I need something else for the pain (…) the TENS® nonsense is not working". Alysha (participant 5) said: "We are going to do this [labour] without pain relief or what so ever." Birth partners sometimes put the woman's wishes forward. Carlotta's (participant 29) partner said: "We've had a lengthy discussion about all the painkillers (…) epidural is the most suitable one. We realised we've just got the paracetamol (…) with paracetamol she's still in pain, so… we're in the 21st century so there's a wide range of painkillers to choose from".

Table 1: Birth details (n = 41).

Episode	Participant	Type of birth	Parity	Gender baby	Foetal monitoring	Type of pain relief	Number of midwives	Additional details
8.1	1	Elective caesarean section	2	M	CTG	Spinal anaesthesia	1	Repeat caesarean section
	2	SVD	2	M	CTG	Entonox	1	
	3	Secondary caesarean section	1	M	CTG	Spinal anaesthesia; General anaesthesia	2	Epidural anaesthesia not effective
8.2	4	SVD	1	M	Doptone	Entonox	1	
	5	SVD	1	M	CTG		1	Preterm birth; Admission neonatal unit
	6	SVD	2	M	Doptone		1	Birth in birthing pool
8.4	7	Ventousebirth	1	F	CTG	Entonox	1	
	8	SVD	2	M	Doptone	Entonox	2	Adherence to birth plan. Use of fitness/yoga ball during contractions; Birth in birthing pool; Birth on all-fours.
	9	Elective caesarean section	4	F		Spinal anaesthesia; General anaesthesia	1	Epidural anaesthesia not effective
8.5	10	SVD	3	F	CTG	Entonox	1	Preterm birth at gestational age: 33+4; Entonox on request
	11	SVD	3	M	CTG	Entonox	1	
	12	SVD	3	F		Entonox	1	Entonox on request
8.6	13	SVD	1	M	CTG	Entonox	1	Teenager
	14	SVD	3	F	CTG	Entonox	2	
	15	SVD	2	M	CTG	Entonox	1	
8.7	16	SVD	1	M	CTG	Entonox	2	Chinese ethnicity
	17	SVD	3	F	CTG	Entonox	1	Birth in birthing pool; Entonox on request
	18	SVD	5	F	CTG	Entonox	1	
9.1	19	SVD	1	F	CTG	Entonox	2	
	20	Secondary caesarean section	1	F	CTG	Spinal anaesthesia	3	Failed induction, requests caesarean section on 3rd day of induction
	21	SVD	5	F	Doptone	Entonox	2	Birth on all-fours
9.2	22	Elective caesarean section	5	M	-	Spinal anaesthesia	1	
	23	SVD	3	M	CTG	TENS; Entonox	1	Preterm birth at gestational age 34+5; Admission neonatal unit
	24	SVD	3	M	CTG	Entonox	1	
9.3	25	SVD	2	F	CTG	Entonox	1	
	26	SVD	1	F	CTG	Entonox	1	Use of fitness/yoga ball during contractions; Entonox on request
	27	Elective caesarean section	4	F		Spinal anaesthesia	1	Polish ethnicity; Repeat caesarean section
9.5	28	SVD	1	F	Doptone	Entonox	1	Use of birthing pool during contractions
	29	SVD	1	F	CTG	Entonox	2	Spanish ethnicity; Wanted an epidural but birth was imminent so wasn't administered
	30	Elective caesarean section	3	F		Spinal anaesthesia	1	Repeat caesarean section
9.9	31	Elective caesarean section	3	F		Spinal anaesthesia	1	
	32	Secondary caesarean section	2	F	CTG	Entonox; Spinal anaesthesia	2	Prolonged labour

10. 7	33	Elective caesarean section	1	M		Spinal anaesthesia	1	Breech position
	34	SVD	1	F	CTG	Entonox	3	Mother has Chron's disease
	35	SVD	4	M	CTG	Entonox	2	
10.8	36	SVD	1	MM	CTG	Entonox	1	Twins; Entonox on request
	37	SVD	1	M	CTG	Entonox	1	
	38	Elective caesarean section	2	M		Spinal anaesthesia	1	Maternal request because of severe symphysis pubis dysfunction
10.1	39	SVD	1	M	CTG	Entonox; Epidural anaesthesia	1	Request for epidural anaesthesia; Prepared for ventouse birth in theatre but baby was born spontaneously; Episiotomy
	40	Secondary caesarean section	1	F	CTG	Spinal anaesthesia	3	Assisted conception (IVF)
	41	Emergency caesarean section	1	M	CTG	Spinal anaesthesia; General anaesthesia	2	History of 4 miscarriages; Use of fitness/yoga ball during contractions; Epidural anaesthesia; Persisting bradycardia; Epidural anaesthesia not effective
TOTAL		SVD 26/ 63.4% Ventouse birth 1/ 2.5% Elective caesarean section 8/ 19.5% Secondary caesarean section 6/ 14.6%	2.1 (±1.3; range 1-5) Primiparous18/ 44% Multiparous23/ 56%	F 20/ 48% M 22/ 52%	Doptone 5/ 12.2% CTG 3/ 73.2%	Entonox 38/ 93% TENS 1/ 2% Epidural anaesthesia 1/ 2% Spinal anaesthesia 13/ 32% General anaesthesia 3/ 7%	1.4 (0.6; range 1-3)	

SVD = Spontaneous Vaginal Delivery; M = Male; F = Female; CTG = Cardiotocography; Entonox = Medical nitrous oxide and oxygen mixture; TENS = Transcutaneous Electrical Nerve Stimulation; IVF – In Vitro Fertilisation

Table 2: Coding tree shared-decision making.

Theme	Categories	Codes (N=287)
Theme 1. Choice talk	Introduction of options/ choices by the woman or birth partner	35
	Introduction of options/ choices by the midwife	53
	The midwife assures the woman knows available options	26
Theme 2. Option talk	Midwife lists/ describes options	4
	Detailed information options and consequences	23
	Exploration knowledge, preferences, wishes, needs, values	14
Theme 3. Decision talk	Deliberation	7
	Supporting/ considering preferences	47
	Consensus-based decision	78

Compared to women, the midwife more often introduced the moment of choice, simultaneously assuring the intrapartum options. Choice was usually introduced as a closed-ended question, referring to a choice between 'yes' or 'no', albeit that sometimes questions hinted a positive answer. Holly's (participant 37) midwife asked: "I am going to be looking after you now, is that okay"? Sitara's (participant 2) midwife asked: "Do you want me to examine you"? Heidi's (participant 13) midwife introduced several choices and options, using open-ended and closed-ended questions: "If you need to take the gas and air, when I examine you that's absolutely fine. And if you want me to stop it at any time you tell me (…) Do you want the placenta to come out naturally? (…) Will you do a bit skin to skin? You want the baby on your tummy? And who is cutting the cord? (…) is mom cutting cord"?

Theme 2: Option Talk

All fragments related to women's physical intrapartum care needs and there was emphasis on description of the details of various options and the consequences of the options and less on listing options, comparing alternatives and exploring the woman's preferences, needs and values. Most often option talk contained one-way messages. Heidi's (participant 13) midwife described the options with/ without prophylactic Oxytocin: "Or else we can give you a little injection and the placenta will come out that way". Carlotta's (participant 29) midwife provided more detailed information and the consequences of epidural anaesthetics: "If you go for an epidural the anaesthesiologist will come and talk to you (…) the increased risks of having an instrumental (…) it doesn't always take all the pain away". Sarah (participant 17) received information about the consequences of using of Entonox in the birthing pool: "Because it makes you feel a bit drowsy, it won't be safe to stay in the pool". Carlotta's (participant 29) midwife explored her preferences and values about epidural anaesthesia: "Are you sure you want an epidural? What's making you to have an epidural"?

Theme 3: Decision Talk

Following on from choice and option talk, a decision was often made without further deliberation although some fragments showed that choices were more extensively explored or that the woman consulted her significant other. Women arrived at decisions that

reflected their informed preferences. Decisions were verified by the midwife. Women were often supported by the midwife in exploring what mattered to them, usually following on from choice talk. The dialogue between Joan (participant 20) and her midwife showed further consideration of Joan's options after three days of induction with prostaglandins after she was informed about the options for a mechanical induction or for a caesarean section. Joan: "I did two loads of that gel stuff but my cervix is still quite firm and closed and I don't think I can go through again just to be on the same point. Midwife: "There is still an option of mechanical induction, like a balloon catheter inside the cervix." (…) Joan: Uhm... I want the section."Jennifer's (participant 34) decision was verified: Well, Jill [other midwife] said that before you want your waters breaking, you want the epidural put in, right?"Although consensus-based decision-making was included in the fragments, none of them showed explicit formulation of consenting such as: "do you agree?" or "do you consent to this?" Choice talk often simultaneously included consent, but not necessarily informed consent because optimal option talk was often lacking. Consensus-based decision was predominantly worded as an informal "okay?". Samantha's (participant 6) midwife said: "Listen to your body (…) when it's telling you to push then often time is right. But only when you're ready then, *okay*?"Sarah's (participant 23) midwife asked more specifically: "Are you *okay* with that decision then?"Consent-related questions were predominantly casually answered by women, like Natalia (participant 27) did: "Oh, yes please; or the way Lisa (participant 12) consented: "Yes, I suppose so".

Discussion

This media analysis, taken from the documentary series *One born every minute*, showed the portrayal of the elements of shared decision-making. We used Elwyn's three-step Shared decision-making model [15], allowing us to evaluate and understand the portrayal of shared decision-making in intrapartum midwifery care. We believe that the use of an a priori model in constructing our analysis increased the robustness of our analysis [26]. Of the shared decision-making steps, choice talk and decision talk were most often portrayed and did sometimes occur at the same time; not necessarily following on from option talk. Option talk received less attention in the series. The main finding is that midwives in this study did not always follow the stepwise or the linear format presented in Elwyn's model [15]. Instead, they utilised a more fluid transition between the different steps. Although shared-decision was portrayed, it cannot be ignored that we also identified 145 unilateral decision-making fragments. Although the number of shared decision-making fragments outweighed unilateral decision making, it indicates the use of midwife-determined decision-making during intrapartum care [13]. We have to bear in mind that women use childbirth reality television as their source of information and might therefore accept that shared decision-making is not the norm. Shared decision-making is still evolving in the midwifery profession [27,28]. Opposed to our findings, decision-making in the *One born every minute* series televised between 2010 and 2012 was found to be predominantly unilateral and clinician-determined [13]. We, however, observed that the 2015-2017 series included more shared decision-making than unilateral decision-making. This suggests that shared decision-making in midwifery is indeed transforming although this might have been caused by the use of our emancipatory approach of the study. Nevertheless, the series offer the potential to raise woman's awareness of autonomy, participation and self-management of care – thus having an emancipatory effect [20]. We have to consider that our emancipatory perspective might have introduced bias from the outset of the study [20]. For midwifery reflective purposes, it might be beneficial to analyse the unilateral decision-making fragments; in order to reflect on, and learn from these portrayals to improve decision-making practice and to make shared decision-making routine intrapartum practice - facilitating women's autonomy in childbirth. Decision-making processes require midwives' awareness and understanding of their role and responsibilities and their communication skills [28]. Skills and experiences of midwives with shared decision-making seem to vary between midwives [27]. There is also evidence that the degree of involvement in decision-making regarding birth issues varies among women [10]. These factors might have introduced variance in midwives' and women's application of shared decision-making in the televised childbirth series we have analysed.

The series portrayed midwives that build relationships with the women in their care - we identified 227 dialogues. The relationship between the woman and the midwife is the essential element of woman-centred care - the relationship being key for facilitating shared decision-making [29]. The midwives in the series were genuinely interested in the women in their care, they paid attention to women's emotional wellbeing and needs and also put effort in establishing rapport. Midwives' relationship-building exertions might explain women's acceptance of unilateral decision-making and/ or limited representation of deliberation and the informal way of reaching consensus. Being acquainted with a woman, knowing her personal situation, respecting her wishes and thoughts and sharing the dynamics of the birth experience, can create a sense of partnership between the woman and the midwife which might facilitate an obvious decision-making process that than occurs with little need on the equity in decision-making [29,30]. Midwives' efforts to establish a relationship might have facilitated women's feelings of empowerment as illustrated in choice talk in our study - by allowing women to introduce (the timing of) their own decisions. It can be suggested that shared decision-making can only thrive within an interpersonal relationship between woman and midwife [29]. Further exploration for the association between the woman-midwife relationship and shared decision-making might contribute to the understanding and utilisation of decision-making processes in midwifery care.

Theme 1 indicated that women were obviously aware of intrapartum options prior to giving birth, particularly illustrated by participant 8 who presented her birth plan. This suggests that women either had gone through steps of decision-making prior to the event of labour and birth [31]. The fragments did not show evidence of relational continuity, i.e. the same midwife during the continuum of the childbearing period, continuity of information or organisation [32]. We were therefore unable to establish antenatal decision-making elements and if and how these might have preceded or influenced intrapartum decision-making. Partners served as the woman's advocate, as shown in theme 1, acknowledging the role of the partner in providing relational continuity in childbirth decision-making [31]. This emphasises that the midwife needs to involve the partner in the (intrapartum) shared decision-making process [11,28,31], opposed to Elwyn's theory appointing the midwife and the woman as the only stakeholders in the decision-making process [15].

Although *One born every minute* has been criticised for not representing the reality of midwifery practice, including overrepresentation of medicalised birth and the subordinate role of the woman in the childbirth process [1,6-8,12], it might be beneficial for (student) midwives to use the series for educational and professional developmental purposes. It may be of merit to watch the series from the woman's perspective. To look through the woman's eyes and observe and reflect on how midwifery intrapartum care is being portrayed and how interaction, collaboration and liaison between the women and midwives take place. These observations might provide food for thought on how midwives, midwifery care, including shared decision-making and woman-midwife partnership are perceived by women, and if and how midwives feel the need to change this.

Conclusion

Shared decision-making was being portrayed as woman and midwife-initiated, as they both introduced (moments of) choice. The shared decision-making model's steps choice talk and decision talk were most often portrayed while option talk was under utilised. Listing women's options and exploring her preferences, wishes and values and deliberation of women's intrapartum options and choices were insufficiently put into practice. The shared-decision making process was not portrayed as a linear stepwise format. Shared decision-making occurred within the context of the woman-midwife relationship during the intrapartum period, requiring reflection and further attention in practice, education and research. Birth partners should not be disregarded in intrapartum shared decision-making processes.The portrayal of moments including shared-decision making in the *One born every minute* series is increasing.

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